aetna™

California Small Group
Employer Application
FOR GROUP COVERAGE (1 - 100 EMPLOYEES)

TO COMPLY WITH CALIFORNIA LAW, WHEREVER THE TERM "SPOUSE" APPEARS IT SHALL BE CONSTRUED TO INCLUDE DOMESTIC PARTNER.

"Aetna" is a brand name used for products and services provided by one or more of the Aetna group of subsidiary companies. Aetna Life Insurance Company underwrites Aetna Vision℠ Preferred plans, Elect Choice EPO plans, and Managed Choice POS plans. Aetna Health of California Inc. underwrites HMO plans. Aetna Dental of California Inc. and Aetna Life Insurance Company provide Aetna Dental plans. For Vision coverage, First American Administrators, Inc. provides certain claims administration services. EyeMed Vision Care LLC ("EyeMed") provides certain network administration services.

1. Employer information

Company name (legal name)	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
Phone number ( )	Fax number ( )		
Company contact – name and title	Company contact email		
Billing contact name (if different from company contact) *Online statements are available. Activate access to your eBusiness account at* ***www.aetna.com/employersregister*** *when you get your approval letter.*	Billing 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: _____			

2. Effective date of group plan
The actual effective date will be assigned by the Aetna underwriting department if the application is approved.

Requested effective date:_____

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

3. Medical coverage selection

Pick 5 plans from Aetna (employer can pick a maximum of 5 plans for current and future hires)

HMO	☐ Full HMO ☐ HMO Deductible ☐ HMO Aetna Value Network ☐ HMO Basic ☐ HMO AWH Southern CA
OAMC/EPO/PPO	☐ OA Managed Choice POS ☐ Savings Plus OA Managed Choice POS ☐ AWH Southern CA OA Managed Choice POS ☐ OA Elect Choice EPO ☐ AWH Southern CA OA Elect Choice EPO ☐ Open Choice PPO
Plan Name: ______________________	

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Plan Name: ______________________	

Are you a religious employer exempt from the Affordable Care Act (ACA) and want to decline contraceptives, comprehensive infertility and Gamete intrafallopian transfer (GIFT) coverage? Yes ☐ No ☐

4. Dental coverage selection – Available as standalone or in addition to other Aetna coverage.

(Not available to groups of one.)

Aetna Dental® Plan

☐ **Non-voluntary dental plan(s)**: Option ______________________ ☐ **Voluntary dental plan(s)**: Option ______________________

Pediatric dental and medically necessary orthodontia coverage for insureds under age 19 is included in all medical plans.

Employees in AZ, CA, GA, MA, MD, MO, NC, NJ and TX must either live or work within the approved DMO® service area to be eligible to enroll in the DMO®.

5. Vision coverage selection – Available as standalone or in addition to other Aetna coverage. *(Not available to groups of one.)*

Aetna Vision℠ Preferred – Plan option name ______________________

Pediatric vision for insureds under age 19 is included in all medical plans.

6. 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 commonly owned associated companies?	☐ Yes ☐ No
Are multiple companies or multiple addresses to be included under this plan?	☐ Yes ☐ No

If you answered **yes** to any 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(s)**	**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 or 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:	
	- Submit a copy of the current carrier bill.	
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 available to any of their clients (employer businesses.) - If **yes**, you are not eligible for small group coverage.	☐ Yes ☐ No
Are you a professional employer organization (PEO)?		☐ Yes ☐ No
If yes	- Are you an existing Aetna customer that is a PEO? Aetna group number: _____	☐ 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

7. 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 (valid and invalid waivers)	
Number of full-time employees excluding union employees		Number of employees working outside California List all states outside of California _____	
Number of part-time employees		Number of employees not actively at work	
Number of 1099 employees		Number of COBRA/Cal-COBRA continuees	
Number of union employees		Number of employees in waiting period and not eligible	

8. Full time equivalents for the prior calendar year

The "full-time equivalent" (FTE) employee counting method in 26 U.S.C. 4980H(c)(2) must be utilized to determine group size for medical coverage. This method is the same calculation used to determine employer liability under the "Shared Responsibility for Employers" provisions of the ACA and Internal Revenue Code.

A. FTEs from full-time employees. 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. FTEs from part-time employees, i.e., 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.	

9. COBRA/Cal-COBRA/TEFRA/DEFRA

Is your group subject to: ☐ COBRA ☐ Cal-COBRA?

How many full-time 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 or Cal-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 or Cal-COBRA? These present or former employees/dependents must be listed below. Attach a separate sheet, if needed.	

Name of applicant	Qualifying event (e.g., termination of employment, divorce, etc.)	Have they elected COBRA/ Cal-COBRA?	Date of qualifying event	Date coverage COBRA/Cal-COBRA terminates
		☐ Yes ☐ No		
		☐ Yes ☐ No		
		☐ Yes ☐ No		

10. Medicare primary versus secondary

How many full-time and part-time employees have you employed for at least 20 or more weeks during this calendar year 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 this calendar year or prior calendar year, your group is Medicare primary. If you employed 20 or more employees for 20 weeks in this calendar year or prior calendar year, your group is Aetna primary.	

11. Total average number of employees

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 – example: 24.6 = 25. Do not spell out the number – 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 identification status of the related entities.	

12. Eligibility waiting period

The eligibility date will be the first day of the policy month after the waiting period for 0, 30 or 60 days. An eligibility waiting period of 90 days will begin the day after 90 calendar days has been completed. Policy month refers to the contract effective date of the first or fifteenth 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 "90 days" is selected, the enrollment eligibility date will begin the day after 90 calendar days have been completed.	
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
Waiting period for future employees: First day of policy month following: ☐ 0 days ☐ 30 days ☐ 60 days **OR** ☐ 90 days (eligibility date is the day after 90 days is completed)	

13. Employer premium contributions

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

14. 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 – orthodontic max $ _____

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

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

Signature section

The Applicant agrees to the following:

- An employee cannot contribute to non-contributory coverage, unless an authorized representative of Aetna approves the change in writing.
- An employee cannot contribute for contributory coverage for the current coverage period at a higher rate than shown on this application.
- Only a person who is a bona fide, permanent full-time employee (working an average of 30 hours a week over the course of a month), or a permanent part-time employee (working 20-29 hours a week), is eligible for coverage, unless otherwise specifically provided in the Group Agreement/Group Policy or required by federal/state law.
- The Group Agreement/Group Policy determines the:
  - Contractual provisions
  - Procedures
  - Exclusions and limitations
- The Group Agreement/Group Policy will govern in the event they conflict with any:
  - Benefits comparison
  - Summary
  - Other description of the plan
- All statements in this application are representations and not warranties.
- I acknowledge that Aetna provided written information that I used in selecting this plan. Brokers, agents or consultants are not 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.
- I agree to make all Aetna plan related paper or online member documents available to my employees.
- I agree to make payroll and other records, directly related to the employee's plan coverage, available to Aetna for inspection. This will occur after a reasonably advanced request at:
  - Aetna's expense
  - My office during regular business hours

  This provision shall survive termination of plan coverage and the applicable plan documents.
- I am responsible to select, in accordance with applicable state law, the plans offered to my employees and the contribution amounts.
- Information on agent's compensation is available from my agent or at **aetna.com**.
- Participating physicians, hospitals and other health care providers are independent contractors. They are neither agents nor employees of Aetna.
- 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 it cannot guarantee any results or outcome.
- I hereby apply for the coverages indicated above. I certify that all information in this application is accurate and complete.
- **Attention California residents**: I understand Aetna will rely on the information I provide to determine:
  - Eligibility for coverage
  - Setting premium rates
  - Compliance with applicable laws
  - Other purposes

  If Aetna demonstrates that I have acted fraudulently or intentionally misrepresented material facts, Aetna may rescind the policy or may increase premiums after giving me at least 30 days prior notice by certified mail. However, after 24 months following the issuance of the policy, Aetna will not rescind the policy for any reason and will not cancel the policy, limit the policy, or raise premiums due on the policy due to omission, misrepresentation or inaccuracies in the application, whether willful or not. Aetna does not base its eligibility rules on any of the following factors:
  A. Health status
  B. Medical condition, including physical and mental illnesses
  C. Claims experience
  D. Receipt of health care
  E. Medical history
  F. Genetic information
  G. Evidence of insurability, including conditions arising out of acts of domestic violence
  H. Any other health status-related factor as determined by any federal regulations, rules or guidance issued pursuant to Section 2705 of the federal Public Health Service Act

Signature section *(Continued)*

- I understand that by December first of each year, Aetna will notify Aetna Medicare members of all benefit and premium changes effective as of January first of the following calendar year.

EMPLOYER ACKNOWLEDGMENT – Employer waiting period

The Affordable Care Act and subsequent federal regulations prohibit group health plans and health insurance issuers from requiring any eligible plan participants and beneficiaries (employees and dependents) to wait no more than 90 days before their health coverage goes into effect.

- The regulations define the group health plan as the Employer or plan administrator.
- The regulations define the issuer 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 90 day waiting period is honored. However, if either party doesn't comply, both are subject to a penalty.
- I agree to provide the following information of the plan participants and beneficiaries to Aetna:
  - Effective date information
  - Eligibility
  - Waiting period required under federal law
- Aetna will use the information provided by the employer to enroll plan participants and beneficiaries in the employer's group health insurance coverage. In the event this information changes, the employer shall inform Aetna immediately.

ELECTRONIC ENROLLMENT, BILLING/PAYMENT AND ACCESS AGREEMENT

Enrollment: As of my participation date:

1. I agree to keep copies (paper or electronic) of actual enrollment forms. I 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. I agree to create and maintain records on secure information systems that can generate hard copies of enrollments or changes maintained on electronic information systems. Any hard copy records generated pursuant to this provision shall meet reasonable standards of availability, authenticity, non-repudiation and integrity.
3. I agree that all enrollment and eligibility information presented to Aetna is accurate and timely updated. I acknowledge that Aetna can and will rely on such information in determining whether an individual is eligible for benefits under the plan. I agree to pay Aetna promptly any applicable back premiums as the result of a discrepancy between the enrollee information and the actual information presented by the enrollee. The premium due to Aetna starts accruing as of the date on which the enrollee's information changed.
4. Insured plans must either:
   - Use Aetna-supplied forms in paper format or electronic format
   - Agree to incorporate the following four points into my enrollment materials
     - Names of the Aetna company offering the insurance coverage
     - State-specific fraud warning statement
     - A statement that the terms of the insurance documents will govern the member's rights and responsibilities
     - An acknowledgment that participating providers are not agents or employees of Aetna and that network composition can change.
5. I am 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, Aetna will regard the submission as verification that no premium/contribution was paid by the member/dependent for that period.

Billing/payment: I agree to receive my bill online each month. Any contractual provisions related to non-payment of premium continue to be applicable. I 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: I agree that each employee will agree to terms associated with the issuance and use of their 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. Any individual to whom a password has been issued agrees to contact Aetna immediately if they become aware of a security breach.

A security breach is:

- An attempt to gain unauthorized access
- Actual unauthorized access
- Use of unauthorized information
- Disclosure of unauthorized information
- Modification of unauthorized information
- Destruction of unauthorized information

Unauthorized interface with system operation.

NOTICE: California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.

Continued on next page

Signature section *(Continued)*

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 will provide SBCs to plan participants and beneficiaries in compliance with the federal regulation and guidance related to SBCs, including the requirements for timely delivery. 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 and attestation

I hereby certify that I have advised the applicant not to terminate any existing coverage until receiving written notice from Aetna that the coverage 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 attestation

I, _____ (print name), attest to the following:

1. The information on the application is complete and accurate; and
2. I explained to the applicant, in easy-to-understand language, the risk to the applicant of providing inaccurate information and that the applicant understood the explanation.

If you, as the agent or broker, willfully state as true any material fact(s) that you know to be false, you will, in addition to any applicable penalties or remedies available under current law, be subject to a civil penalty of up to ten thousand dollars ($10,000).

Agent or broker signature: _____

Agent or broker name:		TIN:		
Agency name:		National producer number (NPN):		
Pay commissions to (check one): ☐ Broker ☐ Agency				
% of credit:		Phone:	Fax:	
Address:		City:	State:	ZIP:
Signature*:	Date:	Email:		
Broker admin assistant name:		Broker admin assistant email:		
*I hereby certify that I am licensed to sell Aetna products in the state of California.				

Agent or broker name:		TIN:		
Agency name:		National producer number (NPN):		
Pay commissions to (check one): ☐ Broker ☐ Agency				
% of credit:		Phone:	Fax:	
Address:		City:	State:	ZIP:
Signature*:	Date:	Email:		
Broker admin assistant name:		Broker admin assistant email:		
*I hereby certify that I am licensed to sell Aetna products in the state of California.				

General agent name:	TIN:		
Email:	Selling agent:		
Phone:	Fax:		
Address:	City:	State:	ZIP:
Signature*:		Date:	
GA admin assistant name:	GA admin assistant email:		
*I hereby certify that I am licensed to sell Aetna products in the state of California.			