AETNA NEW JERSEY

Through First National Administrators (2-50)

1. Employer Application Form
2. Employer Certification Form
3. Employee Census (Quote must reflect total employees enrolling with correct DOH, DOB, Status & Gender)
4. Employee applications signed by both the employer and employee
5. Waiver form completely filled out for each employee waiving coverage
6. Copy of signed quote – MUST be signed by employer or case WILL NOT be approved
7. Copy of itemized prior carrier list bill
8. First month's premium check made payable to: Aetna (MUST BE COMPANY CHECK)
9. Proof of Full Time Student Status
10. Case submission Checklist
11. Addendum to New Business Input Form
12. NJ Funding Attestation Form
13. HSA Declaration of Understanding

Participation Requirements

75% of eligible employees must have coverage including those under a spouse's health benefit plan, Medicare or another group health benefits plan.

Tax Documents - subject to change according to Aetna underwriters:

- Existing Corp – Most recent WR-30
- K1 or Schedule C plus Proof of Eligibility Form. K1's MUST equal 100%
- Newly Formed Business – Payroll records and letter from attorney or CPA listing the names of all employees, number of hours worked on a regular basis, indication of salary draw. Also must have Tax ID # AND Copy of Business License

*Effective dates: 1st & 15th only - NOTE – All required paperwork must be received by Aetna on the 25th of the previous month for the 1st of the month effective dates and the 10th of the month for a 15th of the month effective date.

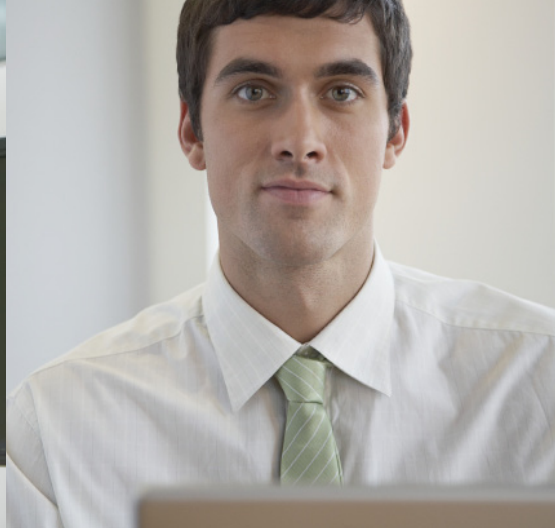
Rates based upon final submission

ATTENTION ALL BROKERS!!

You **MUST** be appointed with Aetna PRIOR to the sale of ANY Aetna case. Failure to do so will result in not being paid Aetna commissions now or in the future. Having a vendor number does not necessarily mean you are appointed. If you are submitting a case and have not been appointed yet, please call Noreen at FNA/Greater Metro Commission Dept.

FNA
FIRST NATIONAL ADMINISTRATORS
Employee Benefit Consultants

Revised 5/3/2013



New business case submission checklist

New Jersey

Step 1:

Complete/Review Employer Application

- ☐ Medical Application
- ☐ Certification Form
- ☐ Dental/Life/Disability Application
- ☐ Joinder Agreement filled out for Life or out-of-state products.
- ☐ WR-30 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 for Small Group Employers Attestation Form
- ☐ HSA Declaration of Understanding for HSA compatible plans

Step 2:

Complete/Review Employee Change Form

- ☐ Medical Employee (EE) Enrollment Form for each employee
- ☐ Dental/Life/Disability (EE) Enrollment form
- ☐ Waiver Form for each employee waiving coverage

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 New Jersey and appointed by Aetna

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 for Small Group employers Attestation Form.

Signature _____

14.03.947.1-NJ A (4/11)

Detailed submission guidelines attached.

Effective dates may be the **first or fifteenth of the month only**.

If purchasing a group Medicare plan, only the first of the month effective date is available for the entire group's submission.

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

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

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

WR-30 or other applicable tax documents

- Out-of-state employees require proof of employment if not identified on WR-30
- If owner, partner or corporate officer not listed on WR-30, 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.

14.03.947.1-NJ A (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.

APPLICATION FOR A SMALL GROUP HEALTH BENEFITS POLICY

Please Print or Type	For Aetna Use Only
☐ New Policy ☐ Change in Policy Requested Effective Date _____ **NOTE:** The Effective Date will be on or after the date Aetna approves the application.	Policy Number _____

Section I: POLICYHOLDER INFORMATION

1. Policyholder (Full Legal Name of Company)		2. Tax Identification Number		
3. Main Address: Street		City	State	ZIP
Mailing Address: Street		City	State	ZIP
Telephone Number ( )	Facsimile Number ( )	Email Address		
4. Name of Correspondent			Telephone	

5. Type of Organization
☐ Corporation ☐ Partnership ☐ Proprietorship ☐ Other (explain):

6. Nature of Business (specify)	SIC Code

7. Number of eligible employees in your company

Refer to the New Jersey Small Employer Certification for the definition of an eligible employee.

8. Number of eligible employees to be insured	9. Class or classes to be excluded

10. Insurance requested for
☐ Employees Only ☐ Employees and Dependents
Should the plan provide coverage for domestic partners as permitted by P.L. 2003, c.246? ☐ Yes ☐ No
If "Yes", should the plan provide coverage for children of a covered domestic partner? ☐ Yes ☐ No

11. Is the Employer subject to the requirements of COBRA?
☐ Yes ☐ No

12. Is the employer subject to the requirements of Medicare as Secondary Payor Rules for eligibility due to
age? ☐ Yes ☐ No
disability? ☐ Yes ☐ No

13. Waiting period before employees become insured (may not exceed 6 months):
Current Employees: _____
New or Rehired Employees: _____

14. What percentage of the premium will the employer pay?

15. Deposit $ _____ Premium Paid: Monthly	Premium will be due as of the effective date. The premium for the first month of coverage must be attached.

Affiliates, subsidiaries or branches (must be included for the purposes of participation)

Legal Name and Location	No. Eligible Employees In This Company	No. Eligible Employees to Be Insured

Section II: SPECIFICATIONS FOR COVERAGE

Health Benefits:

☐ NJ HMO: Plan Option - _____ RX Option - _____

☐ NJ HMO No-Referral: Plan Option - _____ RX Option - _____

☐ NJ Cost-Sharing HMO: Plan Option - _____ RX Option - _____

☐ NJ Cost-Sharing HMO No Referral: Plan Option - _____ RX Option - _____

☐ NJ HMO HSA Compatible No Referral: Plan Option - _____ RX Option - _____

Plan Administration: ☐ CalYr ☐ PlnYr

☐ NJ POS: Plan Option - _____ RX Option - _____

☐ NJ POS No-Referral: Plan Option - _____ RX Option - _____

☐ NJ Cost-Sharing POS: Plan Option - _____ RX Option - _____

☐ NJ Cost-Sharing POS No Referral: Plan Option - _____ RX Option - _____

☐ NJ POS HSA Compatible No Referral: Plan Option - _____ RX Option - _____

Plan Administration: ☐ CalYr ☐ PlnYr

☐ NJ PPO Basic Hospital

☐ NJ PPO First Dollar

☐ NJ PPO HSA Compatible: Plan Option - _____

☐ Out-of-State/Situs PPO Plans:

☐ $250 (High) ☐ $500 (Medium) ☐ $1,000 (Low)

☐ Standard Health Benefits Plans:

☐ NJ HMO: Plan Option - _____ RX Option - _____

☐ NJ POS: Plan Option - _____ RX Option - _____

☐ NJ Indemnity: Plan Option - _____

☐ Other Plan _____

If you have selected an HSA-compatible plan:

- Do you plan on making contributions to your employee's HSA accounts? ☐ Yes ☐ No
- Do you plan to offer your employees payroll deductions to fund their HSA accounts? ☐ Yes ☐ No

Section III: ALL QUESTIONS MUST BE ANSWERED

1. Is there any Group Health Plan:
   - now in force and to be continued? ☐ Yes ☐ No
   - currently being applied for? ☐ Yes ☐ No

   If "Yes", identify the name of the Group Health Plan, give a description of the plan(s) and the name of insurance carrier(s):

   _____

2. Name of present or prior group carrier _____

   Effective date of prior coverage _____ Cancellation/Termination Date _____

   Is the coverage applied for in this application replacing other group insurance? ☐ Yes ☐ No

   If "Yes" give reason _____

   Plan being replaced ☐ A ☐ B ☐ C ☐ D ☐ E ☐ HMO ☐ HMO/POS ☐ Dual Contract POS ☐ Other _____

3. Has your firm been uninsured for 3 or more months prior to application? ☐ Yes ☐ No
4. What forms of Insurance are now or were in force? ☐ Health Benefits ☐ Prescription Drugs
   (Attach copies of Booklet/Certificate and most recent Billing Statement.)
5. Are extended benefits provided in case of termination of health benefits? ☐ Yes ☐ No
6. To the best of your knowledge, are there any current or former employees or their eligible dependents whose health insurance is being continued? ☐ Yes ☐ No

Please provide the following information for each current/former employee or dependent on health continuations.
If additional space is needed, attach a separate sheet, signed and dated.

Name of Employee/ Dependent	Date of Birth	Type of Continuation State/Federal/ Extended Benefits	Reason for Termination Disability/Other	Continuation Dates	
				Start	End

Section III: ALL QUESTIONS MUST BE ANSWERED *(continued)*

7. To the best of your knowledge:
   a. Are any employees or dependents presently incapacitated? ☐ Yes ☐ No
   b. Are any dependent children incapable of self-support due to a physical or mental disability? ☐ Yes ☐ No

Additional space to explain if items 1, 2 or 3 were answered "Yes". Refer to the question number, and give details, including names, where appropriate.

8. Does the employer participate in an arrangement with a Professional Employer Organization? ☐ Yes ☐ No
(Refer to Advisory bulletin 00-SEH-02 if you need information concerning what constitutes a Professional Employer Organization.)

Section IV: AGENT/PRODUCER INFORMATION

Information on agent's compensation is available from your agent or at Aetna.com.

Agent/Broker Name: _____ Aetna Agent Number/Tax ID/SSN: _____

Agency Name: _____ % of Credit: _____

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

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

Signature: _____ Date: _____ E-Mail Address: _____

Agent/Broker Name: _____ Aetna Agent Number/Tax ID/SSN: _____

Agency Name: _____ % of Credit: _____

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

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

Signature: _____ Date: _____ E-Mail Address: _____

General Agent Name: Greater Metro Agency Aetna Agent Number/ID Number: _____

Phone Number: (973) 257-5558 Fax Number: (____) _____

Address: 26B Hill Road City: Parsippany State: NJ ZIP: 07054

Signature: _____ Date: _____ E-Mail Address: _____

Section V: SIGNATURE

It is understood that, except as provided under applicable regulations, no individual shall become insured while not actively at work on a full-time basis, and only full-time employees are eligible. A full-time employee is one who regularly works at least 25 hours per week at his employer's place of business.

It is further understood that no agent has power on behalf of Aetna Health Inc. and Aetna Life Insurance Company to make or modify any request or application for insurance or to bind Aetna Health Inc. and Aetna Life Insurance Company by making any promise or representation or by giving or receiving any information.

It is further understood that no insurance will be effective unless and until the application is accepted in writing by Aetna Health Inc. and Aetna Life Insurance Company. Final rates will be based on enrollment data as of the Policy effective date. No contract of insurance is to be implied in any way on the basis of the completion and/or submission of this application.

Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

Date at _____ on _____

Print Name of Officer, Partner or Proprietor _____

Signature of Officer, Partner or Proprietor _____

Witness to Signature _____

Note: If there are any modifications to the statements and answers given in this application (i.e., crossed out, whited-out, erased information), the applicant must attest to the modifications by giving a complete signature in the margin near the modification.

Aetna® Employer Certification

Legal Name and Address of Company	Group Policy Number or Group Number (if a current customer)

Group Health Benefits Policy Participation

Please indicate below the number of employees by work location/State. All employees must be included, regardless of whether or not they currently have medical coverage and through whom that coverage is provided.

	Number of Employees				
Work Location (list by State)	**Full-time**	**Part-time**	**Retired**	**COBRA or State Continuees**	**Other**

(For Existing Small Employer Groups in the State of New Jersey OR New Applicants)	
An Eligible Employee is one who works on a full-time basis with a normal workweek of 25 or more hours for compensation. An employee who works less than 25 hours per week on a temporary or substitute basis, or an employee participating in an employee welfare arrangement established pursuant to a collective bargaining agreement is not an eligible employee.	
Total # Eligible Employees	
Total # Eligible Employees applying/enrolling for health benefits coverage	
Total # Eligible Employees waiving health benefits coverage under the policy with coverage under their spouse's coverage, other than individual coverage, Medicare, Medicaid, or NJ FamilyCare or any other group Health Benefits Plan through a different employer.	
Total # Eligible Employees waiving health benefits coverage under the policy with coverage under a Health Benefits Plan issued by another carrier and offered by the small employer.	
Please separately list the name(s) of the other carrier(s) and the number of employees covered under each: _____ _____	 Number of Employees Number of Employees
Total # Eligible employees waiving health benefits coverage under the policy without coverage under a spouse's coverage, other than individual coverage, Medicare, Medicaid, or NJ FamilyCare or any other group Health Benefits Plan.	
Total # Employees in an ineligible class or classes	
Is your firm subject to Working Aged Provisions of federal law (TEFRA/DEFRA)? (You may be subject to the law if you employed 20 or more employees for 20 weeks in the current or prior calendar year)	☐ Yes ☐ No
Is your firm subject to the requirements of the federal COBRA law? (You may be subject to the law if you employed 20 or more employees during 50% or more of the working days during the previous calendar year.)	☐ Yes ☐ No

CERTIFICATION AS A SMALL EMPLOYER IN THE STATE OF NEW JERSEY IN ACCORDANCE WITH NEW JERSEY STATUTE, CHAPTER 27A OF TITLE 17B

For a policy of Group Health Benefits Insurance

(Please sign and date appropriate section indicating whether or not you meet the definition of a small employer.)

"Small Employer" means, in connection with a Group Health Plan with respect to a Calendar Year and a Plan Year, any person, firm, corporation, partnership, or political subdivision that is actively engaged in business that:

- employed an average of at least two, but not more than 50, eligible Employees on business days during the preceding Calendar Year, and
- employs at least two Employees on the first day of the Plan Year, and
- the majority of the Employees are employed in New Jersey.

All persons treated as a single employer under subsection (b), (c), (m) or (o) of section 414 of the Internal Revenue Code of 1986 shall be treated as one employer. In the case of an employer that was not in existence during the preceding Calendar Year, the determination of whether the employer is a small or large employer shall be based on the average number of Employees that it is expected that the employer will employ on business days in the current Calendar Year.

☐ **I certify that I qualify as a Small Employer in the State of New Jersey.**

AND

☐ **I certify that the information provided to Aetna is true and complete.** I understand that if the above information is not complete or is not provided to Aetna in a timely manner, then health benefits coverage does not have to be offered or continued. I further understand that incomplete or untrue information may void health benefits coverage.

I understand that I and my employees may be subject to fines if an employee who is a resident of New Jersey and is eligible for coverage under this group health benefits plan is enrolled in an individual health benefits plan issued on or after August 1, 1993.

Signature of Officer, Partner or Owner | Title | Date

Print Name of Officer, Partner or Proprietor

Signature of Witness | Date

☐ **I certify that I am NOT a Small Employer in the State of New Jersey as defined above.**

Signature of Officer, Partner or Owner | Title | Date

Print Name of Officer, Partner or Proprietor

Signature of Witness | Date

Any person who includes any false or misleading information on an application or enrollment form or certification for a health benefits plan is subject to criminal and civil penalties.

COMPLETE THIS SECTION ONLY IF YOU HAVE CERTIFIED THAT YOU ARE A SMALL EMPLOYER IN THE STATE OF NEW JERSEY.

*EMPLOYEE CENSUS INFORMATION

Please include the following persons in the following list:

a. employees, owners, partners, officers, and independent contractors who are actively working for the employer on a regular basis, and are paid by the employer on a regular basis, whether or not they are eligible to be covered under the policy.

b. employees, owners, partners, officers, and independent contractors who are not working, but who are currently covered under the employer's health benefits plan for reasons such as continuation of coverage or total disability.

Please use the following letters to indicate Status:

F: Full-time employee who works 25 or more hours per week
P: Part-time employee who works less than 25 hours per week
T: Temporary employee
I: Independent Contractor
D: Totally Disabled employee
C: Continuee under state or federal law
U: Employee participating in an employee welfare arrangement established pursuant to a collective bargaining agreement.

Name	Job Title	Date of Employment	Hours Worked per Week	Status	Work Location (State)	Gender	Date of Birth
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
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20							
21							
22							
23							
24							
25							
26							
27							
28							
29							
30							

*If additional space is needed, attach a separate sheet.

New Jersey Small Group Enrollment/Change Request
Aetna Health Inc.
Aetna Life Insurance Company

Employer Group Information - To Be Completed by Employer

Group Name			
HMO Only - Group No.	Class Code		
PPO Only - Control No.	Suffix	Account No.	Plan No.

A. Type of Activity - To Be Completed by Employer. To Add, Change, or Remove coverage for dependents over the limiting age, but less than 30, Aetna Form HINT Supplemental Enrollment Information Form Implementing P.L. 2005, c. 375, must be completed. ***Refer to instructions on Page 3 before completing this form. Print clearly.***

1. Enrollment

☐ New Enrollee/Subscriber

Effective Date ___/___/___

Date of Hire ___/___/___

2. Change - *Check all that apply.*

	Date of Event	Reason
☐ Add Spouse/Civil Union Partner	___/___/___	
☐ Add Domestic Partner	___/___/___	
☐ Add Dependent Child	___/___/___	
☐ Name Change	___/___/___	
☐ Change Plan	___/___/___	
☐ Other	___/___/___	
☐ Add/Change Primary Office ID Number	___/___/___	

3. Remove or Terminate - *Check all that apply.*

	Effective Date	Reason
☐ Remove Spouse/Civil Union Partner*	___/___/___	
☐ Remove Domestic Partner*	___/___/___	
☐ Remove Dependent Child*	___/___/___	
☐ Employee Withdrawal/ Termination	___/___/___	

NOTE: Employee must be enrolled for spouse/civil union partner/dependent(s) to have coverage.

* Please complete *Add/Change/Remove* and *Name* columns in Section D.

4. Continuation of Coverage, i.e. COBRA, State, Total Disability
- Not all options are available or applicable. Contact Employer for available options.

Coverage For: ☐ Employee ☐ Spouse/Civil Union Partner* ☐ Dependents

Length of Continuation: ☐ 18 mos. ☐ 29 mos. ☐ 36 mos. ☐ Total Disability**

Date of Loss of Coverage: ___/___/___

Date of Qualifying Event: ___/___/___

* Civil union partners are eligible to make an election pursuant to NJSGC, if applicable.

** Attach proof of total disability.

B. Employee Information - Complete Sections B - I.

Social Security Number	Last Name, First Name, M.I.		Home Telephone ( )
Home Address	Apt. No.	City, State	ZIP Code
Employer Name	E-Mail Address		Work Telephone ( )
Work Address	City, State		ZIP Code
Date of Employment:	Hours Worked Per Week:		

C. Medical Plan Options - Your selection must be offered by your employer.

Check One:

☐ NJ HMO: Plan Option _____ Rx Option _____

☐ NJ HMO No-Referral: Plan Option _____ Rx Option _____

☐ NJ Cost-Sharing HMO: Plan Option _____ Rx Option _____

☐ NJ Cost-Sharing HMO No-Referral:
Plan Option _____ Rx Option _____

☐ NJ HMO HSA Compatible No-Referral:
Plan Option _____ Rx Option _____
Plan Administration: ☐ CalYr ☐ PlnYr

☐ NJ POS: Plan Option _____ Rx Option _____

☐ NJ POS No-Referral: Plan Option _____ Rx Option _____

☐ NJ Cost-Sharing POS: Plan Option _____ Rx Option _____

☐ NJ Cost-Sharing POS No-Referral:
Plan Option _____ Rx Option _____

☐ NJ POS HSA Compatible No-Referral:
Plan Option _____ Rx Option _____
Plan Administration: ☐ CalYr ☐ PlnYr

☐ NJ PPO Basic Hospital

☐ NJ PPO First Dollar

☐ NJ PPO HSA Compatible: Plan Option _____

☐ Out-of-State/Situs PPO Plans:
☐ $250 (High) ☐ $500 (Medium) ☐ $1,000 (Low)

☐ Standard Health Benefits Plans:
☐ NJ HMO: Plan Option _____ Rx Option _____
☐ NJ POS: Plan Option _____ Rx Option _____
☐ NJ Indemnity: Plan Option _____

☐ Other Plan: _____

D. Individuals Covered - List individuals for whom you are adding/changing/removing coverage. Attach sheet to list additional children. Attach proof if full-time post-secondary student.

	(A)dd (C)hange (R)emove	Last Name, First Name, M.I.	Sex M F	Birthdate MM DD YYYY	Social Security Number	Other Rx Drug Coverage	Other Health Coverage	Previous Coverage Check if "Yes"	Primary Office ID Number / NPI Number	Current Patient
Employee			☐ ☐	/ /		Yes ☐	Yes ☐	Yes ☐	Office / NPI	Yes ☐
Spouse/ Civil Union Partner			☐ ☐	/ /		☐	☐	☐	Office / NPI	☐
Domestic Partner			☐ ☐	/ /		☐	☐	☐	Office / NPI	☐
Child			☐ ☐	/ /		☐	☐	☐	Office / NPI	☐
Child			☐ ☐	/ /		☐	☐	☐	Office / NPI	☐
Child			☐ ☐	/ /		☐	☐	☐	Office / NPI	☐

E. Pre-Existing Conditions Statement

NOTE: This information may **ONLY** be used to determine if a condition is a pre-existing condition. You **CANNOT** be denied coverage under a health benefits plan on the basis of accurate responses to the following questions. Carriers can only use the information to expedite the processing of claims.

Yes No

☐ ☐ 1. During the past 6 months, have you or any dependent to be covered had or been diagnosed as having any of the following? If "Yes," check appropriate box(es) below.

- ☐ a. Alcoholism or Drug Abuse
- ☐ b. Arthritis
- ☐ c. Blood Disorder
- ☐ d. Back or Neck Disorder, Injury
- ☐ e. Cancer or Tumors
- ☐ f. Diabetes
- ☐ g. Gastro or Intestinal Disorder
- ☐ h. Heart Disorder or Condition or Chest Pain
- ☐ i. High Blood Pressure
- ☐ j. Kidney or Liver Disorder
- ☐ k. Lung or Respiratory Disorder or Pain
- ☐ l. Mental or Nervous Disorder
- ☐ m. Paralysis, Stroke or Epilepsy

Yes No

☐ ☐ 2. During the past 6 months, have you or any dependent to be covered:

- ☐ ☐ a. been examined or treated by a physician or other health care provider for any condition, illness, or injury, other than as stated above?
- ☐ ☐ b. been advised to have treatment or surgery or testing that has not been done?
- ☐ ☐ c. been admitted to a hospital or other health care facility as an inpatient?
- ☐ ☐ d. taken prescribed medications?

Please give details for "Yes" answers to any part of Questions 1 or 2 on a separate sheet of paper. This separate sheet should be signed and dated.

F. Other/Previous Insurance

Is your Spouse/Civil Union Partner Employed? ☐ Yes ☐ No If "Yes," give name & address of spouse/civil union partner's employer.

If "Yes" to **Other Health Coverage** (Section D), give names & policy numbers of insurance carrier, HMO, or other source. If enrolled in Medicare Parts A and/or B, identify the coverage and provide the Medicare ID number.

If "Yes" to **Other Rx Drug Coverage** (Section D), give name & policy number of insurance carrier, HMO, or other source.

If "Yes" to **Previous Coverage**, identify name(s) of persons, give effective date and date coverage terminated, name of previous carrier and plan number and submit a copy of the Certificate of Creditable Coverage that was issued by the previous carrier, if available.

G. Dependent Information

Does any dependent listed in Section D live at a different address than the Employee? ☐ Yes ☐ No If "Yes," who and at what address?

Explain the circumstances.	If any dependent's last name differs from yours, explain the circumstances.

H. Race/Ethnicity - To be completed by the Employee, at his/her option. *NOTE: your response is appreciated but NOT required!*

Choose a category that most closely describes you:

☐ American Indian or Alaskan Native ☐ Black, not of Hispanic origin ☐ Hispanic
☐ Asian or Pacific Islander ☐ White, not of Hispanic origin

I. Employee Signature

If you have questions concerning the benefits and services provided by or excluded under this Agreement, contact a Member Services representative at 1-800-702-3862 (for HMO or POS products) or 1-888-802-3862 (for Traditional or PPO products) before or after signing this form.

I represent that all the information supplied in this application is true and complete. I hereby agree to the conditions of enrollment on the reverse side of the employee copy of this Enrollment/Change Request form. I authorize deductions from my earnings for any required contributions.

Employee Signature - *Required*	E-Mail Address	Date
X		/ /

J. Employer Verification - To Be Completed by Employer

Employer Signature - *Required*	Title	Date
X		/ /

Employee copy may be used as a temporary ID card for 30 days from the effective date if authorized by employer. Coverage must be verified with Aetna Health Inc. and/or Aetna Life Insurance Company prior to visiting a specialist or admission to a hospital.

Instructions

Employer

- Complete the **Employer Group Information** in the upper right corner of the form.
- **Section A - Type of Activity:** Check boxes indicating reason(s) for submitting application.
  - Complete **Section J - Employer Verification** on Page 3 of this form.
  - Employer must complete this section for all new enrollments, coverage changes and terminations.
  - Employer must sign and date the Enrollment/Change Request form in order for it to be processed.

Employee - Complete Sections B - I.

Section B - Employee Information:

Complete **all** information in order for your application to be processed.

Section C - Medical Plan Options:

- Check one Plan Option box and indicate Plan Option name (where applicable) and check one copay.
- Select only an option offered by your employer.

Section D - Individuals Covered:

- Do not complete this form for dependents over the limiting age, but less than 30; Aetna Form, HINT Supplemental Enrollment Information Form Implementing P.L. 2005, c. 375, must be completed.
- Add/Change/Remove - Use "A", "C", or "R" to indicate whether you are adding, changing or removing coverage for an individual.
- Print your full name along with the name(s) of your dependents, if applicable. Indicate Sex, Birthdate, and Social Security Number for each individual listed.
- If a dependent is a full-time post-secondary student, you **must** attach a current course schedule or a letter from the school or its authorized representative confirming full-time student status. If dependent is disabled and being continued beyond the limiting age, attach proof of disability.
- If you or your dependent(s) have other Health or Rx drug coverage, check off the "Yes" box(es) and complete Section F - Other/ Previous Insurance.
- From the appropriate provider directory, locate the **6-digit** office ID number for the primary care physician and/or dentist (if applicable). Indicate office ID number selection(s) on the form.
- You may obtain each provider's NPI number by contacting the provider directly. Providers with multiple office locations and individual providers who belong to more than one practice or provider entity may have more than one NPI number. You should confirm the correct NPI number for the specific provider and office location where you will be seen by contacting the office directly.
- If you are a current patient, please check the "Current Patient" box.

Section E - Pre-Existing Conditions Statement:

Complete this section for all new enrollments. **Exceptions** for Small Employer Group coverage, this section must be completed only by persons enrolling for coverage in a group of 2 - 5 employees, and by late entrants.

Continued on next page

Instructions *(continued)*

Employee - Complete Sections B - I.

Section F - Other/Previous Insurance:

Complete this section for all new enrollments or coverage changes. Coverage includes group coverage, governmental coverage, a church plan or Medicare.

Section G - Dependent Information:

Complete this section for all new enrollments or coverage changes.

Section I - Employee Signature:

- Complete this section for all new enrollments, coverage changes and terminations.
- Employee must sign and date the Enrollment/Change Request form in order for it to be processed.

Section J - Employer Verification:

- Employer must complete this section for all new enrollments, coverage changes and terminations.
- Employer must sign and date the Enrollment/Change Request form in order for it to be processed.

Conditions of Enrollment

Applicant Acknowledgments and Agreements

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

1. a) I authorize the sources stated below to give to Aetna Health Inc. and/or Aetna Life Insurance Company information about me and my minor children, if applying for coverage. Such information will pertain to employment, other health coverage, and medical advice, treatment or supplies for any physical or mental condition. Authorized sources are any physician or medical professional; any hospital, clinic or other medical care institution; any carrier; any employer.
   b) I understand that I may revoke this authorization at any time. I agree that such revocation will not affect any action which Aetna Health Inc. and/or Aetna Life Insurance Company has taken in reliance on the authorization. I understand this authorization will not be valid after 30 months, if not revoked earlier.
   c) I know that I have a right to receive a copy of the authorization if I request one.
   d) I agree that a photocopy of this authorization is as valid as the original.
2. I acknowledge by enrolling in an Aetna plan, coverage is provided by Aetna Health Inc. and/or Aetna Life Insurance Company in accordance with the contract.
3. Enrollment of myself and of the listed dependents into the plan is effective on acceptance by Aetna Health Inc. and/or Aetna Life Insurance Company.
4. Coverage and benefits are contingent on timely payment of premiums and may be terminated as provided in the plan documents. My employer is hereby authorized to withhold payments from my wages, as appropriate.

Misrepresentation

5. Any person who includes any false or misleading information on an Enrollment/Change Request Form for a health benefits plan is subject to criminal and civil penalties.

New Jersey 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	Date of Employment	Date of Birth (MM/DD/YYYY)
☐ Single ☐ Married ☐ Widowed ☐ Divorced		

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 the pre-existing conditions exclusion.

I understand that if I later wish to enroll for any of the coverage(s) refused, I will be required to submit an Enrollment Form (and Pre-Existing Condition Statement), and coverage may be subject to a pre-existing conditions exclusion.

Signature of Employee	Date (MM/DD/YYYY)

Signature of Witness	Date (MM/DD/YYYY)

Proof of Eligibility Form

For Small Employer (2-50) Sole Proprietors, Partners or Corporate Officers

(To be used for eligible individuals that are not reported on a quarterly wage and tax form)

Full Name (First, MI, Last)	Phone No.
Title	Percentage of Ownership in Firm
Company Name	
Address	City / State / Zip code

Please check one of the following:

In order to satisfy the Small Employer Requirements for Proof of Eligibility, *the following most recent documents are required*:

(Anyone eligible must appear on the below documents)

		Submit all applicable:	Must Submit one of the following:
Sole Proprietor			
☐	➢ Sole Proprietor ➢ Franchise ➢ Limited Liability Company operating as a sole proprietor or single member LLC	➢ Filed Assumed Name Certificate (Fictitious Name or DBA) ➢ Filed Certificate of Organization (only required for LLC) ➢ Filed Business License	➢ IRS Form 1040 C or 1040 F ➢ IRS Form 1040 SE ➢ IRS Form 1040 ES (estimated tax)
Partner		**Submit all applicable:**	**Must Submit one of the following:**
☐	➢ Partnership ➢ Limited Liability Partnership (member)	➢ Partnership Agreement (Filed) ➢ Filed Assumed Name Certificate (Fictitious Name or DBA) if applicable ➢ Filed Certificate of Organization (only required for LLC or LLP) ➢ Filed Business License	➢ IRS Form 1065 schedule K-1 ➢ IRS Form 1040 SE ➢ IRS Form 1040 ES (estimated tax)
Corporate Officer		**Submit all applicable:**	**Must Submit one of the following:**
☐	➢ Limited Liability Company operating as a corporation ➢ C-Corporation ➢ Personal Service Corporation ➢ S-Corporation	➢ Filed Assumed Name Certificate (Fictitious Name or DBA) ➢ Articles of Incorporation ***or*** Statement by Domestic Stock (complete, including name of officers, shareholders and directors) ➢ Filed Certification of Qualification (if incorporated in a different state)	➢ IRS Forms 1120, 1120 A or 1120 W (C-Corp & Personal Service Corp) ➢ IRS Form 1120 S schedule K-1 or 1040 ES (estimated tax) (S-Corp) ➢ IRS Form 8832 (Entity Classification; for LLC's treated as a Corporation)

I attest that while I am not listed on the state quarterly wage and tax statement for this company, all of the following are true:

1. I am a sole proprietor, partner or corporation officer of the company indicated above; and
2. I am actively at work at this company on a full time, permanent basis working no less than the minimum number of hours required by the applicable State Laws; and
3. I draw wages, compensation, dividends or other distributions from this company on a regular basis and do not derive substantial earned income from any other employment; and
4. I have satisfied the designated waiting period before health insurance coverage is to become effective.

I understand this information may be subject to audit and agree to provide Aetna and/or its affiliates, with any and all information and documentation necessary to validate the above statements. I also understand that any misrepresentation by me of my true circumstances may result in the termination of group health coverage from Aetna and/or its affiliates, for me, my enrolled dependents and or this company as Aetna and/or its affiliates may choose. Aetna and/or its affiliates also expressly reserve any other rights and remedies.

Signature:	Date:

Health Savings Account Declaration of Understanding

I, the undersigned policyholder, or authorized representative of the policyholder, make this declaration of understanding that I acknowledge that I have chosen to offer a high deductible health plan (HDHP) to covered employees. Covered employees may choose to pay for qualified medical expenses using a health savings account established pursuant to § 223 of the federal Internal Revenue Code of 1986 (26 U.S.C. §223). This declaration of understanding is being made upon issuance or renewal of an HDHP. I shall retain a signed copy for my records.

Covered Services/Deductible Applicability: Medical and/or Prescription Drug Benefits

The following is an HDHP overview. Consult your plan documents to determine governing contractual provisions, including procedures, which health care services are covered and to what extent, and exclusions and limitations relating to the plan being offered.

- The HDHP provides payment for covered preventive care services like routine screenings, physicals and immunizations, not subject to the deductible.
- The HDHP does include deductibles — a set amount of expenses the member will pay for covered medical services and supplies under the medical plan and/or pharmacy benefits (if covered by a pharmacy rider) each year before the medical benefits plan begins to make payment. The medical plan may include separate deductibles for in-network and out-of-network services. Consult your plan documents for further information.

Note: If the HDHP provides prescription drug benefits, the member will pay the cost of the prescription(s) until the deductible has been met. When the member fills the prescription(s) at an Aetna participating pharmacy, the member may pay a lower out-of-pocket amount, because Aetna has negotiated pricing on behalf of its members.

- When the deductible is met, the HDHP will provide coverage for covered medical services and supplies under the medical plan and/or prescription benefits (if covered by a pharmacy rider) incurred, less any applicable copayment or coinsurance (a percentage of the provider's negotiated charges), each time the member seeks care from a preferred (in-network) doctor or facility. Each time the member seeks care from a non-preferred (out-of-network) doctor or facility, he or she may experience a higher coinsurance (a percentage of the covered charge) and the provider may balance bill the member for the remaining charge. Consult your plan documents for further information.
- The HDHP does include an out-of-pocket maximum — a cap that limits the amount the member will pay for covered medical services and supplies under the medical plan and/or prescription benefits (if covered by a pharmacy rider) in a given year. All amounts paid as deductible, copayment and coinsurance shall count toward the out-of-pocket maximum. When the out-of-pocket maximum has been reached, the member has no further obligation to pay any amounts as deductible, copayment and coinsurance for covered medical services and supplies under the medical plan and/or prescription benefits (if covered by a pharmacy rider) for the remainder of the year for preferred (in-network) or, if any, up to the annual or lifetime benefit maximum for non-preferred (out-of-network) care. Consult your plan documents for further information.

Policyholder Responsibility

- You, as the employer, are not responsible or liable for your employee's HSA account once it is opened. The employee owns and retains your contributions to his/her account as soon as the funds are deposited, even if he or she changes jobs or health insurance plans.
- The employer, the covered member or an eligible family member may make contributions to the HSA. There is no minimum amount required to establish the account or earn interest, but there is an annual maximum contribution permitted as specified by the IRS. Since both employees and employers can make contributions to the HSA, it is important to coordinate contributions to avoid excess contributions and tax penalties.
- If you, as the employer, make contributions to the HSA, you must make comparable contributions to all employees' Health Savings Accounts (unless made through a Section 125 plan). Consult your tax advisor for further guidance.
- It is important to note that if you, as the employer, make contributions to the HSA through payroll deductions, these contributions are generally made using pre-tax dollars (money that has not been subject to income tax). Pre-tax employer and/or employee contributions are treated as employer contributions, and the employee cannot deduct employer contributions on his or her federal income tax return as HSA contributions. Contributions to the HSA using post-tax dollars (money that has already been subject to income tax) by the employer, employee or eligible family member are tax-deductible by the covered employee.
- You, as the employer, are not required to determine whether HSA distributions are used for qualified medical expenses. Individuals who establish HSAs should maintain records of their medical expenses to show that the distributions have been made exclusively for qualified medical expenses. Distributions of an HSA are between the account holder and the IRS.

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Claims Processing

- If the covered member and/or their dependents use a preferred (in-network) provider, the provider will initiate the payment claim process with Aetna, and the member typically pays nothing during time of care unless a copayment or coinsurance amount is required. Aetna's medical systems will interface with the provider and automatically process the claim.
- If the covered member and/or their dependents use a non-preferred (out-of-network) provider, the provider will initiate the payment claim process with Aetna unless the covered member and/or their dependents elect to file their own claims.
- In both instances, the member and provider will receive an Explanation of Benefits (EOB) or Explanation of Payment (EOP). To check claim status and view EOB statements, Aetna members can access the secure Aetna Navigator™ self-service website at **www.aetnanavigator.com**.
- Amounts not covered by the HDHP may be the responsibility of the member. When the member and/or their dependents have a qualified expense (e.g., doctor visit, prescription refill), the member can choose to withdrawal money from his/her HSA using his/her debit card or checkbook (if applicable), tax free, to be reimbursed for this out-of-pocket expense. Or, the member can choose to pay out of pocket and save the HSA for future qualified health related expenses. Any unused dollars roll over year after year.

.

By signature, I acknowledge my receipt and understanding of this declaration. If I am not an individual policyholder, I certify that I am a party authorized to represent the group policyholder. I will forward a signed copy of the declaration to Aetna and retain a signed copy for my records

Signature	Print Name
Title (if applicable)	Date
Customer Name	Group Number

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New Jersey Small Employer Funding Certification and Statement of Understanding Attestation Form

Aetna considers an underlying plan to be any employer-funded arrangement or plan that, directly or indirectly, subsidizes, funds or reimburses (or is intended, directly or indirectly, to subsidize, fund or reimburse) any part of an individual or single subscriber's network deductible expenses. In setting the premium rate for benefits plans with a network deductible of $1,000 or more, Aetna assumes that the employer may fund 50% or less of an individual or single subscriber's network deductible. If the employer is funding the network deductible in excess of 50%, it can be material to the development of pricing for coverage. As such, it is important for us to understand when underlying plans are in use and/or when the Employer implements an underlying plan that funds the network deductible in excess of 50%.

1. **Is an underlying plan or arrangement offered, made available or utilized by your company?**
   _____Yes _____No

2. **If yes, to 1 above, what percentage (%) of the network deductible is funded by the underlying plan? _____%**

If "yes," to 1 above, please attach a complete description of the underlying plan.

By signing below, you are certifying and agreeing that:

(1) The information provided above is true and complete.

(2) You will notify Aetna immediately in the event that such information is incorrect or incomplete, or you implement or purchase (or you intend to implement or purchase) any underlying plan to fund the network individual or single subscriber deductible in excess of 50% as described above (if you are not already funding in excess of 50%).

NJ Small Group HMO and POS HSA Compatible Plans:
You must complete this form when your group's HSA Compatible benefits plans are effective with Aetna initially; you decide (or intend) to implement or purchase an underlying plan that funds the network single subscriber deductible in excess of 50% during the year; and annually thereafter prior to the renewal effective date of your group's plans.

You are required to select one of the following deductible funding options for HMO and/or POS HSA Compatible benefits plans: (i) funding 50% or less; or (ii) funding more than 50% of the network single subscriber deductible per year. Benefit plan(s) and premiums will differ depending on the selected deductible funding option. Higher premiums will apply if you choose to fund more than 50% of the network single subscriber deductible per year. Please consult your final rate document.

_____
Company Name

_____ _____
Signature of Officer Title

_____ _____
Name of Officer (Please Print) Date

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

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Small Group Underwriting

PEO (Professional Employer Organization)/ Leased Employees

This form is required on all new business sales where leased employees are involved.

Group Name
Address *(Street, City, State, Zip Code)*

1.	Are you currently a client of a PEO (Professional Employer Organization) or use an employee leasing arrangement?	☐ Yes ☐ No
	If Yes, provide the name of the PEO.	
2.	Is group health insurance covered under your PEO contract?	☐ Yes ☐ No
3.	Who is considered the employer of the eligible employees? Check one. ☐ Plan Sponsor/Employer/Group ☐ PEO ☐ Co-Employer with PEO and Plan Sponsor	
4.	By enrolling for coverage as a small employer I am not in violation of any contract with the PEO.	☐ Agree ☐ Disagree

Employer Name (Print)	
Employer Signature	Date

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)