New business case submission checklist

Connecticut
Groups of 50 or Fewer Eligible Employees

Step 1:

Complete/Review Employer Application

- ☐ QPOS/MC/Dental/Life Application
- ☐ Joinder Agreement filled out for Life or out-of-state products.
- ☐ UC-5A or other applicable tax documents (Proof of Eligibility Form, if owner/officer/partner not on tax form)
- ☐ Initial premium check made payable to Aetna Inc.
- ☐ Copy of current/prior medical carrier's latest bill with employee roster and premium summary page
- ☐ Employer Funding Certification and Statement of Understanding

Step 2:

Complete/Review Employee Enrollment/Change Form

- ☐ Employee (EE) Enrollment Form for each employee (QPOS/MC/Dental/Life)
- ☐ All individuals waiving coverage must complete and sign Section B and E on the enrollment form
- ☐ Each employee must complete a Family Health Statement Form

Step 3:

Complete/Review Broker Information

- ☐ Illustrative signed rates and copy of census (Employee Listing Report) from Aetna rating tool
- ☐ Agent/broker must be licensed in Connecticut and appointed by Aetna

Effective dates may be the **first or fifteenth of the month only**. All required paperwork must be received by Aetna on the 25th of the previous month for 1st of the month effective dates and the 10th of the month for 15th of the month effective dates.

Send all information to:

E-mail
CranSGNBSubmissions@Aetna.com

or

Mail
Aetna Small Group
3 Independence Way
4th floor
Princeton, NJ 08540

Broker Name _____ Agency Name _____

For questions on this submission, please contact _____

Phone ( ) _____ Fax ( ) _____

E-mail Address _____

Prospect/Client Name _____

Prospect E-mail Address _____

All paperwork is enclosed and my submission is complete. I understand incomplete paperwork could delay the effective date of coverage.

Signature _____

For assistance with your new case submissions, contact your Aetna Sales Manager or call us at 1-888-277-1053.

14.03.947.1-CT E (4/11)

Submission details and guidelines

Employer information

Employer application

- Employer signature must be an owner or corporate officer
- Number of eligible and enrolled employees
- Premium percentage paid by employer
- Indicate selected products in Section II — Specifications for Coverage
- Complete grid for any employee/dependent health continuations (e.g., COBRA continuation)
- Applications will not be accepted more than 90 days from date signed

UC-5A or other applicable tax documents

- Out-of-state employees require proof of employment if not identified on UC-5A
- If owner, partner or corporate officer not listed on UC-5A, submit the Small Group Proof of Eligibility Form signed by employees and with requested documents
- Newly hired employees should be written on the QWTS and signed and dated by the employer.

Initial premium check made payable to Aetna Inc.

- Company check required

Copy of current/prior medical carrier's latest bill

- Include employee roster and premium summary page

Employee information

Employee applications filled out by each employee

- Any alterations must be initialed and dated by employee
- Individual Waiver Section completely filled out for each employee waiving coverage

Dental submissions*

- Employer Master Application
- Employee Enrollment Form
- First month premium check required (on company check stock) — Medical, Dental and Group Insurance may be submitted on one check
- Copy of illustrative Dental rates and census

Group Insurance submissions*

- Employer Master Application
- Employee Enrollment Form
- First month premium check required (on company check stock)
- Group Insurance and Dental may be submitted on one check
- Copy of illustrative Life rates and census if Term Life selected
- Individual Health Statement required if selecting Life amount in excess of Guaranteed Issue amount
- Completed Joinder Agreement

Avoid potential delays in getting your client enrolled.

Make sure your new case submissions are complete!

*If submitting standalone Dental or Life submission, tax documents and copy of prior carrier's bill are also required.

www.aetna.com

14.03.947.1-CT E (4/11)

Addendum to New Business Input Documents
Mandatory Requirement for Health Care Reform

Aetna is collecting employee count information to comply with the health care reform law.

We are asking you to provide the average number of people you employed in the prior calendar year. We need this information so we can accurately report your data and calculate any potential rebates to which you and your covered subscribers may be entitled under the new medical loss ratio requirements set forth in the Affordable Care Act (ACA).

The law defines the number of employees as "the average number of employees employed by the employer's company during the preceding calendar year." An employee is defined as any person for whom the company issues a W-2, including full-time, part-time, and seasonal workers, and regardless of insurance eligibility (sample calculation below). We need the average number of total employees for your company in 2010 to support the 2011 calculations and reports and the payment of any rebates due in 2012.

How to calculate the average number of total employees*

To calculate average number of employees for the year, determine the average number of employees for each month in 2010, add them together and then divide the total by twelve. In the example below, 253 / 12 = 21. Round up or down to the nearest whole number.

Month	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Average
Full Time	15	14	14	15	14	15	16	16	15	14	14	14	
Part Time	5	6	5	5	6	6	7	7	5	5	5	5	
Seasonal	0	0	0	0	0	2	3	3	2	0	0	0	
Total	20	20	19	20	20	23	26	26	22	19	19	19	21

*Subject to change based on future regulatory guidance

Please enter your calculated average number of employees in the box below.

Average Employees in 2010 (whole numbers only; please print legibly)

By signing below I certify that:

- I am an authorized representative of the plan(s) for which this information is being provided.
- The information I have provided is true and correct.
- Aetna may rely on the responses I have provided.

First Name (Please Print): **Last Name (Please Print):** **Title:**

Company Name: **Email Address (optional):**

Signature: **Today's Date:**

Aetna reserves the right to audit all information provided. Providing false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company, may violate applicable insurance statutes.

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

Connecticut Small Group Business (1 - 50 Eligible Employees*) Employee Enrollment/Change Form

* Life Insurance available only to groups of 2 to 50 eligible employees.

Member Aetna ID Number (if available)

Employer Name

INSTRUCTIONS: You, the employee, must complete this enrollment form in full or it will be returned to you resulting in a delay in processing. You are solely responsible for its accuracy and completeness. **If waiving coverage, please complete Sections B and E.**

Effective Date

Date of Hire

- ☐ New Hire
- ☐ Rehire/Reinstatement
- ☐ New Group Enrollment
- ☐ Late Enrollment
- ☐ Other _____

- ☐ Change of coverage
- ☐ Add Spouse/Civil Union Partner/ Domestic Partner/Dependent Child
- ☐ Name Change
- ☐ Other _____

- ☐ Employee Termination
- ☐ Remove Spouse/Civil Union Partner/Domestic Partner/ Dependent Child
- ☐ Cancel Coverage

COBRA/State Continuation for:
☐ Employee ☐ Dependent
Length of Continuation:
☐ 18 ☐ 36 ☐ Other _____
Original Qualifying Event Date _____
Reason _____

A. Coverage Selection – *Please print clearly, using black ink. (Shaded sections for Employer/Aetna Use Only)*

Control/Group No.	Suffix	Account	Plan No.	Class Code	Control/Group No.	Suffix	Account	Plan No.	Control/Group No.	Suffix	Account	Plan No.

1. Medical - Check one.

- ☐ 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: _____

2. Dental - Check one.

Standard Plans
Option: _____
Options 2 & 4: DMO® ☐ *or* PPO ☐

Voluntary Plans
Option: _____
Option 2: DMO® ☐ *or* PPO ☐

Before today, were you covered under this employer's dental plan? ☐ Yes ☐ No

3. Life and Disability

- ☐ Basic Life/AD&D Ultra®
- ☐ Optional Dependent Life
- ☐ Short Term Disability
- ☐ Life & Disability Packaged Plan

Beneficiary Designation - **Full Name** (First, Middle, Last)

Beneficiary Social Security Number

Relationship to Employee

B. Employee Information - *Must be completed by the employee.*

Social Security Number	Last Name, First Name, M.I.		Home Telephone	Primary Language Spoken (Optional)
Home Address	Apt. No.	City, State		ZIP Code
Work Address	City, State		ZIP Code	Work Telephone

Salary $ ☐ Hourly ☐ Weekly ☐ Monthly	No. of Hours Worked Per Week	Check One ☐ Full-Time ☐ Part-Time	Marital Status ☐ Married ☐ Single ☐ Civil Union Partner ☐ Domestic Partner	No. of Dependents Including Spouse/Civil Union Partner/ Domestic Partner

C. Individuals Covered - *List individuals for whom you are enrolling or adding/changing/removing coverage. Attach additional sheets if necessary.*

NOTE FOR MEDICAL AND DENTAL COVERAGE: While the Federal Patient Protection and Affordable Care Act mandates coverage of dependent children up to age 26 for medical plans and some dental plans, your plan may allow coverage beyond age 26. Some exceptions apply. Please refer to your plan documents or contact your benefits administrator.

Name (Last, First, M.I.)	Sex M/F	Social Security Number	Birthdate (MM/DD/YYYY)	Height (ft, in)	Weight (lbs)	Coverage Election	Other Health Coverage	Other Dental Coverage	Prior Dental Coverage	Student (Life Only)	Out of Area	Primary Office ID Number (if applicable)	Current Patient	Dental Office ID Number (if applicable)	Current Patient
Employee 1.						☐ Medical ☐ Dental ☐ Life/Dis	Yes ☐	Yes ☐	Yes ☐	Yes N/A	Yes ☐		Yes ☐		Yes ☐
Spouse /Civil Union Partner/Domestic Partner 2.						☐ Medical ☐ Dental ☐ Life	☐	☐	☐	N/A	☐		☐		☐
Child 3.						☐ Medical ☐ Dental ☐ Life	☐	☐	☐	☐	☐		☐		☐
Child 4.						☐ Medical ☐ Dental ☐ Life	☐	☐	☐	☐	☐		☐		☐

D. Race/Ethnicity – Optional (This information is designed for the purpose of data collection and will not be used for determining eligibility, rating or claim payment.)

Employee 1.	☐ White – 01 ☐ African American or Black – 02 ☐ Hispanic or Latin – 03 ☐ Asian – 04 ☐ Other – 05 _____	**Child 3.**	☐ White – 01 ☐ African American or Black – 02 ☐ Hispanic or Latin – 03 ☐ Asian – 04 ☐ Other – 05 _____
Spouse/Civil Union Partner/Domestic Partner 2.	☐ White – 01 ☐ African American or Black – 02 ☐ Hispanic or Latin – 03 ☐ Asian – 04 ☐ Other – 05 _____	**Child 4.**	☐ White – 01 ☐ African American or Black – 02 ☐ Hispanic or Latin – 03 ☐ Asian – 04 ☐ Other – 05 _____

E. Declination/Waiver of Coverage - *Check all that apply*

I understand I am eligible to apply for this coverage through my employer; however, I am waiving coverage as noted below.

☐ Waive Medical coverage for:	☐ Myself	☐ Spouse	☐ Child(ren)	**Reason for declining coverage** *(If applicable attach front/back of your health ID card.)*
☐ Waive Dental coverage for:	☐ Myself	☐ Spouse	☐ Child(ren)	☐ Spousal group coverage ☐ COBRA coverage
☐ Waive Life coverage for:	☐ Myself	☐ Spouse	☐ Child(ren)	☐ Medicare ☐ Military coverage
☐ Waive Disability coverage for:	☐ Myself			☐ Medicaid ☐ Another group plan provided by my employer
				☐ Individual coverage ☐ Do not want
				☐ Retiree coverage ☐ Other: _____

I certify I have been given the right to apply for this coverage; however, I am waiving coverage as noted above. By declining this group coverage I acknowledge that I and/or my dependents may have to wait until the plan's next anniversary date to be enrolled for group coverage. Pre-existing conditions, when enrolled in other than an HMO plan, may not be covered for twelve months. **NOTE:** If your Plan contains a pre-existing conditions provision, the preexisting conditions exclusion and limitation will not apply to a person under 19 years of age.

Please sign here ONLY if you are declining coverage for yourself and/or dependent(s).	***Date (Month/Day/Year)***
X Employee Signature	

F. Dependent Information

List any dependent in Section D living at another address.	Name:	Reason:	Address:
If any dependent's last name differs from yours, explain.	Name:	Reason:	

FOR DEPENDENT LIFE: If age +19 and a full-time student, provide the following:

Child Name	School Name	Expected Graduation Date	Number of Credit Hours

G. Other Insurance

Does anyone age 19 or over enrolling on this enrollment form have prior medical coverage? ☐ Yes ☐ No If Yes, provide the information requested in the table below. Proof of coverage should accompany this enrollment form for pre-existing condition credit if enrolling in other than an HMO plan. **Acceptable forms of proof are:**

1. Certificate of Creditable Coverage from prior carrier, or
2. Copy of ID card or most recent payroll stub showing medical coverage deduction, or
3. Copy of most recent medical premium bill from prior carrier.

Name of Covered Individual	Carrier Name	Group Number	Start Date	Termination Date	Health
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No

Conditions of Enrollment

On behalf of myself and the dependents listed on Page 1, I agree to or with the following:

1. I acknowledge that by enrolling in the following plans, coverage is provided by the following entities (collectively referred to as "Aetna"):
   - Aetna HMO plans: Aetna Health Inc.
   - Aetna POS plans and in-network portion of the QPOS plans: Aetna Health Inc. and/or Aetna Life Insurance Company.
   - Out-of-network portion of the QPOS plans, Indemnity, PPO plans, Life, Accidental Death & Dismemberment, DMO®, and Dental PPO plans: Aetna Life Insurance Company
2. I understand and agree that my employer's application will determine coverage and that there is no coverage unless and until both the eligible employee and employer applications have been accepted and approved by Aetna. Even if this enrollment form is approved, any misstatements or omissions may result in future claims being denied and the policy or my coverage under the policy begin rescinded or reevaluated, as of the effective date, for eligibility and rating purposes.

   For life coverages: I understand that the effective date of insurance for myself or for any of my dependents is subject to my being actively at work on that date and that the effective date of insurance for any of my dependents is also subject to the dependent health condition requirements of the benefit plan. Further, I understand that any insurance subject to evidence of good health or medical information will not become effective until Aetna gives its written consent. For Dependent Life, dependents are eligible from 14 days of age up to their 19th birthday or up to their 23rd birthday, if a full-time student.

continued on next page

Conditions of Enrollment *(continued)*

3. I understand and agree that this Enrollment/Change Form may be transmitted to Aetna or its agent by my employer or its agent. I authorize any physician, other healthcare professional, hospital or any other healthcare organization ("Providers"), to give to Aetna or its agent information concerning the medical history, services or treatment provided to anyone listed on this Enrollment/Change Form, including those involving mental health, substance abuse and HIV/AIDS. I further authorize Aetna to use such information and to disclose such information to affiliates, Providers, payors, other insurers, third party administrators, vendors, consultants and governmental authorities with jurisdiction when necessary for my care or treatment, payment for services, the operation of my health plan, or to conduct related activities. I have discussed the terms of this authorization with my spouse/civil union partner/ domestic partner and competent adult dependents and I have obtained their consent to those terms. This authorization will remain valid for the term of the coverage and for so long thereafter as allowed by law. I understand that I am entitled to receive a copy of this authorization upon request and that a photocopy is as valid as the original.
4. The plan documents will determine the rights and responsibilities of member(s) and will govern in the event they conflict with any benefits comparison, summary or other description of the plan.
5. I understand and agree that, with the exception of Aetna Rx Home Delivery®, all participating providers and vendors are independent contractors and are neither agents nor employees of Aetna. Aetna Rx Home Delivery, LLC, is a subsidiary of Aetna Inc. The availability of any particular provider cannot be guaranteed and provider network composition is subject to change. Notice of the change shall be provided in accordance with applicable state law.
6. I understand and agree that, with certain exceptions described in the plan documents, HMO and DMO® plans only provide coverage for referred benefits, and that, in order to be covered, services must be performed either by a participating primary care physician, primary care dentist, or by the participating specialist, hospital, pharmacy, dentist, or other provider as authorized by a referral from a participating primary care physician. In Connecticut, DMO plans provide out-of-network benefits. However, in order to receive maximum benefits, members must select and have care coordinated by a participating primary care dentist. Connecticut DMO is not an HMO.

Misrepresentation

7. 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.

I represent that all information supplied in this form is true and complete. I have read and agree to the Conditions of Enrollment and Misrepresentation on this **Connecticut** Small Group Business (1 - 50 Eligible Employees) Employee Enrollment/Change Form. I understand that, in the event I fail to sign this form within 31 days after the above transaction request or for any reason Aetna does not receive notice of the above transaction request within a reasonable time following the event, my and my dependents' eligibility may be affected. I am employed by the employer shown on Page 1, and I am working full time at least 30 hours per week for this employer at the regular place of business.

Employee Signature	*Employee E-mail Address (optional)*	*Date (Month/Day/Year)*
X		

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: _____

Small Employer Health Benefits Waiver of Coverage

Employer Information

Group Policy Number	Policyholder Name

Employee Information

Name (Last, First, Middle Initial)		Social Security Number
Marital Status □ Single □ Married □ Widowed □ Divorced	Date of Employment	Date of Birth (MM/DD/YYYY)

Refusal (please check the appropriate box)

I was given the opportunity to enroll in this plan of group health benefits offered by my employer and insured by Aetna, Inc. I **refuse** the following:

□ Employee, Spouse and Child(ren) coverage □ Spouse coverage □Child(ren) coverage

Reason for Refusal (please check all appropriate boxes)

□ Other Group Health Plan sponsored by this employer
□ Other Group Health Plan sponsored by another organization
□ Other Group Health Plan sponsored by my spouse's employer
□ Other reasons (please explain) _____

Please identify Group Health Plan(s) and provide name(s) of Policyholder(s), carrier(s) and policy number(s)

Policyholder Name	Carrier	Policy Number
Policyholder Name	Carrier	Policy Number

If you are declining enrollment for yourself or your dependents (including your spouse) because of other Group Health Plan coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.

If the reason for refusal of coverage is coverage under another Group Health Plan, it is important to provide information concerning that Group Health Plan on this Waiver of Coverage form. If you fail to provide this information on this Waiver of Coverage form and you later become ineligible for such other coverage and then wish to enroll in any of the refused coverages, you will be considered a Late Enrollee and may be subject to pre-existing conditions exclusion.

Signature of Employee	Date (MM/DD/YYYY)
Signature of Witness	Date (MM/DD/YYYY)

Aetna® Family Health Statement

Check One: ☐ New Group
☐ New Employee Add
☐ Existing Employee Change

A. Employer Information – *To be completed by Employer*

Employer Name (Please Print)		Policy Number	
Employer Street Address (P.O. Box not acceptable)	City	State	Zip
Applicant's Occupation	Hours Worked/Week	Full Time Hire Date (MM/DD/YYYY)	

B. Decline Coverage – *Must be completed by the employee.*

☐ I **Decline** to enroll for Health coverage due to the existence of other group health coverage for:

☐ Myself ☐ Spouse ☐ Dependent Child(ren)

If I and/or my dependents decline coverage and desire to participate in the plan at a later date, **I may** have to submit evidence of insurability satisfactory to the insurance company.

Employee Signature	Date (MM/DD/YYYY)

C. Request Coverage – *Answer ALL questions if additional space is needed, attach separate sheet. Complete for all family members applying for coverage*

Name (First, Initial, Last)	**Height** (ft., in.)	**Weight** (lbs.)	**Birthdate** (MM/DD/YYYY)	**Sex** M/F	**Full Time Student** Yes/No – If Yes, Name School
Employee					☐ No ☐ Yes -
Spouse					☐ No ☐ Yes -
					☐ No ☐ Yes -
					☐ No ☐ Yes -
					☐ No ☐ Yes -
					☐ No ☐ Yes -

Employee Social Security Number		Employee Marital Status ☐ Single ☐ Married		
Employee Street Address (P.O. Box not acceptable)		City	State	Zip
Employee Home Telephone ( )	Employee Work Telephone ( )	Where would you prefer to be called during the day? ☐ Home ☐ Work		

I hereby represent and agree that all the answers and statements in this request are full, complete and true, to the best of my knowledge and belief and understand that the said answers and statements form the basis upon which insurance will be made effective. I understand that omissions, misrepresentations, or misstatements about medical history could result in the denial of an otherwise valid claim and rescission, voiding, or reformation of insurance.

Employee Signature	Date (MM/DD/YYYY)
Spouse Signature	Date (MM/DD/YYYY)

Other side must be completed.

Employer Name (Please Print)

D. Employee Eligibility

- Are you now actively at work full time (30+ hrs/week)? ☐ Yes ☐ No
- Does your spouse have medical coverage elsewhere? ☐ Yes ☐ No
- Is any person to be insured currently covered under COBRA? ☐ Yes ☐ No
- Is any person to be insured enrolled in Medicare? ☐ Yes ☐ No

If Yes, who: _____ ☐ Medicare A ☐ Medicare B

E. Health Information – To request coverage answer ALL questions. Details may be submitted via sealed envelope marked "confidential" for "Yes" answers, details must be provided. *If illness is unlisted, provide details in the row marked "other".*

1. Are you, your spouse, or any dependent to be insured, currently disabled or unable to perform their normal activities? ☐ Yes ☐ No
   Who/Why: _____
2. Have you, or any dependent, been hospitalized, or been advised to be hospitalized within the past 5 years for any reason? ☐ Yes ☐ No
   Who/Why: _____
3. Have you, or any dependent, had surgery, or been advised to have surgery within the past 5 years for any reason? ☐ Yes ☐ No
   Who/Why: _____
4. Are you, or any dependents to be covered, currently pregnant? ☐ Yes ☐ No
   Who/Expected Delivery Date: _____
5. Is this pregnancy the result of infertility treatment? ☐ Yes ☐ No
   Please explain: _____
6. Are you or any dependents to be covered, currently taking any medication? ☐ Yes ☐ No
   Who/Why: _____
   Medication: _____
7. Have you, or any dependent, had medical expenses in excess of $5,000.00 in the last 12 months? ☐ Yes ☐ No
   Who/Why: _____
8. Have you, or any dependent ever had, or has a Medical Professional told, counseled, or treated, you or any dependent, for any of the following:

	Yes	No	Person Affected	Diagnosis & Date Diagnosed	Treatment and/or Medication	Degree of Recovery	Name, Address & Telephone Number of Physician and/or Hospital
a) Chest Pain, Heart Attack, or other heart condition	☐	☐					
b) Condition/Disease of the circulatory system (i.e. blood vessels, phlebitis, leg ulcers)	☐	☐					
c. Cancer, tumor, or lymph node enlargement (indicate type of cancer and location)	☐	☐					
d. Acquired Immuno Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)	☐	☐					
e. High Blood Pressure (if yes, provide most recent reading)	☐	☐					
f. Diabetes or disorder of endocrine system or glands (indicate if insulin dependent)	☐	☐					
g. Alcohol or drug use, abuse, and/or dependency	☐	☐					
h. Disease of the kidney, bladder or urinary tract	☐	☐					
i. Crohns, Colitis, diseases of stomach, intestine, esophagus or gallbladder	☐	☐					

Employer Name (Please Print)

E. Health Information (Continued)

j. Disorder of the liver or pancreas	☐	☐					
k. Disorder of the lungs or respiratory system	☐	☐					
l. Organ Transplants (if yes, include type and date)	☐	☐					
m. Neurologic problems--disorder of the brain, seizures, epilepsy, central nervous system--stroke or paralysis	☐	☐					
n. Nervous, mental, depression, stress or anxiety related disorder, eating disorder	☐	☐					
o. Disorder of the blood (including anemia)	☐	☐					
p. Lupus or Arthritis (if yes, indicate type and severity of disability)	☐	☐					
q. Congenital anomalies or disorders	☐	☐					
r. Other (any disease/condition not listed above)	☐	☐					

Associated Companies

For Small Employers (2-50) with Affiliated Companies, Subsidiaries or Common Ownership

Legal Business Name	
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:

Please Note:

- 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.
- Some states do require affiliated groups to enroll as one, please check your local state requirements.

Business Name (the primary company applying must also be included below)	**Tax Identification Number**	**Owner's name(s)**	**Percentage of Ownership**	**Number of Employees**	**Is group to be included**	**Separate or Common Filing**
					❑Yes ❑No	❑Separate filing ❑Common filing
					❑Yes ❑No	❑Separate filing ❑Common filing
					❑Yes ❑No	❑Separate filing ❑Common filing
					❑Yes ❑No	❑Separate filing ❑Common filing
					❑Yes ❑No	❑Separate filing ❑Common filing

If you have answered '**NO**" to "Is group to be included" above, please explain why:	
Is your company a branch of another company, or does your company have branch offices?	❑Yes ❑No
If yes: Is each branch office a separate legal entity?	❑Yes ❑No
Is each branch office a location of one legal entity?	❑Yes ❑No
How many branch offices are there?	
Are tax filings separate or as one common filing?	❑Separate filing ❑Common filing
Where is each branch located? (List each branch office address separately)	**Number of employees at each location**

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages.

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 misrepresentation or fraudulent statement may result in rescission of the group policy, termination of coverage, increase in premiums, or other consequences. 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.

Employer Signature	Date
Print Name	Title

Request for Participation and Joinder Agreement

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 Employer's selection(s):

Medical Out-of-State (OOS) Plan:	OOS PPO*	☐ 250	☐ 500	☐ 1000
Dental Out-of-State (OOS) Plan (as applicable):	OOS PPO*	☐ 1000	☐ 1500	☐ 2000

☐ Group Life (in and/or out-of-state)

☐ Group Disability (in and/or out-of-state)

The undersigned, as a Participating Employer in the Industry Trust corresponding to the Standard Industry Classification ("SIC") code selected below: 1) agrees to be bound by the terms of the Agreement and the Group Policy issued to the Trustee (including any amendments); 2) requests coverage for its eligible employees under the Group 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 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.

	SIC Code
Agent(s) of Record	SSN/TIN
Signed at (City/State)	Date
(Employer)	
Signature – Title	
(Print Name)	

*An OOS Indemnity plan will be substituted for any out-of-state employee not residing in a PPO service area.

New Business Late Submission Form

Aetna Small Group
Northeast Region

For use on new business cases submitted to Aetna Small Group AFTER:

- **25th** of the month for **1st** of month effective dates
- 1**0th** of the month for **15th** of month effective date

In order for new business cases to be submitted late, up to and including the requested effective date, this form is required. Cases received after the effective date will be moved to the next available effective date.

We want to assure that both Group Administrator and the Broker understand the impact of a late submission.

Please sign below. Your signature acknowledges the following:

- This new business case has been submitted to Aetna's Underwriting Department after the deadline for the proposed effective.
- The case will be subject to underwriting review and evaluation.
- This does not guarantee coverage until approved by Aetna Underwriting.
- The application for coverage may not be approved until after the effective date.
- If approved, we understand that Aetna will not be able to produce a group/control number, member ID numbers or member ID cards until the installation is completed.

A. Group Information

1. Group Name	
2. Group Address	
3. Group Administrator Signature	4. Date (MM/DD/YYYY)

B. Broker Information

1. Broker Name	
2. Broker Signature	3. Date (MM/DD/YYYY)