California Small Group Business
Employer Application

FOR GROUP COVERAGE (2 - 50 ELIGIBLE EMPLOYEES)

Life, Accidental Death & Dismemberment, Aetna PPO Plan and Aetna EPO Plan are underwritten by Aetna Life Insurance Company of Hartford, Connecticut. Aetna HMO Plan is underwritten by Aetna Health of California Inc. Dental plans are provided by Aetna Dental of California Inc. and Aetna Life Insurance Company of Hartford, Connecticut.

1. Employer Information

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:

Has the company entered above been insured by Aetna within the last 12 months? ☐ Yes ☐ No
If yes, please provide prior group number and termination date. ____________________

2. Medical Coverage Selection

Aetna Options (check all that apply below)

- ☐ **HMO:**
  - ☐ **$10/$10** ☐ **$15/$15** ☐ **$10/$30** ☐ **$20/$40** ☐ **$30/$40**
- ☐ **EPO**
- ☐ **MC:**
  - ☐ **$0 90/70** ☐ **$250 80/60** ☐ **$500 70/50** ☐ **Basic**
  - ☐ **$0 90/60** ☐ **$500 80/60** ☐ **$1,000 80/50**
  - ☐ **MC HDHP $2,100 100/50 (HSA Compatible)**
  - ☐ **MC HDHP $3,000 90/50 (HSA Compatible)**
  - ☐ **MC HDHP $5,000 100/50 (HSA Compatible)**
- ☐ **PPO:**
  - ☐ **$250 90/70** ☐ **$500 80/60**
- ☐ **Aetna Indemnity Plan**
- ☐ **Out-of-State PPO (choose one):**
  - ☐ **$250** ☐ **$500** ☐ **$1,000** ☐ **Traditional Choice**

3. Dental Coverage Selection

Aetna Dental™ Plan

☐ Single or ☐ Dual Option

☐ DMO 1	☐ PPO 1
☐ DMO 2	☐ PPO 2
☐ Freedom-of-Choice 1	☐ PPO 3
☐ Freedom-of-Choice 2	☐ PPO 4

☐ Out-of-State PPO Plan:
☐ 1000 ☐ 1500 ☐ 2000

Orthodontia coverage is included in all Plan Options for groups with 10 or more eligible employees only.

4. Life and Accidental Death & Dismemberment Coverage Selection

Groups with 10 to 50 eligible employees may select one, two or three options for Life, Accidental Death & Dismemberment. 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
	Life	**Life**	**Life**
All Groups	☐ $10,000 ☐ $15,000 ☐ $20,000 ☐ $50,000	☐ $10,000 ☐ $15,000 ☐ $20,000 ☐ $50,000	☐ $10,000 ☐ $15,000 ☐ $20,000 ☐ $50,000
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.

5. 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): ____________________

6. 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

* Requires a minimum of 50% per employee per month (employee coverage only -- does not apply to dependent coverage).
** Only available to groups requesting Multi-Option-Requires a minimum of $80.00 per employee per month or the actual cost of the plans (whichever is less)

7. Employer Eligibility Information

In the chart below, please enter the total number of employees who were eligible to enroll for medical coverage for the last 4 calendar quarters. Please 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

	1st Prior Quarter	2nd Prior Quarter	3rd Prior Quarter	4th Prior Quarter
Total number of Eligible Employees				

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

Work Location (By state)	Total* Number of Eligible Employees	Total Number of Non-eligible Employees	Total Number of Eligible COBRA or Cal-COBRA	Total Number of COBRA or Cal-COBRA not yet electing coverage
California				
Total:				

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

Total number of medical 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) or CAL-COBRA (less than 20 total employees during at least 50% of the working days in the previous calendar year or previous calendar quarter)? ☐ COBRA ☐ CAL-COBRA

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

Does the group allow permanent employees** who work 20-29 hours/week to be eligible for coverage? ☐ Yes ☐ No

Does the group allow Domestic Partners to be eligible for coverage? ☐ Yes ☐ No

Are there excluded classes of employees (i.e., Management/Non-management, Union/Non-union, Salary/Hourly): ☐ Yes ☐ No

If Yes, describe the excluded class(es): ____________________

Please list, if any, other medical carriers that will be offered alongside with Aetna's medical coverage. Also identify how many employees are enrolling with the other medical carrier:

Carrier 1: ____________ Enrolled: ________; Carrier 2: ____________ Enrolled: ________

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 ☐ 180 days

* Small employer eligibility will be determined based upon Total Eligible Employees listed here unless a signed and notarized affidavit is submitted along with this Verification Form attesting that you employed an average of 2 – 50 employees on 50% of your business days during the last calendar quarter or calendar year.
** Sum of Full Time employees listed for each work location must equal Total number of employees eligible for health benefits. Permanent employees who work at least 20 hours and meet criteria of *California Health and Safety* Codes Section 1357*(b)*(1) and Section 10700 may be considered "Full Time employees."

8. 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

9. 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).

10. 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.

11. 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.

It is agreed that no coverage shall become effective as to any person who is not then a bona fide, permanent full-time employee (working 30 hours per week or more), or a permanent employee (working 20-29 hours per week, if coverage is offered).

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.

Participating physicians, hospitals and other health care providers are independent contractors and are neither agents nor employees of Aetna.

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.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information

concerning any fact material thereto may have violated state law.

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.

(continued on back cover)

11. Signature Section *(Continued)*

I hereby apply for the coverage(s) indicated above. I affirm that all information provided in this application is accurate and complete to the best of my knowledge or belief. 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 at its sole discretion.

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.

CALIFORNIA HMO APPLICANTS — NOTICE OF BINDING ARBITRATION — Any dispute arising from or related to the Group Agreement will be determined by submission to binding arbitration, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. The agreement to arbitrate includes, but is not limited to, disputes involving alleged professional liability or medical malpractice, that is, whether any medical services covered by the Group Agreement were unnecessary or were unauthorized or were improperly, negligently or incompetently rendered.

This agreement also limits certain remedies and may limit the award of punitive damages. See Sections "Binding Arbitration" and "Limitations on Remedies" of the Evidence of Coverage for further Information.

The undersigned representative of the Employer understands that the Employer and any Groups eligible through the Employer, if different from the Employer, and any Members who enroll under this health plan are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of binding arbitration. This means that the Employer, Groups, Members and other interested parties will not be able to try their case in court. The undersigned representative of the Employer further understands and accepts that the Employer, Groups and Members are giving up certain remedies and there may be certain limitations to the recovery of punitive damages.

Signed at (Location): ______________________________ ______________________________

City, State — Applicant (Company Name)

By: ______________________________ ______________________________

Authorized Applicant Signature — Official Title

____

Date

12. 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.

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: ______________

13. Administration Kits

Send Administration Kits to: ☐ Group ☐ Agent/Broker ☐ General Agent

14. For Aetna Use Only

Group Number ____________ Control Number ____________ SCD ____________ Effective Date ____________