Aetna®

Employer Information Form
RESPONSE REQUIRED

We need your help to comply with laws that may apply to us and your plan - for example, state small group laws and also federal laws like COBRA, Medicare Secondary Payer and Mental Health Parity. Whether a law applies to your group may depend on how many people you employ full time, how many you employ in total or how many people are enrolled in your group plan - and when. We also ask for some of this information so that we may charge an appropriate premium for your group.

PART I - CURRENT EMPLOYEE CENSUS

Employee Breakdown by State - Please tell us how many employees, including any owners and partners (excluding 1099 employees) you have, by state, in each category below:

Business Location State	Business Location Zip Code	Full-Time Employees	Part-Time Employees	Seasonal Employees	Retirees	Individuals on State Continuation or COBRA	Grand Total
						Total	

How does your company define the minimum number of hours worked per week to qualify as a Full-Time employee? _____

Please indicate in which state your company is headquartered. _____

Medical Coverage Summary - For all the people adding up to the "Grand Total" figure you reported above, please classify them into the following categories:

Eligible* Employees Enrolled in an Aetna Medical Benefits Plan	Eligible* Employees Enrolled in another Carrier's Medical Benefits Plan	Eligible* Employees Waiving Medical Benefits Coverage for Spouse/ Partner's Medical Benefits Plan	Eligible* Employees Waiving Medical Benefits Coverage for any other Creditable Coverage Reason	Eligible* Employees Waiving Medical Benefits Coverage for any reason OTHER than Creditable Coverage (do not want coverage, cannot afford coverage, etc)	All Other Employees NOT Eligible* for Medical Benefits Coverage (including retirees, State Continuation & COBRA Enrollees	Grand Total

PART II - EMPLOYER INFORMATION

1) In total, how many full-time and part-time employees (including any seasonal employees, owners or partners) have you employed:

   a. for 20 or more weeks during this calendar year or prior calendar year? _____

      (1) How many of the employees that you noted in a. above are self-employed, independent contractors (or their employees and agents), leased employees, or non-employee directors? _____

   b. on 50% or more of your business days during the prior calendar year? _____

      (1) How many of the employees that you noted in b. above are self-employed, independent contractors (or their employees and agents), leased employees, or non-employee directors? _____

2) Do you have any 1099 employees eligible for coverage?
   Yes ☐ No ☐ If yes, how many? _____

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

4) Is your plan required to file an ERISA Form 5500?
   Yes ☐ No ☐

5) Please indicate your contribution toward your employees' medical coverage:

Employee:	☐ 0%	☐ 25%	☐ 50%	☐ 75%	☐ Other: _____%	☐ Other: _____$
Dependent(s):	☐ 0%	☐ 25%	☐ 50%	☐ 75%	☐ Other: _____%	☐ Other: _____$

6) Do you, as an employer, cover your employees under Worker's Compensation? (If yes, please provide documentation as proof of coverage in conjunction with your response.)
   Yes ☐ No ☐

7) 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)?
   Yes ☐ No ☐ If yes, what _____%

PART III - SIGNATURE

By signing below, I represent to Aetna that the above information is accurate to the best of my knowledge and belief, and I understand that:

- Aetna is relying on what I have stated above;
- Aetna may raise premiums if anything stated above is materially incorrect;
- It is unlawful to defraud an insurer;
- If I have knowingly misrepresented anything above, Aetna may have the right to rescind or cancel my company's insurance; and
- Subject to state and federal law restrictions, Aetna may have the right not to renew coverage if my company does not meet Aetna's contribution and participation requirements as stated in my application/contract.

Signature of Owner/Officer or Authorized Representative of the Company:		Telephone Number:
Print Name:	Date Signed:	Tax Identification Number (TIN):

* Please note, the minimum # of hours to be eligible for Small Group medical coverage by state:

32 hours:	MS
30 hours:	AL, AK, AR, CA, CT, District of Columbia, DE, IA, ID, IN ,KS, ME, MA, MD, MI, MO, MT, NC, ND, NE, NV, RI, SC, SD, TN, TX, UT, VT, VA, WI, WY
25 hours:	AZ, FL, GA, HI, IL, LA, NH, NJ, NM, OH, PA, Puerto Rico, WV
24 hours:	CO, OK
20 hours:	KY, MN, NY, WA
17.5 hours:	OR