Arizona Small Group Business
Employer Application

FOR GROUP COVERAGE (2 – 50 ELIGIBLE EMPLOYEES)

Life, Accidental Death & Dismemberment, Disability, Aetna Indemnity and Aetna PPO plans are underwritten by Aetna Life Insurance Company. Aetna HMO, Aetna CPOS and Aetna QPOS plans are underwritten by Aetna Health Inc., Aetna Life Insurance Company and/or Corporate Health Insurance Company. Dental plans are underwritten by Aetna Health Inc. and/or Aetna Life Insurance Company.

Company Name (Legal Name)	DBA/Doing Business As (if applicable)		
Street Address (P.O. Box not acceptable)	City	State	Zip
Bill Address (If different than above)	City	State	Zip
Company Contact Person - Title	Phone Number ( )	Fax Number ( )	
E-Mail Address	Federal Tax ID Number	Date Business Established (Mo/Yr):	
Employer Classification ☐ Corporation ☐ Non-Profit ☐ Partnership ☐ Sole Proprietor ☐ Other: SIC Code:			

Medical Coverage Selection

(Please select all plans in which your employees have enrolled.)

- ☐ **HMO $15/$30/$250**
- ☐ **HMO+ (QPOS):**
  - ☐ $10/$20/$0
  - ☐ $15/$30/$250
  - ☐ $20/$40/$500
- ☐ **CPOS:**
  - ☐ $250 90/70
  - ☐ $500 90/70
  - ☐ $250 80/60
  - ☐ $500 80/60
  - ☐ $750 80/60
  - ☐ $1,000 70/50
  - ☐ $1,500 70/50
- ☐ **PPO:**
  - ☐ $500 90/70
  - ☐ $500 80/60
  - ☐ $750 80/60
  - ☐ $1,000 70/50
  - ☐ Basic
- ☐ **PPO – (HSA Compatible):**
  - ☐ HDHP $2,000 100/50
  - ☐ HDHP $2,650 80/50
  - ☐ HDHP $5,100 100/50
- ☐ **Indemnity $500 80%**
- ☐ **Out-of-State PPO:**
  - ☐ $250 ☐ $500 ☐ $1,000

Dental Coverage Selection

Aetna Dental™ Plan

- ☐ Plan Option 1
- ☐ Plan Option 2
- ☐ Plan Option 3
- ☐ Plan Option 4
- ☐ Plan Option 5
- ☐ Out-of-State PPO:
  - ☐ $1,000 ☐ $1,500

Orthodontic coverage for dependent children is included **only** in Plan Options 1, 2, 4 and 5 and **only** to groups with 10 or more eligible employees.

Life, Accidental Death & Dismemberment, & Disability Coverage Selections

Groups with 10 to 50 eligible employees may select one, two or three options for Life, Accidental Death & Dismemberment and Disability. If more than one option is selected, describe each class of employees, indicate the amount selected for each class and attach a list of employee names with each class designation. (Limited to 3 classes. The highest option selected can be no more than 5 times the lowest option.)

	Class 1			Class 2			Class 3		
All Groups	**Life**	**or**	**Life & Disability Packaged Plan**	**Life**	**or**	**Life & Disability Packaged Plan**	**Life**	**or**	**Life & Disability Packaged Plan**
	☐ $10,000 ☐ $15,000 ☐ $20,000 ☐ $50,000		☐ Low ☐ Medium ☐ High	☐ $10,000 ☐ $15,000 ☐ $20,000 ☐ $50,000		☐ Low ☐ Medium ☐ High	☐ $10,000 ☐ $15,000 ☐ $20,000 ☐ $50,000		☐ Low ☐ Medium ☐ High
Additional options for Groups with 10 – 50 eligible employees	☐ $75,000 ☐ $100,000 ☐ $125,000			☐ $75,000 ☐ $100,000 ☐ $125,000			☐ $75,000 ☐ $100,000 ☐ $125,000		
Class Description									
Optional Dependent Term Life (Available only to groups with 10 to 50 eligible employees.) ☐ Yes ☐ No									

Please keep a copy of this application for your records. If the application is accepted by Aetna it becomes part of the issued Group Agreement and/or Group Policy.

Effective Date

Actual effective date will be assigned by the Aetna underwriting department if application is approved.

Requested effective date (may be the 1st or 15th of the month only): ______________________________

Employer Contribution(s)

	Employer's Contribution for Employee Coverage	Employer's Contribution for Dependent Coverage
Medical*	_________%	_________%
Medical*	$________	$________ or ________%
Dental	_________%	_________%
Basic Employee Term Life (including AD&D)	_________%	_________%
Optional Dependent Term Life	N/A	N/A
Life & Disability Packaged Plan	_________%	N/A

* Requires a minimum of 50% per employee per month (employee coverage only -- does not apply to dependent coverage).

Employee Information

Note that Aetna Small Group Underwriting requires all Small Employers to provide documentation verifying the number of eligible employees for the last calendar quarter. Aetna Small Group Underwriting may request documentation for the last 12 months prior to the requested effective date should eligibility be a concern.

Please enter current information regarding your company's eligible and non-eligible employees and COBRA participants.

Work Location (By state)	Total Number of Eligible Employees	Total Number of Non-Eligible Employees	Total Number of Eligible COBRA
Arizona			
Total:			

Total number of employees that are enrolling into an Aetna Medical Product: _________________

Total number of waivers: _______________

Is your group subject to COBRA (20 or more total employees during at least 50% of the working days in the previous calendar year)?
☐ Yes ☐ No

Is your group subject to Medicare as Secondary Payor (20 or more employees for each working day in each of 20 or more calendar weeks in the current calendar year or the preceding calendar year)? ☐ Yes ☐ No

Does the group have a flex plan under Section 125 of the Internal Revenue Service Code? ☐ Yes ☐ No

Depending upon the group's effective date, the eligibility date will be the 1st or 15th day of the month following satisfaction of the waiting period.
Waiting period for employees: ☐ 0 days ☐ 30 days ☐ 60 days ☐ 90 days ☐ 120 days ☐ 150 days ☐ 180 days (Aetna Standard)
☐ If a different waiting period is desired, please indicate: 1st or 15th of the month following _________ days

Employee Eligibility Criteria

Aetna assumes an industry standard Employee Eligibility Criteria definition, which is as follows: An eligible employee works on a permanent basis and who is working a minimum average of 30 hours per week and is actively engaged in the conduct of the business of the small employer, in the small employer's regular place of business, and who has met any authorized waiting period requirements. Part-time (averaged less than 30 hours per week), seasonal, 1099 contractors, retirees, stockholders or substitute employees are not considered eligible employees.

If the company's Employee Eligibility Criteria definition differs from the above definition, please provide the company's definition in the space below or as a separate attachment. Note that final rates may be impacted should Aetna underwriting deem that the company's definition places an increased risk to Aetna.

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Prior Carrier Information

Health:
Will coverage be transferring from another carrier: ☐ Yes ☐ No
If yes, name of the carrier: ______________________ Proposed Termination Date: __________
If prior carrier is Aetna, provide group or control #: ______________ Total Replacement: ☐ Yes ☐ No
Has the group been uninsured for three or more months prior to the requested effective date: ☐ Yes ☐ No

Dental:
Will coverage be transferring from another carrier: ☐ Yes ☐ No
If yes, name of the carrier: ______________________ Proposed Termination Date: __________
If prior carrier is Aetna, provide group or control #: ______________ Total Replacement: ☐ Yes ☐ No
Prior Coverage included coverage for (check all that apply) ☐ Major Services ☐ Orthodontia
Has the group been uninsured for three or more months prior to the requested effective date: ☐ Yes ☐ No

Life and AD&D:
Will coverage be transferring from another carrier: ☐ Yes ☐ No
If yes, name of the carrier: ______________________ Proposed Termination Date: __________
If prior carrier is Aetna, provide group or control #: ______________ Total Replacement: ☐ Yes ☐ No

Disability:
Will coverage be transferring from another carrier: ☐ Yes ☐ No
If yes, name of the carrier: ______________________ Proposed Termination Date: __________
If prior carrier is Aetna, provide group or control #: ______________ Total Replacement: ☐ Yes ☐ No

Workers' Compensation Information

Aetna's coverage is not occupational in nature and, consequently, it is not a substitute for Workers' Compensation coverage.
Name of current Workers' Compensation carrier: ______________________ Renewal Date: __________
Is Workers' Compensation coverage provided on all employees? ☐ Yes ☐ No
If not, please provide a list of all employees enrolling that are NOT covered by Workers' Compensation or similar legislation (including title).

Medical Information

Is any person to be covered unable to work due to illness or injury? ☐ Yes ☐ No
Is any person unable to perform the normal duties of another person in the same employment class of the same age and sex? ☐ Yes ☐ No
If yes is answered to either question, attach a sheet with the names of the individual(s), dates and degree of recovery.

Signature Section

The Applicant agrees that at no time shall any employee be permitted or required to contribute for non-contributory coverage; or, unless the change is approved in writing by an authorized representative of Aetna, to make contributions for contributory coverage at a rate higher than the initial contribution rate applicable for the employee's then current coverage. All statements herein shall be deemed representations and not warranties.

The Applicant acknowledges that it has selected this plan based upon written information provided by Aetna and that no broker, agent or consultant is authorized to modify the terms of the offer or to agree to changes. All material terms of plan coverage are set forth in the plan documents. Applicant agrees to make payroll and other records directly related to employee's coverage under the Group Agreement or Group Policy available to Aetna for inspection, at Aetna's expense, at Applicant's office, during regular business hours, upon reasonable advance request. This provision shall survive termination of the Group Agreement or Group Policy.

Applicant has selected, in accordance with applicable state law, the plan to be offered to Applicant's employees and Applicant has solely determined any/all health plan options for the Applicant's employees and the contribution amounts.

In accordance with current IRS regulations and the 1986 Tax Reform Act, a life insurance position schedule may be deemed discriminatory and result in imputed income tax to certain employees and possibly an excise tax to employers. Employers should consult with legal counsel prior to electing a position schedule. Aetna disclaims any responsibility if the employer elects such a position schedule and it is later deemed discriminatory.

The plan documents will determine the contractual provisions, including procedures, exclusions and limitations relating to the plan and will govern in the event they conflict with any benefits comparison, summary or other description of the plan.

With the exception of Aetna Rx Home Delivery, participating physicians, hospitals and other health care providers are independent contractors and are neither agents nor employees of Aetna. Aetna Rx Home Delivery, LLC, is a subsidiary of Aetna Inc.

Applicant agrees to deliver, or otherwise make available to enrollees, all Aetna paper or online member documents and other plan-related materials upon request by Aetna.

I understand that if it is determined that I have committed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact, my company's group health coverage may be terminated or my company may be charged a different premium for this coverage.

All data that may have a bearing on coverage or premiums will be open for Aetna to inspect while the Group Agreement or Group Policy is in force.

The availability of a plan or program may vary by geographic service area. Some benefits are subject to limitations or maximums.

Aetna does not provide health or dental care services and, therefore, cannot guarantee any results or outcome.

This information, as well as other personal and privileged information, subsequently collected by the insurance institution or agent may, in certain circumstances, be disclosed to third parties without authorization.

A right of access and correction exists with respect to all personal information collected.

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Signature Section (continued)

Further disclosures required by Arizona law will be furnished to the policyholder upon request.

Personal information may be collected from persons other than the individual or individuals proposed for coverage.

I hereby apply for the coverage(s) indicated above. I certify that all information provided in this application is accurate and complete.

I understand that this application will form a part of the Group Agreement or Group Policy issued by Aetna (a sample of which may be available on request), and by my signature below I agree to be bound by the terms and conditions of that Group Agreement or Group Policy. I understand that Aetna may choose not to accept this application consistent with provision of Arizona law.

JOINDER AGREEMENT - REQUEST FOR PARTICIPATION (For life, disability, accidental death and dismemberment, out-of-state medical and out-of-state dental employee benefits): The undersigned employer agrees to the establishment of an insurance trust fund ("Fund") for the purposes of implementing a Trust Agreement ("Agreement"), and to the designation of the Chase Manhattan Bank Delaware, Wilmington, DE, as "Trustee" for the Fund and Agreement. The undersigned, as a Participating Employer in the Industry Trust corresponding to the standard industry classification ("SIC") code selected above: 1) agrees to be bound by the terms of the Agreement and the policy issued to the Trustee (including any amendments); 2) requests coverage for its eligible employees under the policy (subject to applicable underwriting requirements) as of the effective date requested or as of the date of approval of the Employer for participation under the Agreement, whichever is later, and continue as long as the Employer remains actively in business; and 3) agrees to make the required contributions to the Fund; in the event of default, it will be liable to the insurer for such unpaid contributions for the coverage period, and such insurer will terminate coverage. The insurer may also terminate coverage as of the date the group fails to meet minimum underwriting requirements in effect on that date. In addition, the Participating Employer, in accordance with ERISA Title I Section 503, designates Aetna Life Insurance Company ("Aetna") as the Named Fiduciary under the Plan, with complete and discretionary authority to review all denied claims for benefits under the Plan, and to construe disputed/doubtful Plan terms. Aetna shall be deemed to have properly exercised such authority unless it has abused its discretion by acting arbitrarily and capriciously.

Signed at (Location): ______________________ (City, State) ______________________ (Applicant (Company Name))

By: ______________________ (Authorized Applicant Signature) ______________________ (Official Title)

______________________ (Date)

Agent/Broker Certification

I hereby certify that I am not aware of any information not disclosed in this application by the client which may have bearing on this risk, including my knowledge that replacement life insurance is ☐ is not ☐ (check one) a part of this transaction.

I hereby certify that I have advised the client not to terminate any existing coverage until receiving written notice from Aetna that the coverage being applied for by this application is accepted.

Agent/Broker Name: ______________________ Aetna Agent Number/Tax ID/SSN: ______________________

Agency Name: ______________________ % of Credit: ______________________

Phone Number: (______) ______________________ Fax Number: (______) ______________________

Address: ______________________ City: ______________________ State: ________ Zip: ________

Signature: ______________________ Date: ____________ E-Mail Address: ______________________

Agent/Broker Name: ______________________ Aetna Agent Number/Tax ID/SSN: ______________________

Agency Name: ______________________ % of Credit: ______________________

Phone Number: (______) ______________________ Fax Number: (______) ______________________

Address: ______________________ City: ______________________ State: ________ Zip: ________

Signature: ______________________ Date: ____________ E-Mail Address: ______________________

General Agent Name: ______________________ Aetna Agent Number/ID Number: ______________________

Phone Number: (______) ______________________ Fax Number: (______) ______________________

Address: ______________________ City: ______________________ State: ________ Zip: ________

Signature: ______________________ Date: ____________ E-Mail Address: ______________________

For Aetna Use Only

Group Number ____________ Control Number ____________ SCD ____________ Effective Date ____________

Is Agent/Agency licensed and appointed? ☐ Yes ☐ No Appointment Expiration Date ______________________