aetna®

Employer Application

Small Group Aetna Funding Advantage

Company name (Legal name) (the "Applicant", "we" or "our")	Doing business as (if applicable)		
Street address (PO box not acceptable)	City	State	ZIP code
Billing address (if different than above)	City	State	ZIP code
Telephone number ( )	Fax number ( )		
Company contact name	Company contact email		
Billing contact name (if different from company contact)	Billing contact email		
Enrollment contact name (if different from company contact)	Enrollment contact email		
Nature of business / SIC code	Federal tax ID number	Date business established (Month/Year)	

Employer classification ☐ Corporation ☐ Nonprofit ☐ Partnership ☐ Sole proprietor ☐ LLC ☐ LLP
☐ Other: _____

Plan selection and requested effective date (Plan availability is dependent upon the group's size.)

☐ Plan option 1 _____ ☐ Plan option 2 _____ ☐ Plan option 3 _____ ☐ Plan option 4 _____

We or any third party on our behalf fund or subsidize a portion of the employee's cost sharing responsibilities (deductibles, coinsurance or copays) under the health plan. ☐ Yes ☐ No If **yes**, how much? _____ %

We request that coverage be effective on _____ (must be the first day of a month). The actual effective date will be assigned by Aetna if this application is accepted. Do not cancel your current coverage until you receive written confirmation from Aetna that it accepted your application.

Applicant signature and agreement to Master Services Agreement

We hereby apply to Aetna to administer the plan(s) indicated above for our employees. Aetna may choose not to accept this application. If accepted, Aetna will issue a Master Services Agreement (MSA) to us. This application, including all of the information and terms on the following pages, will be incorporated into the MSA. Our signature below will constitute our acceptance of the MSA and we agree to be bound by all of its terms and conditions.

We certify that all of the information we've provided in this application is accurate and complete to the best of our knowledge and belief. We agree to provide Aetna with copies, records and other information it requests to verify information provided or administer the plans. We also agree to provide, at Aetna's reasonable request, access to our payroll and other employee information relevant to plan administration and / or eligibility determination.

We designate the Aetna affiliate identified in the MSA (the "Aetna Administrator") as the Named Fiduciary of the plans, with complete authority to review all denied claims for benefits (including but not limited to denial of certification of the medical necessity of any treatment). In exercising its fiduciary responsibility, the Aetna Administrator will have discretionary authority to determine whether and to what extent plan participants and beneficiaries are entitled to benefits and to construe disputed or ambiguous plan terms. The Aetna Administrator will be deemed to have properly exercised its authority unless it is determined to have acted arbitrarily or capriciously.

We agree not to make any changes in employee contribution requirements for plan coverage without Aetna's prior written agreement. We also agree that no coverage will be provided for any individual who is not a bona fide eligible employee performing the duties of his or her occupation or a bona fide eligible dependent of such an employee.

Signed at (location) city, state	Applicant (company name)	
Authorized applicant signature	Official title	
Print name of authorized applicant		Date

Benefit waiting period (BWP)

We wish to waive the benefit waiting period for all current employees enrolling with the company as of the initial contract effective date only.	☐ Yes ☐ No

Waiting period for future employees: ☐ first of the month following 0 days ☐ first of the month following 30 days ☐ first of the month following 60 days ☐ exactly 90 days

If "exactly 90 days" is selected, the enrollment eligibility date will begin 90 calendar days following the date of hire.

If "0" days is selected and the employee is hired on the first of the month, the effective date will be the date of hire.

Employer contribution(s)

Employer contribution for employee		Employer contribution for dependent	

Employee Information

Number of full time eligible	Number of part time	Number of COBRA	Number of union

Normal work week a full-time employee is required to work to be eligible for coverage. _____ hours a week	
Total number of employees in benefit waiting period and not eligible	
Classes excluded: ☐ None ☐ Union – Local # _____	Domestic partners: ☐ Same sex ☐ Opposite sex ☐ None

Full time equivalents for the prior calendar year – only complete if domiciled in Colorado, Connecticut, Maryland, New Jersey or North Carolina.

A. Number of full-time employees working on average 30 hours or more a week (or 130 hours a month) for more than 120 days a year (even if they are not eligible or enrolling for health coverage).	
B. Number of part-time employees, who worked on average less than 30 hours a week, but more than 120 days a year. (Add up the total number of hours worked in a week by part-time employees and divide by 30.) Example: 10 employees working 20 hours a week: 200 ÷ 30 = 6.66 = 6 (rounding down to the nearest whole number)	
C. Total number of FTEs = A + B.	

Average total number of employees –only complete if domiciled in Wisconsin

To calculate the average total number of employees, determine the number of employees for each month, add each month's number to get an annual total, and then divide by 12. Round up or down to the nearest whole number. For example: 24.6 = 25.

What is the average number of employees employed for the entire previous calendar year regardless of whether or not they were eligible for coverage? An employee is defined as any person for whom the company issues a W-2, including full time, part time, temporary, seasonal, salaried, and hourly workers. For newly formed business, calculate the prior year average using only those months the group was in business; or use reasonable expected total employees if the group was not in business the prior year. The determination of how to count employees of related corporate entities when calculating group size is based on whether the entities are considered a single employer under Section 414 of the Internal Revenue Code (subsection (b), (c), (m) or (o)) and is not based on the multiple tax ID status of the related entities.	

Business eligibility

Our company is a subsidiary, affiliate, or under common control of another company.	☐ Yes ☐ No
Our company files or is eligible to file state or federal taxes with another company(ies) on a combined or consolidated basis.	☐ Yes ☐ No
There are other entities associated with the group that are eligible to file a combined tax return under section 414 of the Internal Revenue Code.	☐ Yes ☐ No
There are associated companies to be included with this group that are commonly owned.	☐ Yes ☐ No

If **yes** to any question above, provide the following information:

- A copy of the Quarterly Wage and Tax Statement and most current ownership tax documents (i.e., Schedule C, Schedule K-1, etc.) must be provided for each group to be included for coverage.
- If you file or are eligible to file multiple businesses under one tax ID number, all businesses must be included as one group.

Our company is ERISA qualified.	☐ Yes ☐ No

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Business eligibility *(Continued)*

Business name (Indicate all groups including the company the groups are being written under)	Tax identification number	Address	Owner's name(s)	Percentage of ownership	Number of employees	Is group to be included
						☐ Yes ☐ No
						☐ Yes ☐ No
						☐ Yes ☐ No
						☐ Yes ☐ No
						☐ Yes ☐ No

If we have answered **no** to "Is the group to be included" above, the reason is provided here:

Our company is a branch of another company or our company has branch offices.		☐ Yes ☐ No
If yes	Is each branch office a separate legal entity?	☐ Yes ☐ No
	Is each branch a location of one legal entity?	☐ Yes ☐ No
	How many branch offices are there?	
	Are taxes filed separately or as one common filing?	☐ Separately ☐ One common filing
	Where is each branch located? (List each branch business address separately.)	Number of employees at each location
We use the services of a payroll company. If we have answered **yes**, the name of the payroll company is provided here:		☐ Yes ☐ No
We are a professional employer organization (PEO).		☐ Yes ☐ No
If yes	We offer health coverage to our clients under our PEO plan.	☐ Yes ☐ No
	Our clients are enrolling under this health plan.	☐ Yes ☐ No
	We are only covering the administrative staff of the PEO.	☐ Yes ☐ No
We are currently a client of a professional employer organization (PEO). If we have answered **yes**, the name of the PEO is provided here:		☐ Yes ☐ No

Medicare

Our company is Medicare primary (employed less than 20 employees for 20 consecutive weeks in the current or prior year) or group health plan primary (employed 20 or more employees for 20 consecutive weeks in the current or prior year). **Include**: Full time, part time, seasonal, temporary, union, owners, partners, officers **Exclude**: Self-employed persons, independent contractors (1099), directors, leased employees	☐ Medicare primary ☐ Group health plan primary
The number of full-time and part-time employees we have employed for 20 or more weeks during this calendar year or prior calendar year	

COBRA

The following is a list of **all** individuals we presently cover under COBRA (former employees and / or dependents must be included). Attach a separate sheet if needed. Aetna needs this information to determine how long each of those members will continue to have COBRA coverage. We understand that we and Aetna have obligations to notify and terminate continuation coverage in accordance with COBRA regulations.

Name of applicant	Qualifying event (e.g., termination of employment, divorce, etc.)	Date of qualifying event	Date COBRA coverage terminates

Prior carrier information – Submit a copy of the current carrier bill with employee roster if replacing an existing medical plan.

Carrier name	Start date	End date
Our business has been insured or administered with Aetna previously. If **yes**, provide group number: _____		☐ Yes ☐ No
Is this plan a total replacement of any existing group medical plans?		☐ Yes ☐ No

Subrogation information

Aetna contracts with a national supplier of third-party recovery services to perform subrogation / reimbursement services.

The national supplier offers access to quarterly subrogation reports which may be viewed or printed from their client reporting website.

Our company wants to access the quarterly subrogation reports. ☐ Yes ☐ No

*If we have answered **yes**:*

These reports contain protected health information (PHI) under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). To provide access to a contact for these reports containing PHI, print *all* information below. The designated contact will receive an email with the login credentials and detailed instructions on how to use the website.

Contact requesting access: _____ Email: _____

Recovery fees

Our company is self-funded for workers' compensation.	☐ Yes ☐ No
Does the company have any other governing plan documents (i.e., master plan document or wrap document)?	☐ Yes ☐ No
Confirm recovery services for workers' compensation matters involving employees will be provided, subject to the subrogation service fee in the Master Services Agreement (MSA). Workers compensation matters will be pursued when Aetna is the stop loss carrier and has paid claims as part of the stop loss policy.	☐ Yes ☐ No

Aetna Funding Advantage and Aetna Health Information Advantage (AHIA) reporting

(AHIA reporting is only available to groups of five or more enrolled employees.)

We authorize Aetna to provide access to our information, which may include protected health information (PHI), to the broker / general agent designated contact listed below through the software (including any other information and documentation) developed by or on behalf of Aetna or its affiliates and licensed to broker / general agent designated contact ("licensed software"). We represent that we have entered into a Business Associate Agreement with the broker / general agent in accordance with applicable HIPAA requirements. Access is granted for the purpose of providing consulting and / or broker services. Broker's / general agent's access to the licensed software and any data accessed through the licensed software shall be limited to such uses directly related to the provision of such consulting and / or broker services. If at any time the broker / general agent ceases providing such services to us for any reason, we will immediately notify Aetna and acknowledge that the broker's / general agent's access to our information shall be terminated immediately. We acknowledge that any continued access due to our failure to notify Aetna is solely our responsibility.

Company contact name	
Mailing address	Contact email
Telephone number	Date of birth (mmddyyyy)

Company contact 2 name	
Mailing address	Contact 2 email
Telephone number	Date of birth (mmddyyyy)

Broker contact name	
Mailing address	Broker email
Telephone number	Date of birth (mmddyyyy)

General agent contact name	
Mailing address	General agent email
Telephone number	Date of birth (mmddyyyy)

Additional understandings

Electronic enrollment and billing

In connection with the proposed coverage, we agree:

1. To keep copies (paper or electronic) of actual enrollment forms and agree to maintain a complete record of enrollment and eligibility information (via electronic, interactive voice response technology and / or hard copy format), including evidence of coverage elections, evidence of eligibility, changes to such elections and terminations. We will make records available to Aetna upon request and retain for seven years.

Continued on next page

Additional understandings *(Continued)*

2. To create and maintain the records on secure information systems that can generate hard copy records of enrollments or changes entered or maintained on those information systems. Any hard copy records generated pursuant to this provision will meet reasonable standards of availability, authenticity, non-repudiation and integrity.
3. That all enrollment and eligibility information presented to Aetna is accurate and timely updated. We acknowledge that Aetna can and will rely on this enrollment and eligibility information in determining whether an individual is eligible for benefits under the plan. In the event of a discrepancy between enrollee information submitted and information actually presented by the enrollee on any particular claim for benefits, and the result is that Aetna must pay a higher benefit to reflect the actual information presented by the enrollee, we agree to pay promptly to Aetna applicable back premiums accruing as of the date on which the enrollee's information changed.
4. That we are responsible for adhering to all applicable laws and regulations when submitting terminations to Aetna.
5. That if we submit a retroactive termination request to Aetna, no premium / or contribution will have been paid by the member / dependent for that period.
6. To receive Aetna's bill online each month.

Electronic communications

We authorize Aetna to send communications electronically to individuals enrolled in our plan. We represent that our employees have access to email where they work. We will use our best efforts to assure that our plan participants agree to terms associated with the issuance and use of their password and system access.

Compliance with laws

We will comply with all laws and regulations regarding our employee benefit plans and will use our best efforts to assist Aetna in complying with those laws and regulations as they apply to the plans. Specifically, we agree to provide Aetna timely eligibility and effective date information regarding plan participants that take into account the eligibility conditions, non-discrimination rules and waiting period requirements provided under federal law. In the event this information changes, we will inform Aetna immediately.

Broker certification

I hereby certify that: 1) any information I am aware of that may have bearing on this risk has been disclosed in this application by the applicant, 2) I will advise Aetna immediately if I become aware of new information of this nature not previously disclosed, 3) I have explained the details of the coverage applied for to the applicant and have complied with underwriting rules and regulations applicable to the product, and, 4) that I have advised the applicant not to terminate any existing coverage until receiving written notice from Aetna that the coverage being applied for by this application is accepted.

TPA – vendor name _____

Broker name			National producer number
Agency name			Tax ID number
Address			Pay fees to (check one) ☐ Broker ☐ Agency
City			Telephone number
State	ZIP	% of credit	Fax number
Signature			Date
Broker admin assistant name			Broker email
Admin email			
Broker name			National producer number
Agency name			Tax ID number
Address			Pay fees to (check one) ☐ Broker ☐ Agency
City			Telephone number
State	ZIP	% of credit	Fax number
Signature			Date
Broker admin assistant name			Broker email
Admin email			
General agent name			Tax ID number
Selling agent name			Email address
Address			Telephone number
City	State	ZIP	Fax number
GA admin assistant name			General agent email
Admin email			