New York Small Group Business
Employer Application

☐ **Aetna Life Insurance Co.**
151 Farmington Avenue
Hartford, CT 06156

☐ **Aetna Health Inc.**
1425 Union Meeting Road
Blue Bell, PA 19422

☐ **Aetna Health Insurance Co. of New York**
333 Earle Ovington Blvd. - Suite 104
Uniondale, NY 11553

FOR GROUP COVERAGE (2–50 ELIGIBLE EMPLOYEES)

Life, Accidental Death & Dismemberment, Aetna EPO plans, Aetna Indemnity, and Aetna Managed Choice Plan PPO are provided by Aetna Life Insurance Company. Aetna Primary Care Plan HMO, Aetna QPOS, and Aetna NYC Community Plan℠ are provided by Aetna Health Inc. and Aetna Health Insurance Company of New York. DMO and PPO dental plans are provided by Aetna Life Insurance Company.

Company Name (Legal Name)	DBA/Doing Business As (if applicable)		
Street Address (P.O. Box not acceptable)	City	State	ZIP
Billing 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: _____ Nature of Business: _____

Medical Coverage Selection

Managed Choice Open Access:
☐ 21a-07 ☐ 21b-07 ☐ 21c-07
☐ 22a-07 ☐ 22b-07 ☐ 22c-07
☐ 24-08 ☐ 24b-07 ☐ 24c-07
☐ 26a-07 ☐ 26b-07 ☐ 26c-07
☐ 27-07 ☐ 29a-07 ☐ 29b-07
☐ 29c-07 ☐ 33a-07 ☐ 33b-07
☐ 33c-07

Managed Choice Open Access (HSA Compatible):
☐ 30-07 ☐ 31-07 ☐ 34-07
☐ 35-08

EPO Open Access:
☐ 1b-08 ☐ 1c-08
☐ 2a-07 ☐ 2b-07
☐ 2c-07 ☐ 3-08
☐ 3b-07 ☐ 3c-07
☐ 4-08 ☐ 4b-07
☐ 4c-07

NYC Community Plan℠:
☐ 1D-07 ☐ 2-07
☐ 3D-07 ☐ 4-07

Indemnity:
☐ 20-07

If you have selected an HSA-compatible plan:
- Do you plan on making contributions to your employees' HSA accounts? ☐ Yes ☐ No
- Do you plan to offer your employees payroll deductions to fund their HSA accounts? ☐ Yes ☐ No

Dental Coverage Selection

Aetna Dental™ Plan
Standard Plans:
☐ Option 2: DMO ☐ Option 3: Freedom-of-Choice: PPO Max
☐ Option 4: PPO Max ☐ Option 5: Active PPO
☐ Option 6: PPO 1500
☐ Option 7: Consumer Directed DentalFund
☐ Option 8: Freedom-of-Choice: PPO 1500
☐ Option 9: PPO 2000
☐ Out-of-State: ☐ $1,000 ☐ $1,500 ☐ $2,000

Voluntary Plans:
☐ Option 2: DMO ☐ Option 4: PPO Max
☐ Option 3: Freedom-of-Choice ☐ Out-of-State: ☐ $1,000

Orthodontic coverage for dependent children is included in Standard Plan Options 2, 3, 5, 6, 8, & 9 and Voluntary Plan Options 2 & 3 and available only to groups with 10 or more eligible employees.

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.

Life, Accidental Death & Dismemberment, and Disability Coverage Selection

Groups with 10 to 50 eligible employees may select one, two, or three options for Life, Accidental Death & Dismemberment, and Disability, with a minimum requirement of three employees in each option. 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 - $10,000 ☐ Medium - $20,000 ☐ High - $50,000** Plans include Dependent Term Life	☐ $10,000 ☐ $15,000 ☐ $20,000 ☐ $50,000	☐ Low - $10,000 ☐ Medium - $20,000 ☐ High - $50,000** Plans include Dependent Term Life	☐ $10,000 ☐ $15,000 ☐ $20,000 ☐ $50,000	☐ Low - $10,000 ☐ Medium - $20,000 ☐ High - $50,000** Plans include Dependent Term Life
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

** Available only for groups of 10 or more lives.

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

Requested effective date (may be the first or 15th of the month only): _____

Employer Contribution(s)

Coverage	Medical	Dental	Employee Life	Dependent Life	Disability
Employer's Contribution for Employee	%	%	%	NA	%
Employer's Contribution for Dependent	%	%	NA	%	NA

Employee Eligibility

Work Location (list by state)	Number of Employees				
	Full-time (based on number of minimum hours allowed by state law)	Part-time	Retired	COBRA or State Continuees	Other (i.e., temporary, substitute, seasonal)

Total number of employees: _____

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

Total number of employees eligible for coverage (must work a minimum of 20 hours per week): _____

Total number of employees waiving Aetna health benefits but covered through their spouse's health benefit plan: _____

Total number of employees waiving Aetna health benefits coverage without coverage elsewhere: _____

Total number of employees covered under another health benefit plan offered by the employer: _____

Do you exclude Union employees under this application? ☐ Yes ☐ No

Eligibility date will be the first day of the policy month following the waiting period.

Waiting period for future employees: ☐ 0 days ☐ 30 days ☐ 60 days ☐ 90 days ☐ 120 days ☐ 180 days

Prior Carrier Information

	Health	Dental	Life	Disability
Is this group transferring from another group carrier?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
If Yes, provide Carrier Name				
Effective Date of Coverage				
Proposed Termination Date				
Is this total replacement?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
If prior carrier Aetna, provide Group/Control Number				
Dental Only – Prior coverage included, check all that apply:		☐ Major Services ☐ Orthodontia		

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, with the exception of the Life insurance coverage, no coverage shall become effective as to any person who is not then a bona fide, full-time employee, regularly performing the duties of his or her occupation (subject to applicable HIPAA requirements for health coverage), unless otherwise specifically provided in the plan documents (which consist of the Group Agreement and/or Group Policy). For life insurance, all statements made by or by the authority of the Applicant for the insurance, reinstatement or renewal of life insurance shall be deemed representations and not warranties. For all other insurance, all statements herein shall be deemed representations and not warranties.

This does not apply to the Life insurance coverage: 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, including the Certificate. 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.

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

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, including the policy and certificate, 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.

This does not apply to the Life insurance coverage: 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 to enrollees all Aetna paper or online member documents and other plan-related materials upon request by Aetna.

As to Accident and Health Insurance coverage, 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, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation. **This fraud warning is not applicable to an application for life insurance.**

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.

I hereby apply for the coverage(s) indicated above. To the best of my knowledge and belief, all information provided in this application is accurate and complete.

This does not apply to the Life insurance coverage: I understand that this application will form a part of the Group Agreement or Group Policy issued by Aetna, 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, subject to any state requirements.

With respect to the Life insurance coverage, the entire contract is set forth in the policy, the certificate, riders, endorsements and the attached application, if any.

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

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

_____ (Witness) _____ (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 am licensed to sell Aetna Small Group products in the state of New York.

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 _____