Connecticut Small Group Business
Employer Application

FOR GROUP COVERAGE (GROUPS OF FEWER THAN 51 ELIGIBLE EMPLOYEES*)

Aetna HMO plans are provided or administered by Aetna Health Inc. Aetna POS plans and In-network portion of the QPOS plans are provided or administered by Aetna Health Inc. and/or Aetna Life Insurance Company. Out-of-network portion of the QPOS plans, Indemnity and PPO plans are provided or administered by Aetna Life Insurance Company. DMO and PPO dental plans are underwritten 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 Name and 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 ☐ LLC ☐ LLP ☐ Other: _____

SIC Code: _____ Nature of Business: _____

Are multiple companies or multiple addresses to be included under this plan? If Yes, provide details. ☐ Yes ☐ No

Medical Coverage Selection

Aetna Open Access® QPOS:
Plan Option: _____

Aetna Open Access® Managed Choice:
Plan Option: _____

Aetna Traditional Choice®:
Plan Option: _____

☐ **Mandated CSEHRP HMO**
☐ **Mandated CSEHRP Traditional Choice**
☐ **Other Plan Option:** _____

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 see Schedule of Benefits for details.

A. Do you qualify for the small employer exemption under Federal Mental Health Parity? ☐ Yes ☐ No

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

C. 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)? If Yes, how much? _____ % ☐ Yes ☐ No

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

Life, Short Term Disability, and Packaged Life/Disability Coverage Selections

Groups of 2 to 9 eligible employees are limited to one class. Groups with 10 to 50 eligible employees may select one, two or three options for Life, Short Term Disability, and Packaged Life & Disability, with a minimum requirement of 3 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.)

Premium Waiver For Totally Disabled Employees. ☐ Yes ☐ No A waiver of premium for any insured who is totally disabled for a period of at least 6 months shall be made available to the policyholder as a part of the application for any group life insurance policy.)

Life Options for All Groups	☐ 10,000 ☐ 15,000 ☐ 20,000 ☐ 50,000		
Additional Life Options for Groups with 10 - 50 Eligible Employees	☐ 75,000 ☐ 100,000 ☐ 125,000		
Life & Disability Packaged Plan	☐ Low ☐ Medium ☐ High		
Short Term Disability	☐ Option 1 ☐ Option 2 ☐ 100 ☐ 200 ☐ 300 ☐ 400 ☐ 500		
Class Description	**Class 1:**	**Class 2:**	**Class 3:**
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.

*Life and Dental Insurance products available only to groups with 2 – 50 eligible employees.

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): _____

Group Ownership Information – OPTIONAL

(This information is designed for the purposes of data collection and will not be used for underwriting.)

Check one or more, if applicable:
☐ Woman Owned Business ☐ Minority Owned Business (indicate status below):
☐ African American or Black ☐ Hispanic or Latino ☐ Asian ☐ Other _____

Employer Contribution(s)

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

Employee Disability Contribution

Employee's disability contribution percent – check one: ☐ Pre-Tax ☐ Post-Tax

Employee Eligibility

	Number of Employees				
Work Location (list by state)	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, etc.)
TOTAL					

What is the normal work week you require a full-time employee to work to be eligible for coverage?	_____ hours per week
The employer may include employees who work normal work week of at least 20 hours per week.	
Total number of eligible employees	
Total number of employees working 20 – 29 hours per week	
Total number of employees enrolling	
Total number of employees waiving	
Total number of employees in benefit waiting period	
Are there excluded classes of employees other than part-time and temporary employees (for example, Union employees)? If Yes, describe class(es) and/or the union local name and number.	☐ Yes ☐ No

Benefit Waiting Period (BWP)

Waive the waiting period for present employees enrolling with the group (even those who have not met the full waiting period).	☐ Yes ☐ No
Eligibility date will be the first day of the policy month following the waiting period. Waiting period for future employees: ☐ 0 days ☐ 1 month ☐ 2 months ☐ 3 months ☐ 4 months ☐ 5 months ☐ 6 months	

Medicare Primary versus Secondary

Is your group Medicare Primary (employed less than 20 employees for 20 consecutive weeks in the current or prior year) or Aetna Primary (employed 20 or more employees for 20 consecutive weeks in the current or prior year)?	☐ Medicare Primary ☐ Aetna Primary
In total, how many full-time and part-time employees (including any seasonal employees, owners or partners) have you employed on 50% or more of your business days during the prior calendar year?	
How many of the employees that you noted above are self-employed, independent contractors (or their employees and agents), leased employees, or non-employee directors?	

COBRA versus Continuation

Is your employer group required to comply with COBRA regulation?			☐ Yes ☐ No
If you answered Yes to the above question but you currently employ less than 20 full-time and part-time employees, provide in total, how many full-time and part-time employees (including any seasonal employees, owners or partners) that you have employed for 20 or more weeks during this calendar year or prior calendar year.			
Are any present or former employees/dependents currently on or eligible to elect COBRA/State Continuation? If Yes, enter information below. Attach a separate sheet, if necessary.			☐ Yes ☐ No
Name of Applicant	**Qualifying Event (e.g., termination of employment, divorce, etc.)**	**Date of Qualifying Event**	**Date of COBRA or State Continuation Coverage Terminates**

Medical Information

Is any person to be covered unable to work due to illness or injury?	☐ Yes ☐ No
Is any person currently receiving Workers' Compensation benefits?	☐ Yes ☐ No
Is any person currently on leave of absence? If so, provide start date and expected date of return below.	☐ Yes ☐ No
If Yes is answered to any of the above, provide name(s) of the individual(s) and details.	

Prior Carrier Information

	Health	**Dental**	**Life**	**STD**
Is this group transferring from another group carrier? (If Yes, be sure and submit a copy of the carrier statement and employee roster.)	☐ 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 Ortho Max $ _____		

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 (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). 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.

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®, 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, or otherwise make available to enrollees, all Aetna paper or online member documents and other plan-related materials upon request by Aetna.

continued on next page

Signature Section *(continued)*

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 subjects such person to criminal and civil penalties.

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.

CT HB 5669 allows employers to elect to stop paying group premiums for employees and their dependents if (1) the employee was voluntarily terminated from employment or is terminated for any other reason, but layoff, and (2) the employer elects to stop payment within 72 hours of the termination by notifying both the carrier and the employee. In order to make this election, notify your billing area.

JOINDER AGREEMENT - REQUEST FOR PARTICIPATION (For life, disability, accidental death and dismemberment, 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 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 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. In addition, the Participating Employer, in accordance with ERISA Title I Section 503, designates Aetna Life Insurance Company ("Aetna") as the Named Fiduciary under the Plan, with complete and discretionary authority to review all denied claims for benefits under the Plan, and to construe disputed/doubtful Plan terms. Aetna shall be deemed to have properly exercised such authority unless it has abused its discretion by acting arbitrarily and capriciously.

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.

Signed at (Location)	City, State	Applicant (Company Name)
	Authorized Applicant Signature	Official Title
	Print Name of Authorized Applicant	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, for all products being applied for, including life insurance, if applicable.

I hereby certify that I am licensed to sell Aetna Small Group products in the state of Connecticut.

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: _____ NPN/Tax ID/SSN: _____

Agency Name: _____ NPN/Tax ID/SSN: _____

Signature *(required)*: _____ Date: _____ E-Mail Address: _____

Pay Commissions to: (check one) ☐ Broker ☐ Agency % of Credit: _____

Phone Number: (____) _____ Fax Number: (____) _____

Address: _____ City: _____ State: _____ ZIP: _____

Agent/Broker Name: _____ NPN/Tax ID/SSN: _____

Agency Name: _____ NPN/Tax ID/SSN: _____

Signature *(required)*: _____ Date: _____ E-Mail Address: _____

Pay Commissions to: (check one) ☐ Broker ☐ Agency % of Credit: _____

Phone Number: (____) _____ Fax Number: (____) _____

Address: _____ City: _____ State: _____ ZIP: _____

General Agent Name: _____ NPN/ID Number: _____

Signature *(required)*: _____ Date: _____ E-Mail Address: _____

Phone Number: (____) _____ Fax Number: (____) _____

Address: _____ City: _____ State: _____ ZIP: _____