



# Pennsylvania Small Group Business Employer Application

**FOR GROUP COVERAGE (2 – 50 ELIGIBLE EMPLOYEES)**

Life, Accidental Death & Dismemberment, Disability and Aetna PPO plans are underwritten by Aetna Life Insurance Company. Aetna HMO plans and Aetna POS plans are underwritten by Corporate Health Insurance and/or Aetna Health Inc. Dental plans are provided or administered by Aetna Health Inc. and Aetna Life Insurance Company.

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 <input type="checkbox"/> Corporation <input type="checkbox"/> Non-Profit <input type="checkbox"/> Partnership <input type="checkbox"/> Sole Proprietor <input type="checkbox"/> Other:			SIC Code:

## Medical Coverage Selection

<input type="checkbox"/> <b>PA HMO:</b> <input type="checkbox"/> Plan 1 <input type="checkbox"/> Plan 2 <input type="checkbox"/> Plan 3	<input type="checkbox"/> <b>PA POS No-Referral:</b> <input type="checkbox"/> Plan 1 <input type="checkbox"/> Plan 2 <input type="checkbox"/> Plan 3	<input type="checkbox"/> <b>PA PPO First Dollar Plan</b>
<input type="checkbox"/> <b>PA HMO No-Referral:</b> <input type="checkbox"/> Plan 1 <input type="checkbox"/> Plan 2 <input type="checkbox"/> Plan 3	<input type="checkbox"/> <b>PA PPO:</b> <input type="checkbox"/> Plan 1 <input type="checkbox"/> Plan 2 <input type="checkbox"/> Plan 3	<input type="checkbox"/> <b>Out-of-State/Situs PPO Plan:</b> <input type="checkbox"/> \$250 (High) <input type="checkbox"/> \$500 (Medium) <input type="checkbox"/> \$1,000 (Low)
<input type="checkbox"/> <b>PA Cost-Sharing HMO:</b> <input type="checkbox"/> Plan 1 <input type="checkbox"/> Plan 2 <input type="checkbox"/> Plan 3	<input type="checkbox"/> <b>PA PPO HSA Compatible:</b> <input type="checkbox"/> Plan 1 <input type="checkbox"/> Plan 2 <input type="checkbox"/> Plan 3	<input type="checkbox"/> <b>Out-of-State/Situs Indemnity Plan</b>
<input type="checkbox"/> <b>PA POS:</b> <input type="checkbox"/> Plan 1 <input type="checkbox"/> Plan 2 <input type="checkbox"/> Plan 3	<input type="checkbox"/> <b>PA PPO Basic Hospital Plan</b>	<input type="checkbox"/> <b>Other Plan:</b> _____

## Dental Coverage Selection

Dental available with an Aetna medical Plan (2-50 eligible employees). Dental plans 2-5 and 7 available stand-alone (10-50 eligible employees). Orthodontic coverage is available only to groups with 10 or more eligible employees and automatically included on Plans 2, 3 and 5.

<b>Aetna Dental™ Plans</b>		
<input type="checkbox"/> Plan 1 HMO Rider	<input type="checkbox"/> Plan 5 Active PPO – High Option	
<input type="checkbox"/> Plan 2 DMO	<input type="checkbox"/> Plan 7 Consumer Directed Dental Fund	
<input type="checkbox"/> Plan 3 Freedom-of-Choice	<input type="checkbox"/> Out-of-State/Situs PPO Plan:	<input type="checkbox"/> Low Option, No Ortho <input type="checkbox"/> Medium Option, No Ortho
<input type="checkbox"/> Plan 4 PPO Max		<input type="checkbox"/> Low Option, Ortho <input type="checkbox"/> Medium Option, Ortho

## Life, Accidental Death & Dismemberment, & Disability Coverage Selections

Groups with 10 to 50 eligible employees may select one, two or three options for Life, Accidental Death & Dismemberment and Disability. 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.)

All Groups	Class 1		Class 2		Class 3	
	Life	Life & Disability Packaged Plan	Life	Life & Disability Packaged Plan	Life	Life & Disability Packaged Plan
	<input type="checkbox"/> \$10,000 <input type="checkbox"/> \$15,000 <input type="checkbox"/> \$20,000 <input type="checkbox"/> \$50,000	<input type="checkbox"/> Low <input type="checkbox"/> Medium <input type="checkbox"/> High	<input type="checkbox"/> \$10,000 <input type="checkbox"/> \$15,000 <input type="checkbox"/> \$20,000 <input type="checkbox"/> \$50,000	<input type="checkbox"/> Low <input type="checkbox"/> Medium <input type="checkbox"/> High	<input type="checkbox"/> \$10,000 <input type="checkbox"/> \$15,000 <input type="checkbox"/> \$20,000 <input type="checkbox"/> \$50,000	<input type="checkbox"/> Low <input type="checkbox"/> Medium <input type="checkbox"/> High
<b>Additional options for Groups with 10 – 50 eligible employees</b>	<input type="checkbox"/> \$75,000 <input type="checkbox"/> \$100,000 <input type="checkbox"/> \$125,000		<input type="checkbox"/> \$75,000 <input type="checkbox"/> \$100,000 <input type="checkbox"/> \$125,000		<input type="checkbox"/> \$75,000 <input type="checkbox"/> \$100,000 <input type="checkbox"/> \$125,000	
<b>Class Description</b>						

**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.

**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): \_\_\_\_\_

**Employer Contribution(s)**

	Employer's Contribution for Employee Coverage	Employer's Contribution for Dependent Coverage
	% Contribution	% Contribution
Medical	_____ %	_____ %
Dental	_____ %	_____ %
Basic Employee Term Life (including AD&D)	_____ %	
Optional Dependent Term Life		_____ %
Packaged Life & Disability	_____ %	

Groups with 2 to 50 eligible employees: The employer must contribute at least 50% of the employee-only annual medical premium. Coverage can be denied based on inadequate contributions. For basic life and disability, the employer must contribute 100% of premiums for groups with 2 to 9 eligible employees and at least 50% of premium for groups with 10 to 50 eligible employees.

**Section 125 Plan**

Does the group have a flex plan under Section 125 of the Internal Revenue Service code?  Yes  No

**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: \_\_\_\_\_

Total number of employees eligible for coverage (must work a minimum of 25 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: \_\_\_\_\_

Are there excluded classes of employees other than part-time and temporary employees (for example, Union employees)?  Yes  No

If Yes, describe excluded class(es): \_\_\_\_\_

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

**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).

**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.

## 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

### Disability:

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

## 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, full-time employee, regularly performing the duties of his or her occupation, unless otherwise specifically provided in the plan documents (which consist of the Group Policy and/or Group Agreement). 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 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 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 schedule. Aetna disclaims any responsibility if the employer elects such a 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.

I hereby apply for the coverage(s) indicated above. I certify that all information provided in this application is accurate and complete to the best of my knowledge and 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 and Out-of-State Medical and Out-of-State Dental Employee Coverage):** 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

*continued on back*

