aetna®

Nevada
Employer Application

FOR GROUP COVERAGE (51 – 100 EMPLOYEES)

Aetna Vision℠ Preferred plans, Aetna Open Access® Managed Choice (OAMC) plans and Aetna Indemnity plans are underwritten by Aetna Life Insurance Company. Aetna Whole Health (AWH) Las Vegas HMO plans and Aetna HNOption plans are underwritten by Aetna Health Inc. and Aetna Health Insurance Company. Dental plans are underwritten by Aetna Life Insurance Company. For Vision coverage, certain claims administration services are provided by First American Administrators, Inc. and certain network administration services are provided through EyeMed Vision Care LLC ("EyeMed").

IMPORTANT FOR INTERNAL PROCESSING: Check applicable box if submitting through:

Private exchange: ☐ Digital ☐ Fidelity ☐ Liazon Benefits ☐ MBA-Buck Private Exchange ☐ Member Benefits Inc.
☐ Other: _____

Third party administrator: ☐ Bankers Cooperative Group ☐ Benefitmall ☐ Crawford Advisors ☐ GBS ☐ Kelly
☐ Paychex ☐ PPI ☐ CoBiz ☐ Other: _____

☐ **Not applicable to this group**

Company name (Legal name)	Doing business as (if applicable)		
Street address (PO box not acceptable)	City	State	ZIP code
Billing address (if different from above)	City	State	ZIP code
Phone number ( )	Fax number ( )		
Are there additional addresses or locations for this business? ☐ Yes ☐ No If **yes**, provide all addresses and locations.			

Company contact – Name and title		Company contact email	
Billing contact name (if different from company contact) *Online statements available. Activate access to your eBusiness account at* ***www.aetna.com/employersregister*** *when you get your approval letter.*		Billing contact email	
Enrollment contact name (if different from company contact)		Enrollment contact email	
SIC code	Nature of business	Federal tax ID number	Date business established (Month/Year):
Employer classification ☐ S Corp ☐ C Corp ☐ Nonprofit ☐ Partnership ☐ Sole proprietor ☐ LLP ☐ LLC ☐ Other: _____			

Effective date of group plan – The actual effective date will be assigned by the Aetna underwriting department.

Requested effective date (may be the first or fifteenth of the month only): _____

Medical coverage selection

☐ **Open Access® Managed Choice (OAMC)** – Plan option _____
☐ **Aetna Whole Health (AWH) Las Vegas HMO** – Plan option _____
☐ **Aetna HNOption** – Plan option _____
☐ **Indemnity** (only available if PPO networks are not available) – Plan option _____

Do you, or any third party on your behalf, in any way fund or subsidize any portion of the member's cost sharing responsibilities (deductibles, coinsurance or copays) under a high deductible health plan (HSA or HRA)? ☐ Yes ☐ No If **yes**, how much? _____

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

Dental coverage selection

Non-voluntary plan – Plan option name _____ Option number _____

Voluntary plan – Plan option name _____ Option number _____

All dental plans are available standalone or in addition to other Aetna coverage selections.

Vision coverage selection

Aetna Vision℠ Preferred – Plan option name _____

All vision plans are available standalone or in addition to other Aetna coverage selections.

Life, STD and LTD plans - for quote requests or questions send to: **51-100Groupinsurancesmallgroup@aetna.com**

Business eligibility

Is your company a subsidiary of another company, an affiliate of another company, or under common control with another company? The Health Insurance Portability and Accountability Act of 1996 (HIPAA) states that all persons treated as a single employer under subsection (b), (c), (m), or (o) of section 414 of the Internal Revenue Code of 1986 shall be treated as one employer.	☐ Yes ☐ No
Does your company file state or federal taxes with another company or other companies on a combined or consolidated basis?	☐ Yes ☐ No
Are there any associated companies to be included with this group that are commonly owned?	☐ Yes ☐ No
Are multiple companies or multiple addresses to be included under this plan?	☐ Yes ☐ No

If you answered **yes** to any of these questions, complete the information below.

- A copy of the Quarterly Wage and Tax Statement 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.

Business names of ALL groups including the company the groups are being written under	Tax identification number	Owner's name	Percentage of ownership	Number of employees	Is group to be included?
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No

If you have answered **no** to "Is the group to be included" above, explain why.

Does your company have branch offices? Is your office a branch location?		☐ 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
Do you use the services of a payroll company?		☐ Yes ☐ No
If yes	- Provide the name of the payroll company:	
	- Is group health coverage available to you as a client of the payroll company?	☐ Yes ☐ No

Continued on next page

Business eligibility *(Continued)*

Are you a professional employer organization (PEO)?		☐ Yes ☐ No
If yes	- Is this an Aetna PEO? Aetna group #: _____	☐ Yes ☐ No
	- Do you offer health coverage to your clients under your PEO plan?	☐ Yes ☐ No
	- Are any of your clients enrolling under this health plan?	☐ Yes ☐ No
	- Are you only covering the administrative staff of the PEO?	☐ Yes ☐ No
Are you currently a client of a professional employer organization (PEO)?		☐ Yes ☐ No
If yes	- Provide the name of the PEO:	
	- Is group health coverage available to you as a client of the PEO? - If **no**, provide a letter from the PEO indicating health coverage is not offered to any employer groups. - If **yes**, you are not eligible for small group coverage.	☐ Yes ☐ No

Participation

How many hours a week must your employees work to be eligible for coverage?			
Number of employees eligible for coverage (employees working the minimum hours to be eligible for coverage)			
Number of employees enrolling		Number of employees waiving Aetna coverage	
Number of full-time employees excluding union employees		Number of employees working outside Nevada List all states _____	
Number of part-time employees		Number of employees not actively at work	
Number of 1099 employees		Number of COBRA continuees	
Number of union employees		Number of employees in waiting period and not eligible	
Excluded classes: ☐ Union – Local number: _____			
Do you want to cover domestic partners as eligible dependents? ☐ Yes ☐ No If **yes**, coverage will include same and opposite sex partners. Please notify Aetna in writing if you intend to have coverage apply differently.			

Total average number of employees

You MUST supply this number: To calculate average 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. Do not spell out the number. For example: write 3, not three.

What is the average number of employees you 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, and seasonal workers, and regardless of insurance eligibility. The determination of how to count employees of related corporate entities when calculating group size for medical loss ratio (MLR) purposes 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.	

Medicare primary versus secondary

How many full-time and part-time employees have you employed for at least 20 or more weeks during the current or prior calendar year? *Include: Full time, part time, seasonal, temporary, union, owners, partners, officers* *Exclude: Self-employed persons, independent contractors (1099), directors* If you employed fewer than 20 employees for 20 weeks in the current or prior year, your group is Medicare primary. If you employed 20 or more employees for 20 weeks in the current or prior year, your group is Aetna primary.	

COBRA / TEFRA / DEFRA

Is your employer group required to comply with COBRA?	☐ Yes ☐ No
How many full- and part-time employees did you employ 50 percent of the business days in the prior calendar year? *Include: Full time, part time, seasonal, temporary, union, owners, partners, officers* *Exclude: Self-employed persons, independent contractors (1099), directors* Each part-time employee counts as a fraction of an employee, with the fraction equal to the number of hours that the part-time employee worked divided by the hours an employee must work to be considered full time.	
Eligible: How many present or former employees / dependents are eligible to elect COBRA? These present or former employees / dependents must be listed below. Attach a separate sheet, if needed.	
Enrolled: How many present or former employees / dependents are enrolled in COBRA? These present or former employees / dependents must be listed below. Attach a separate sheet, if needed. Any individuals eligible for COBRA who are still within their election period, but have not enrolled, and enroll in the future retroactive to the group effective date, will constitute a change in census, and your company's health benefits plan may be charged a different premium for this coverage.	

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

Benefit waiting period

The eligibility date will be the first day of the policy month after the waiting period for 0, 30 or 60 days. Policy month refers to the contract effective date of the first or fifteenth day of the month

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

If the group has a fifteenth day of the month bill cycle, the new hire will be effective on the fifteenth day of the month after the waiting period chosen, except exactly 90 days after date of hire.

Do you want to waive the waiting period for present employees enrolling with the group (even those who have not met the full waiting period)?	☐ Yes ☐ No
Benefit waiting period for future employees: First day of policy month following:	☐ 0 days - A date of hire effective date is not allowed. ☐ 30 days ☐ 60 days
Is a dual waiting period offered? If **yes**, provide the two classes of employees below:	☐ Yes ☐ No

Class 1 name _____ Class 1 waiting period _____

Class 2 name _____ Class 2 waiting period _____

Employer premium contribution(s)

Employer premium contribution for employee	Medical $ _____ or _____ %	Dental _____ %
Employer premium contribution for dependent	Medical $ _____ or _____ %	Dental _____ %

Prior carrier information

Is this plan a total replacement for any existing group plans?	Carrier name	Phone number	Start date	End date
Current medical carrier ☐ Yes ☐ No				
Current dental carrier ☐ Yes ☐ No				

My current group dental plan has the following (Check all that apply):

☐ Discount dental ☐ Preventive only ☐ Preventive and basic ☐ Major services ☐ Orthodontia – Ortho max $ _____

Be sure to submit a copy of the most recent dental benefit summary to receive credit for major and ortho coverage.

Has your business ever been insured with Aetna? If **yes**, provide group number: _____ ☐ Yes ☐ No

Workers' compensation / disability / leave of absence

Do you provide workers' compensation coverage?	☐ Yes ☐ No
Is any person currently receiving workers' compensation benefits?	☐ Yes ☐ No
Is any person to be covered unable to work due to illness or injury?	☐ Yes ☐ No
Is any person currently on leave of absence?	☐ Yes ☐ No

Name	Start date	Expected date of return	Details

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 plan coverage 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 plan coverage and the applicable plan documents.

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 plan options for the Applicant's employees and the contribution amounts.

Information on agent's compensation is available from your agent or at Aetna.com.

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® and Aetna Specialty Pharmacy®, participating physicians, hospitals and other health care providers are independent contractors and are neither agents nor employees of Aetna. Aetna Rx Home Delivery, LLC, and Aetna Specialty Pharmacy, LLC, are subsidiaries 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, dental or vision 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.

Further disclosures required by **Nevada** 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 **Nevada** law.

I understand that Aetna will rely on the information I provide in determining eligibility for coverage, setting premium rates, compliance with applicable laws, and other purposes, and that any material misrepresentation or fraudulent statement may result in rescission of coverage under the group policy, rescission of the group policy, termination of coverage, increase in premiums, or other consequences. Aetna reserves the right to audit and to request documentation as evidence of business activity at any time and from time to time in order to validate my compliance with eligibility and underwriting guidelines as well as validate the applicability of State and Federal laws. I understand that my failure to comply with any such request may also result in termination of coverage, increase in premiums, or other consequences.

Continued on next page

Signature section *(Continued)*

ELECTRONIC ENROLLMENT, BILLING, PAYMENT AND ACCESS AGREEMENT

Enrollment: As part of your participation date, the following terms and conditions apply:

1. You agree to keep copies (paper or electronic) of actual enrollment forms and agree to maintain a reasonably 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. Records must be available to Aetna upon request and retained for seven years.
2. For electronic enrollment submissions or changes you agree 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 shall meet reasonable standards of availability, authenticity, non-repudiation and integrity.
3. You represent that all enrollment and eligibility information presented to Aetna is accurate and timely updated. You acknowledge that Aetna can and will rely on such 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 (including salary data) 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, you agree to pay promptly to Aetna applicable back premiums accruing as of the date on which the enrollee's information changed.
4. Insured plans must either (1) use Aetna-supplied forms in paper format or electronic format or (2) agree to incorporate the following four points into your enrollment materials.
   a. Names(s) of the Aetna company offering the insurance coverage
   b. State-specific fraud warning statement
   c. A statement that the terms of the insurance documents will govern the member's rights and responsibilities
   d. An acknowledgment that participating providers are not agents or employees of Aetna and that network composition can change.
5. You are responsible for adhering to both state and federal laws and regulations when submitting terminations to Aetna.
6. If otherwise permitted, when retro-terminations are submitted, we will regard the submission as verification that no premium / contribution was paid by the member / dependent for that period.

Billing / payment: You agree to receive your bill online each month. Any contractual provisions related to nonpayment of premium continue to be applicable. I / we understand and agree to the terms set forth in this agreement. By signing below, I represent that I am authorized to sign this agreement.

Access: The undersigned employer agrees that each employee will agree to terms associated with the issuance and use of his / her password and system access. An individual's password may be used only by that individual to access the system and may not be shared for any reason. Each individual is personally responsible for the information entered into the system. If an individual to whom a password has been issued becomes aware of a security breach (an incident in which there occurs attempted or unauthorized access, use, disclosure, modification, or destruction of information or interface with system operations), they agree to contact Aetna.

EMPLOYER ACKNOWLEDGMENT – EMPLOYER WAITING PERIOD

Starting with plan years on or after January 1, 2014, the Affordable Care Act and subsequent federal regulations prohibit group health plans and health insurance issuers from requiring any otherwise eligible plan participants and beneficiaries (employees and dependents) to wait more than ninety days before their health coverage is effective. The regulations define group health plan as the employer or plan administrator. The issuer is defined as the insurance company. Since the requirement applies to both the group health plan and the issuer, each party's obligation is satisfied if the ninety (90) day waiting period is honored. However, if neither party complies, both are subject to penalty.

The Employer Group Policyholder ("Employer") represents that it provides to Aetna, effective date information regarding plan participants and beneficiaries that takes into account the eligibility conditions and waiting period requirements required under federal law, in order for such plan participants and beneficiaries to become eligible for coverage under the Employer's group health insurance coverage with Aetna. In compliance with the waiting period requirements, Aetna shall use the effective date information provided by Employer to enroll such plan participants and beneficiaries in the Employer's group health insurance coverage. In the event this information changes, the Employer shall inform Aetna immediately.

SUMMARY OF BENEFITS AND COVERAGE (SBC) FOR GROUP HEALTH PLAN – PLEASE READ. YOU MUST CHECK BELOW TO CONFIRM:

In accordance with my contract with Aetna to distribute information related to enrollment / coverage information,

☐ I have ☐ I have not

received the Summary of Benefits and Coverage document (**https://www.aetna.com/sbcsearch/home**) associated with the plan information referenced in this application. I confirm I have provided SBCs to plan participants and beneficiaries in compliance with the federal regulations and guidance, including the requirements for timely delivery, on this date _____ (MM/DD/YYYY). For information on the SBC regulations and distribution requirements, please review the regulations at the HHS website: **http://cciio.cms.gov/resources/other/index.html#sbcug.**

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

Agent or broker certification

I certify that I am not aware of any information not disclosed in this application by the client that may have bearing on this risk, for all products being applied for.
I represent that I am licensed to sell Aetna products in the state of Nevada.
I 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.
Appointment with Aetna: In order to receive commissions you must be appointed with Aetna. To become appointed with Aetna, apply online: **https://pangea.geninfo.com/Aetna/Apply/Default.aspx.** If you are not yet appointed and your state has a limited time to become appointed, you may want to include another broker from your office.

Agent or broker name:		National producer number: 95-3161239		
Agency name: Word & Brown		TIN:		
Pay commissions to (check one): ☐ Broker ☐ Agency		Phone: ( )	Fax: ( )	
Address:		City:	State:	ZIP:
Signature:	Date:	Email:		% of credit:
Broker admin assistant name:		Broker admin assistant email:		
Agent or broker name:		National producer number:		
Agency name:		TIN:		
Pay commissions to (check one): ☐ Broker ☐ Agency		Phone: ( )	Fax: ( )	
Address:		City:	State:	ZIP:
Signature:	Date:	Email:		% of credit:
Broker admin assistant name:		Broker admin assistant email:		
General agent name:		TIN:		
Selling agent name:		Email:		
Phone: ( )		Fax: ( )		
Address:		City:	State:	ZIP:
Signature:			Date:	
GA admin assistant name:		GA admin assistant email:		