California Small Group Business
Employer Application

FOR GROUP COVERAGE (2 - 50 ELIGIBLE 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. The Aetna companies that offer or administer benefit coverage for the Aetna Golden Medicare Plan® include Aetna Health Inc. and Aetna Health of California Inc. Life, Accidental Death & Dismemberment, Disability, Aetna PPO Plan and Aetna EPO Plan are underwritten by Aetna Life Insurance Company. Aetna HMO Plan is underwritten by Aetna Health of California Inc. Dental plans are provided by Aetna Dental of California Inc. and Aetna Life Insurance Company.

1. Employer Information

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
☐ Corporation ☐ Non-Profit ☐ Partnership ☐ Sole Proprietor ☐ Other: ____________ ☐ SIC Code: ________

Has the company entered above been insured by Aetna within the last 12 months? ☐ Yes ☐ No
If "Yes," please provide prior group number and termination date. ____________________

2. Medical Coverage Selection – Pick-A-Plan (All Plans): ______

HMO: ☐ 10 ☐ 20 ☐ 30 ☐ 40 ☐ 50 ☐ Deductible 1000 ☐ Deductible 1500
☐ Coinsurance 70% ☐ Coinsurance 60%

Value Network℠ HMO: ☐ 10/20 ☐ 20/30 ☐ 30/40 ☐ 40/50

Vitalidad Mexico HMO: ☐ 10

Vitalidad Plus HMO: ☐ 10/5 ☐ 30/10

MC: ☐ 250 90/70 ☐ 250 80/60 ☐ 500 80/60 ☐ 1000 70/50 ☐ 750 80/50/50 ☐ 1250 80/50/50
☐ 2000 80/50/50 ☐ 2500 75/50 ☐ 3500 65/50 ☐ 4500 60/50 ☐ 7500 75/50 ☐ 10,000 100/50
☐ Value 2250 60/50 ☐ Value 3750 50/50 ☐ HSA HDHP 2000 80/50
☐ HSA HDHP 3000 90/50 ☐ HSA HDHP 3500 80/50 ☐ HRA HDHP 3000 70/50

PPO: ☐ 750 80/60

Indemnity Plan: ☐

Does this group qualify for the small employer exemption under Federal Mental Health Parity? ☐ **Yes** ☐ **No**

A. Is Employer, Plan Sponsor or Third Party funding or administering any part of the deductible? ☐ Yes ☐ No
- Who is administering: ☐ Employer ☐ Other (Name of company): ____________________

B. Is the funding set up through a federally qualified HRA or HSA account? ☐ Yes ☐ No

If the funding is not a federally qualified HRA or HSA account, Pick-A-Plan is not available and the only plans that can be offered in conjunction with the funding are the HMO Deductible and MC HRA HDHP 3000. A maximum of 3 medical plans may be offered (including the HMO Deductible or MC HRA HDHP Plans.

3. Dental Coverage Selection

Aetna Dental® Plan
Standard Plans:
Option: ____________________
Voluntary Plans:
Option: ____________________

Orthodontia coverage is available in some plans for dependent children in groups with 10 or more eligible employees with a minimum of 5 enrolled 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.

4. Life and Accidental Death & Dismemberment Coverage Selection

Groups with 10 to 50 employees may select one, two or three options for Life and Accidental Death & Dismemberment, with a minimum requirement of three employees in each class. 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 Group*	☐ 10,000	☐ 15,000	☐ 20,000	☐ 50,000
Additional Options for Groups With 10 – 50 Eligible Employees	☐ 75,000	☐ 100,000	☐ 125,000	
Class Description	**Class 1**	**Class 2**	**Class 3**	

***Optional Dependent Term Life** (Available only to groups with 10 to 50 eligible employees.) ☐ Yes ☐ No

5. 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): ____________________

6. Employer Eligibility/Employee Status

	Number of Employees (min. 30 hours weekly)						
Work Location (list by state)	**Full-time**	**Part-time**	**Retired**	**COBRA**	**1099**	**Union**	**Other** (i.e., temporary, substitute, seasonal, etc.)
Total							

Of the total number of eligible employees indicated above, how many are:

- waiving Aetna medical coverage because they are covered through a spouse's medical plan?	
- waiving Aetna medical coverage because they are covered under a different medical plan offered by the employer?	
- waiving Aetna medical coverage, but do not have coverage elsewhere?	
- currently in the waiting period and not eligible?	
Are part-time employees working _____ hours to be covered?	☐ Yes ☐ No
Are there excluded classes of employees other than part-time and temporary employees (for example, Union/Non-Union, Management/Non-management, Salary/Hourly)? If "Yes," describe class(es) and/or the union local name and number. ____________________	☐ Yes ☐ No
Is your company a subsidiary of another company, an affiliate of another company, or under common control with another company?	☐ Yes ☐ No
Does your company file state or federal taxes with another company(ies) on a combined or consolidated basis?	☐ Yes ☐ No

If 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 Name	Tax Identification Number	Owner's Name(s)	Percentage of Ownership	Number of Employees	Is group to be included
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No

7. COBRA/TEFRA/DEFRA/State Continuation

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
How many employees have terminated in the last 90 days?	
Is your group subject to TEFRA/DEFRA? Under TEFRA/DEFRA, Aetna is primary coverage for groups of 20 or more full-time and part-time employees (based on the total number of employees during 50% of the working days during the previous calendar year). Medicare is primary for groups of less than 20 full-time and part-time employees.	☐ Yes ☐ No
Is your group (check one).	☐ Medicare Primary ☐ Aetna Primary

8. Benefit Waiting Period

The eligibility date will be the first day of the policy month following the waiting period.	
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: ☐ 0 Days ☐ 30 Days ☐ 60 Days ☐ 90 Days ☐ 120 Days ☐ 180 Days	

9. Employer Contribution(s)

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

10. Prior Carrier Information

	Health	Dental	Life
Is this group transferring from another group carrier?	☐ 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
Prior Dental coverage, check all that apply:		☐ Major Services ☐ Orthodontia	

11. 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:	Effective Date: Renewal Date:
Is Workers' Compensation coverage provided on all employees?	☐ Yes ☐ No
If "No," please provide a list of all employees enrolling that are NOT covered by Workers' Compensation or similar legislation (including title).	

12. 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, permanent full-time employee (working 30 hours per week or more), or a permanent part-time employee (working 20-29 hours per week, if coverage is offered).

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 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.

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.

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.

(continued on back cover)

12. Signature Section (Continued)

Attention California Residents: For your protection, California law requires notice of the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

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 termination of the group policy, termination of coverage, increase in premiums, or other consequences but only to the extent permitted by law. 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 but only to the extent permitted by 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 affirm that all information provided in this application is accurate and complete to the best of my knowledge or 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 but only to the extent permitted by law.

Applicant understands that by December 1st of each year Aetna will notify Aetna Medicare members of all benefit and premium changes effective as of January 1st of the following calendar year.

Joinder Agreement – Request For Participation (For life, disability, accidental death and dismemberment, out-of-state medical and out-of-state dental employee benefits): 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 JP Morgan Chase 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 Agreement, whichever is later, and continue as long as the Employer remains actively in business; and 3) agrees to make the required contributions to the Fund; in the event of default, it will be liable to the insurer for such unpaid contributions for the coverage period, and such insurer will terminate coverage. The insurer may also terminate coverage as of the date the group fails to meet minimum underwriting requirements in effect on that date.

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

CALIFORNIA HMO APPLICANTS — NOTICE OF BINDING ARBITRATION — Any dispute arising from or related to the Group Agreement will be determined by submission to binding arbitration, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. The agreement to arbitrate includes, but is not limited to, disputes involving alleged professional liability or medical malpractice, that is, whether any medical services covered by the Group Agreement were unnecessary or were unauthorized or were improperly, negligently or incompetently rendered.

This agreement also limits certain remedies and may limit the award of punitive damages. See Sections "Binding Arbitration" and "Limitations on Remedies" of the Evidence of Coverage for further Information.

The undersigned representative of the Employer understands that the Employer and any Groups eligible through the Employer, if different from the Employer, and any Members who enroll under this health plan are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of binding arbitration. This means that the Employer, Groups, Members and other interested parties will not be able to try their case in court. The undersigned representative of the Employer further understands and accepts that the Employer, Groups and Members are giving up certain remedies and there may be certain limitations to the recovery of punitive damages.

Signed at (Location): ______________________ ______________________

City, State — Applicant (Company Name)

By: ______________________ ______________________

Authorized Applicant Signature — Official Title

____

Date

13. 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.

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: ______________________ Tax ID or SSN: ______________________
Agency Name: ______________________ % of Credit: ______________________
Phone Number: (____) ______________________ Fax Number: (____) ______________________
Address: ______________________ City: ______________________ State: ______ ZIP: ______
Signature: ______________________ Date: __________ E-Mail Address: ______________________

Agent/Broker Name: ______________________ Tax ID or SSN: ______________________
Agency Name: ______________________ % of Credit: ______________________
Phone Number: (____) ______________________ Fax Number: (____) ______________________
Address: ______________________ City: ______________________ State: ______ ZIP: ______
Signature: ______________________ Date: __________ E-Mail Address: ______________________

General Agent Name: ______________________ Tax ID or SSN: ______________________
Phone Number: (____) ______________________ Fax Number: (____) ______________________
Address: ______________________ City: ______________________ State: ______ ZIP: ______
E-Mail Address: ______________________

14. For Aetna Use Only

Group Number __________ Control Number __________ SCD __________ Effective Date __________

Small Group Business COBRA/Cal-COBRA Questionnaire

(For use in California only)

This form must be completed when replacing another group plan.

Does your group currently qualify for (choose one): ☐ COBRA ☐ Cal-COBRA

I. COBRA/Cal-COBRA Continuees – Complete for each employee currently on COBRA or Cal-COBRA

Name	Date of Birth	Social Security Number	Date of Qualifying Event	Qualifying Event	
1.					☐ COBRA ☐ Cal-COBRA
2.					☐ COBRA ☐ Cal-COBRA
3.					☐ COBRA ☐ Cal-COBRA
4.					☐ COBRA ☐ Cal-COBRA

II. Terminated Employees – Complete for each employee terminated in the last 90 (COBRA) or 60 days (Cal-COBRA)

1. Name	Date of Termination	Social Security Number

To the best of your knowledge, will this employee/dependent(s) exercise their COBRA/Cal-COBRA Option? ☐ Yes ☐ No
If answered "Yes" to the above question, is the employee/dependent currently disabled? ☐ Yes ☐ No

2. Name	Date of Termination	Social Security Number

To the best of your knowledge, will this employee/dependent(s) exercise their COBRA/Cal-COBRA Option? ☐ Yes ☐ No
If answered "Yes" to the above question, is the employee/dependent currently disabled? ☐ Yes ☐ No

3. Name	Date of Termination	Social Security Number

To the best of your knowledge, will this employee/dependent(s) exercise their COBRA/Cal-COBRA Option? ☐ Yes ☐ No
If answered "Yes" to the above question, is the employee/dependent currently disabled? ☐ Yes ☐ No

4. Name	Date of Termination	Social Security Number

To the best of your knowledge, will this employee/dependent(s) exercise their COBRA/Cal-COBRA Option? ☐ Yes ☐ No
If answered "Yes" to the above question, is the employee/dependent currently disabled? ☐ Yes ☐ No

III. Misrepresentation

Attention California Residents: **For your protection, California law requires notice of the following to appear on this form:** Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Employer Signature	Title	Date
Company Name		