Through First National Administrators (2-50)

1. **BROKERS MUST BE APPOINTED PRIOR TO SUBMITTING FIRST CASE** (takes up to 2 weeks to process)
2. Employer Application Form
3. Employee applications signed by both the employer and employee
4. Waiver form completely filled out for each employee waiving coverage (Not needed for HMO or NYC Community Plan)
5. Copy of signed quote – MUST be signed by employer or case WILL NOT be approved
6. Proof of Eligibility Form
7. Employee Count Attestation Form
8. Copy of itemized prior carrier list bill – MUST include complete employee list
9. First month's premium check made payable to: Aetna (MUST BE COMPANY CHECK)
10. Proof of Full Time Student Status
11. Case submission Checklist
12. Late Submission Form (due 5 days prior)
13. Employer Funding Certification and Statement of Understanding

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Participation Requirements

Participation Requirement is a minimum of 2 enrolling, 60%, excluding valid waivers. Waivers are defined as spousal, Medicare or VA. HMO – no participation requirements

Tax Documents - subject to change according to Aetna underwriters:

- Existing Corp – Most recent NYS-45
- New Hire – New Hired employees should be written in on the quarterly wage report and signed by the employer. Aetna underwriters may request payroll
- Newly Formed Business – Articles of Incorporation, payroll showing tax withholdings and CPA letter listing names of all employees, # of hours worked on a regular basis, indication of salary draw and Tax ID
- K1 or Schedule C plus Proof of Eligibility Form. K1's MUST equal 100%
- 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 a 15th of the month effective date

**Effective dates: 1st & 15th only*

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.

New business case submission checklist

New York

Groups of 50 or Fewer Eligible Employees

Step 1:

Complete/Review Employer Application

- ☐ HMO/EPO/MC/Dental/Life Application
- ☐ Joinder Agreement filled out for Life or out-of-state products
- ☐ NYS-45 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 (HMO/EPO/MC/Dental/Life)
- ☐ Complete the Individual Waiver Section of the EE app for each employee waiving coverage

Step 3:

Complete/Review Broker Information

- ☐ Illustrative rates and copy of census (Employee Listing Report) from Aetna rating tool
- ☐ Agent/broker must be licensed in New York 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-NY D (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

NYS-45 or other applicable tax documents

- Out-of-state employees require proof of employment if not identified on NYS-45
- If owner, partner or corporate officer not listed on NYS-45, 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.

Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies, including Aetna Life Insurance Company and its affiliates (Aetna).

This material is for informational purposes only. Information is believed to be accurate as of the production date; however, it is subject to change.

www.aetna.com

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New York Small Group Business
Employer Application

☐ **Aetna Life Insurance Company**
151 Farmington Avenue
Hartford, CT 06156

☐ **Aetna Health Inc.**
1425 Union Meeting Road
Blue Bell, PA 19422

☐ **Aetna Health Insurance Company of New York**
333 Earle Ovington Blvd. - Suite 104
Uniondale, NY 11553

FOR GROUP COVERAGE (2–50 ELIGIBLE EMPLOYEES)

Life, Accidental Death & Dismemberment, Aetna EPO plans, Aetna Indemnity, and Aetna Managed Choice Plan PPO are provided by Aetna Life Insurance Company. Aetna Primary Care Plan HMO, Aetna QPOS, and Aetna NYC Community Plan℠ are provided by Aetna Health Inc. and Aetna Health Insurance Company of New York. DMO® and PPO dental plans are provided 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 Person - Title	Phone Number ( )	Fax Number ( )	
E-Mail Address	Federal Tax ID Number	Date Business Established (Mo/Yr):	

Employer Classification ☐ Corporation ☐ Non-Profit ☐ Partnership ☐ Sole Proprietor ☐ Other: ______
SIC Code: ______ Nature of Business: ______

Medical Coverage Selection

Open Access Elect Choice® (OA EPO) Plan Option: ______

Open Access Managed Choice® ((OA MC) Plan Option: ______

Open Access Elect Choice® (OA EPO) HSA Compatible Plan Option: ______

Open Access Managed Choice® (OA MC) HSA Compatible Plan Option: ______

NYC Community Plan℠ Plan Option: ______

Indemnity Plan Option: ______

Dental Coverage Selection

Aetna Dental™ Plan

Standard Plans:
Option: ______
Out-of-State: ______

Voluntary Plans:
Option: ______
Out-of-State: ______

Orthodontic coverage for dependent children is included in Standard Plan Options 2, 3, 5, 6, 8, 9 & 10 and Voluntary Plan Options 2, 3 & 5 and available only to groups with 10 or more eligible employees.

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

If you have selected an HSA-compatible plan:
- Do you plan on making contributions to your employees' HSA accounts? ☐ Yes ☐ No
- Do you plan to offer your employees payroll deductions to fund their HSA accounts? ☐ 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, Accidental Death & Dismemberment, and Disability Coverage Selection

Groups with 10 to 50 eligible employees may select one, two, or three options for Life, Accidental Death & Dismemberment, and Disability, with a minimum requirement of three 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.)

	Class 1		Class 2		Class 3	
All Groups	**Life*** or	**Life & Disability Packaged Plan**	**Life*** or	**Life & Disability Packaged Plan**	**Life*** or	**Life & Disability Packaged Plan**
	☐ 10,000 ☐ 15,000 ☐ 20,000 ☐ 50,000	☐ Low - 10,000 ☐ Medium - 20,000 ☐ High - 50,000** Plans include Dependent Term Life	☐ 10,000 ☐ 15,000 ☐ 20,000 ☐ 50,000	☐ Low - 10,000 ☐ Medium - 20,000 ☐ High - 50,000** Plans include Dependent Term Life	☐ 10,000 ☐ 15,000 ☐ 20,000 ☐ 50,000	☐ Low - 10,000 ☐ Medium - 20,000 ☐ High - 50,000** Plans include Dependent Term Life
Additional options for Groups with 10 – 50 eligible employees	☐ 75,000 ☐ 100,000 ☐ 125,000		☐ 75,000 ☐ 100,000 ☐ 125,000		☐ 75,000 ☐ 100,000 ☐ 125,000	
Class Description						

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

** Available only for groups of 10 or more lives.

Effective Date Actual effective date will be assigned by the Aetna underwriting department if application is approved.

Requested effective date (may be the first or 15th of the month only): ____________________

Employer Contribution(s)

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

Employee Eligibility

Work Location (list by state)	Number of Employees				
	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)

Total number of employees: ________

Is your group subject to COBRA? (20 or more total employees during at least 50% of the working days in the previous calendar year): ☐ Yes ☐ No

Have you employed 20 or more full or part-time employees for 20 or more weeks during the current or preceding calendar year? ☐ Yes ☐ No

Have you employed 100 or more full or part-time employees on 50% or more of the business days in the preceding calendar year? ☐ Yes ☐ No

Total number of employees eligible for coverage (must work a minimum of 20 hours per week): ____________________

Total number of employees waiving Aetna health benefits but covered through their spouse's health benefit plan: __________

Total number of employees waiving Aetna health benefits coverage without coverage elsewhere: ____________________

Total number of employees covered under another health benefit plan offered by the employer: ____________________

Do you exclude Union employees under this application? ☐ Yes ☐ No

Dependent Limiting Age: ☐ 26/26 or ☐ 30/30 (Dependents must satisfy state-mandated eligibility criteria.)

Eligibility date will be the first day of the policy month following the waiting period.

Waiting period for future employees: ☐ 0 days ☐ 30 days ☐ 60 days ☐ 90 days ☐ 120 days ☐ 180 days

Prior Carrier Information

	Health	Dental	Life	Disability
Is this group transferring from another group carrier?	☐ 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		

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. The required number of work hours to qualify as an employee will not exceed 20 hours per week. It is agreed that, with the exception of the Life insurance coverage, 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). For life insurance, all statements made by or by the authority of the Applicant for the insurance, reinstatement or renewal of life insurance shall be deemed representations and not warranties. For all other insurance, all statements herein shall be deemed representations and not warranties.

This does not apply to the Life insurance coverage: 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, including the Certificate. Applicant agrees to make payroll and other employment records, to validate employment, 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.

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

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.

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, including the policy and certificate, 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.

This does not apply to the Life insurance coverage: 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 to enrollees all Aetna paper or online member documents and other plan-related materials upon request by Aetna.

As to Accident and Health Insurance coverage, 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation. **This fraud warning is not applicable to an application for life insurance.**

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. To the best of my knowledge and belief, all information provided in this application is accurate and complete.

This does not apply to the Life insurance coverage: 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. With the exception of the hospital, surgical and medical products, I understand that Aetna may choose not to accept this application at its sole discretion, subject to any state requirements.

With respect to the Life insurance coverage, the entire contract is set forth in the policy, the certificate, riders, endorsements and the attached application, if any.

Signed at (Location): ______________________ City, State ______________________ Applicant (Company Name)

By: ______________________ Authorized Applicant Signature ______________________ Official Title

______________________ Witness ______________________ 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, including my knowledge that replacement life insurance is ☐ is not ☐ (check one) a part of this transaction.

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

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: ______________________ 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: ______________________ Aetna Agent Number/ID Number: ______________

Phone Number: (   ) ______________________ Fax Number: (   ) ______________

Address: ______________ City: ______________ State: ______ ZIP: ______

Signature: ______________ Date: ______ E-Mail Address: ______________

For Aetna Use Only

Group Number ____________ Control Number ____________ SCD ________ Effective Date ____________

Is Agent/Agency licensed and appointed? ☐ Yes ☐ No Appointment Expiration Date ____________

New York Small Group Business (2 – 50 Eligible Employees) Employee Enrollment/Change Form

☐ **Aetna Life Insurance Company**
151 Farmington Avenue
Hartford, CT 06156

☐ **Aetna Health Inc.**
1425 Union Meeting Road
Blue Bell, PA 19422

☐ **Aetna Health Insurance Company of New York**
333 Earle Ovington Blvd., Suite 104
Uniondale, NY 11553

Life, Accidental Death & Dismemberment; Aetna EPO plans; Aetna Indemnity; and Aetna Managed Choice Plan PPO are provided by Aetna Life Insurance Company; Aetna Primary Care Plan HMO; Aetna QPOS; and Aetna NYC Community Plan℠ are provided by Aetna Health Inc. and Aetna Health Insurance Company of New York. DMO® and PPO dental plans are provided by Aetna Life Insurance Company.

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 D.**		
Effective Date **Date of Hire**	☐ New Hire ☐ Rehire/Reinstatement ☐ New Group Enrollment ☐ Late Enrollment ☐ Other ______	☐ Change of Coverage ☐ Add Spouse/Domestic Partner/Dependent Child ☐ Name Change ☐ Other ______	☐ Employee Termination ☐ Remove Spouse/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

Open Access Elect Choice® (OA EPO) Plan Option: ______

Open Access Managed Choice® (OA MC) Plan Option: ______

Open Access Elect Choice® (OA EPO) HSA Compatible Plan Option: ______

Open Access Managed Choice® (OA MC) HSA Compatible Plan Option: ______

NYC Community Plan℠ Plan Option: ______

Indemnity Plan Option: ______

2. Dental

Standard Plans:

Option: ______

Options 3 & 8: DMO® ☐ *or* PPO ☐

Out-of-State: ______

Voluntary Plans:

Option: ______

Option 3: DMO® ☐ *or* PPO ☐

Out-of-State: ______

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
☐ 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.	Job Title	Home Telephone	Primary Language Spoken (Optional)

Home Address	Apt. No.	City, State	ZIP Code

Work Address	City, State	ZIP Code	Work Telephone

No. of Hours Worked Per Week	Check One	Marital Status	No. of Dependents Including Spouse/ Domestic Partner
	☐ Full-Time ☐ Part-Time	☐ Married ☐ Single	

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

NOTE FOR MEDICAL COVERAGE: While the Federal Patient Protection and Affordable Care Act mandates coverage of dependent children up to age 26, 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)	Coverage Election	Other Health Coverage	Other Dental Coverage	Prior Dental Coverage	Out of Area	Student (Life Only)	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 N/A		Yes ☐		Yes ☐
Spouse/Domestic Partner 2.				☐ Medical ☐ Dental ☐ Life	☐	☐	☐	N/A	N/A		☐		☐
Child 3.				☐ Medical ☐ Dental ☐ Life	☐	☐	☐	☐	☐		☐		☐
Child 4.				☐ Medical ☐ Dental ☐ Life	☐	☐	☐	☐	☐		☐		☐

D. Declination/Waiver of Coverage - *To be completed if medical and/or dental coverage is declined or refused by an eligible employee and/or their eligible family members.*

1. Medical Coverage Declined for:
   ☐ Myself ☐ Spouse/Domestic Partner
   ☐ Dependents
2. Dental Coverage Declined for:
   ☐ Myself ☐ Spouse/Domestic Partner
   ☐ Dependents

Reason for Declining Coverage *(If applicable, please attach front/back of your health coverage ID card.)*:

☐ Covered by spouse/domestic partner's group coverage - Carrier Name and ID ________

☐ Enrolled in other Insurance Carrier Plans - Carrier Name and ID ________

☐ Medicare ☐ Covered by TRICARE or CHAMPVA ☐ Other ________

☐ Spouse/Domestic Partner covered by employer's group medical coverage

☐ Spouse/Domestic Partner covered by employer's group dental coverage

I acknowledge I have been given the right to apply for this coverage, however, I am electing not to enroll. By declining this group coverage I acknowledge that myself 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 this plan, may not be covered for twelve months. **NOTE:** If your Plan contains a pre-existing conditions provision, the pre-existing 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).

X Employee Signature | ***Date (Month/Day/Year)***

E. Dependent Information

Does any dependent listed in Section C live at another address? ☐ Yes ☐ No
If Yes, who and what address?

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

F. Other Insurance

If you have checked "Yes" to Other **Health** Coverage (Section C), provide name and policy number of insurance carrier, HMO, or other source; a copy of the insurance card; and the start date of coverage

If you have checked "Yes" to Other **Dental** Coverage (Section C), provide name and policy number of insurance carrier, HMO, or other source; a copy of the insurance card; and the start date of coverage

Is your Spouse/Domestic Partner employed? ☐ Yes ☐ No If "Yes," provide name and address of spouse/domestic partner's employer.

PROOF OF PRIOR COVERAGE - IMPORTANT (*Required for other than Life Insurance*)

Does anyone age 19 and over enrolling on this enrollment form have prior coverage?

☐ Yes ☐ No If you answered "Yes", provide applicant names, start and end dates of prior coverage.

____

____

____

____

____

Proof of coverage should accompany this enrollment form for pre-existing condition credit credit or waiver of dental waiting period

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.

Failure to provide Proof of Prior Coverage may subject you or a family member (age 19 and over) to the full pre-existing conditions limitation with no credit for prior coverage. You may request a Certificate of Creditable Coverage from your prior carrier. **NOTE:** If your Plan contains a pre-existing conditions provision, the pre-existing conditions exclusion and limitation will not apply to a person under 19 years of age.

Conditions of Enrollment

On behalf of myself and the dependents listed on the reverse side, 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 Primary Care Plan HMO, Aetna QPOS, and Aetna NYC Community Plan℠: Aetna Health Inc. and Aetna Health Insurance Company of New York
   - Aetna Managed Choice Plan PPO: Aetna Life Insurance Company
   - Life, Accidental Death & Dismemberment, DMO®, Dental PPO and all other health coverages: Aetna Life Insurance Company.

continued on next page

Conditions of Enrollment *(continued)*

2. I understand that: my employer's application will determine coverage and that there is no coverage unless and until both the eligible employee enrollment form and employer application have been accepted and approved by Aetna. Even if this enrollment form is approved, any material misstatements or omissions may result in future claims being contested and the policy or my coverage under the policy being contested.
   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. 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. Life insurance is incontestable after two years from date of issue, except for non-payment of premiums. 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.
3. I understand and agree that: this enrollment form may be transmitted to Aetna or its agent by my employer or its agent.
4. The plan certificate of coverage will determine the rights and responsibilities of member(s). It 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, 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 dentist or by the participating dentist or other provider as authorized by a referral from a participating primary care dentist.
7. I understand and agree that: as described in the plan documents and when enrolled for medical coverage, any pre-existing conditions for my spouse/domestic partner, dependents or myself may not be covered for 12 months. This does not apply to life insurance coverage. **NOTE:** If your Plan contains a pre-existing conditions provision, the pre-existing conditions exclusion and limitation will not apply to a person under 19 years of age.

[Misrepresentation **(This fraud warning is not applicable to an application for life insurance.)**

8. 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.]

I represent that to the best of my knowledge and belief all information supplied in this form is true and complete. I have read and agree to the Conditions of Enrollment and Misrepresentation on this **New York** Small Group Business (2 – 50 Eligible Employees) Employee Enrollment/Change Form. I understand that if I do not sign this form within 31 days from the date first eligible or 31 days of the qualifying life event (i.e., marriage, divorce, newborn child, adoption, loss of spousal coverage, etc.) I will be considered a late enrollee and the effective date of coverage for me and my dependents may be affected. I am employed by the employer shown on Page 1, and I am working full time at least 20 hours per week for this employer at the regular place of business.

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

This form is attached to and made a part of the group policy.

Addendum to New Business Input Documents
Information Needed to Support Required Medical Loss Ratio Reporting under Health Care Reform Law

Please provide us with your average number of employees in 2012.

This information is needed for Aetna to comply with Federal law. We need to know the total number of all employees you had in 2012, even if you were not covered by Aetna in 2012. This information will help to determine whether you will be owed any rebate for your 2013 medical plan premiums. If you are, rebates will be paid in 2014.

Providing required information now may help you and your employees.

Under the law, a medical plan must spend most of its premium on medical care and activities that improve quality. The health care reform law (the Affordable Care Act) sets rules on the minimum percentage of premium that plans must spend on these costs each year. If a plan does not spend the minimum amount on these costs, it must give policyholders premium rebates. This rule is known as the minimum Medical Loss Ratio (MLR).

The minimum required is different for plans that the government considers Small Group and Large Group. We need to include your plan in the correct group when we report information to the federal government and to determine if you will be owed a premium rebate.

The law defines the number of employees as “the average number of employees employed by the employer’s company during the preceding calendar year.” This generally means persons for whom the company issues a W-2. This includes full-time, part-time, and seasonal workers who may or may not have been eligible for your medical plan or covered by Aetna in 2012. “Preceding year” means that we will use your 2012 employee count to determine if your group is a Small Group or a Large Group, supporting the required reporting and payment of rebates that will happen in 2014 and that are based on 2013 medical cost and quality activity expenditures.

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 2012, 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

If your business is aggregated with one or more other businesses and treated as a single employer under subsection (b) controlled group corporations, (c) partnerships, proprietorships, etc., under common control, (m) employees of an affiliated service group, or (o) other regulations of section 414 of the Internal Revenue Code, please provide the combined total number of employees for all businesses that are included in the “single employer group” under the Internal Revenue Code.

Please enter your calculated average number of employees for 2012 in the box below.

Average Employees in 2012 (whole numbers only; please print legibly)

☐

Sole Proprietorship

☐ Please check here if you are a sole proprietor **

** For purposes of this request and in accordance with Federal guidance, you are a sole proprietor if:

(1) Your trade or business is owned by you, or by you and your spouse; and

(2) You have no non-spouse employees enrolled in coverage.

If you are a sole proprietor** and the only enrolled employees are you and/or a spouse employee, please enter **0** in the Average Number of Employees in 2012 box and check the sole proprietor box in addition to completing the Certification on the following page.

Certification ***(It is important that you complete this portion and return with your response so that our records will be complete.)***

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.

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

Proof of Eligibility Form

Small Employers with 50 or fewer eligible employees
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
Date of Hire	Number of hours worked per week
Company Name	

In order to satisfy the Small Employer Requirements for Proof of Eligibility, *the following most recent IRS Tax documents are required*. (Anyone eligible must appear on the below documents .)

Please check one of the following:	Must submit one of the following identified documents :
❑ C-Corporation	➢W2
❑ S-Corporation	➢IRS Form 1120 S Schedule K-1 along with Schedule E (Form1040)
❑ Partnership	➢IRS Form 1065 schedule K-1; or ➢IRS Form 1120S Schedule K1 along with Schedule E (Form1040)
❑ Limited Liability Company (LLC)	➢May file as either C Corporation or Partnership
❑ Sole Proprietor	➢IRS Schedule SE and Schedule C filed with Form 1040; or ➢IRS Form 1040 Schedule F or K1

I attest that while I am not listed on the state quarterly wage and tax statement for this company, the following are true (check applicable boxes):

❑ 1. I am a sole proprietor, partner or corporation officer of the company indicated above.

❑ 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.

❑ 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.

❑ 4. I have satisfied the designated waiting period before health insurance coverage is to become effective.

❑ 5. I am a retiree of the above company and qualify for benefits under their guidelines.
(Retiree coverage is only available in states where mandated. Maine and New Hampshire - all groups. Florida and Illinois - municipalities only.)

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.

It is unlawful to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

Signature ______________________________ 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

New Business Late Submission Form

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

- **25th** of the month for **1st** of month effective dates
- 10th 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)

New York Employer Funding Certification and Statement of Understanding for Small Employers

Aetna considers underlying plans or arrangements that either partially or completely subsidize any member cost sharing, including, but not limited to, copayments, deductibles and/or member coinsurance balances and the Employer's funding of the deductible in excess of 50% to be material to the provision of coverage. In setting the premium rate for the plan selected, Aetna has assumed both that there are no underlying plans or arrangements subsidizing any portion of the members' cost-sharing responsibilities and that the Employer will not put in place any plan or arrangement that funds the deductible in an amount exceeding 50%. As such, it is important for us to understand when underlying plans or arrangements are in use and/or when the Employer implements a plan or arrangement that funds the deductible in excess of 50%.

Underlying plan or arrangement offered? Yes____ No____

If "yes," please attach a complete description of the underlying plan or arrangement and confirm the following:

Employer further represents and certifies that it is not funding the deductible of the quoted health plan in excess of 50% (whether through an HSA, HRA or any other arrangement created or purchased for this purpose). Yes ___ No___

By signing below, you are certifying that the information provided above is true and complete, and that you will notify us immediately if you intend to use an underlying plan or arrangement to subsidize your employees' cost-sharing responsibilities, or if you intend to put in place any plan or arrangement that funds employees' deductibles in excess of 50%.

____
Employer

____
Signature of Officer

____
Title

____
Date

Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies, including Aetna Life Insurance Company and its affiliates (Aetna).

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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.

Declaration Of Domestic Partnership

I. DECLARATION:

We, ____________________ and ____________________, each
(employee-print name) (domestic partner-print name)

certify and declare that we are domestic partners in accordance with the following criteria:

II. STATUS

1. We affirm that this domestic partnership began on or about __/__/__.

2. We are each other's sole domestic partner, and we intend to remain so indefinitely.

3. Neither of us is married to or legally separated from anyone else nor have had another domestic partner within the prior six months.

4. We are both at least eighteen (18) years of age and mentally competent to consent to contract.

5. We are not related by blood to a degree of closeness that would prohibit legal marriage in the state in which we legally reside.

6. We cohabit and reside together in the same residence and intend to do so indefinitely. We have resided in the same household for at least six months.

7. We are engaged in a committed relationship of mutual caring and support and are jointly responsible for our common welfare and living expenses. Our interdependence is demonstrated by at least three of the following (please check appropriate items):

   ___ Common ownership of real property (joint deed or mortgage agreement) or a common leasehold interest in property
   ___ Common ownership of a motor vehicle
   ___ Driver's license listing a common address
   ___ Proof of joint bank accounts or credit accounts
   ___ Proof of designation as the primary beneficiary for life insurance or retirement benefits, or primary beneficiary designation under a partner's will
   ___Assignment of a durable property power of attorney or health care power of attorney

8. We are not in this relationship solely for the purpose of obtaining benefits coverage.

III. DEPENDENT CHILDREN OF DOMESTIC PARTNER

We understand that dependent children of ______________________ (domestic partner-print name) are eligible for coverage when they are:

- ♦ unmarried,
- ♦ primarily dependent on the employee for support, and
- ♦ meet the age/school and all eligibility requirements of the plan of benefits.

IV. CHANGE IN DOMESTIC PARTNERSHIP:

1. We have an obligation to notify _____________________ (employer-print name) by filing a Declaration of Termination of Domestic Partnership if there is any change in our domestic partnership status as attested to in this Declaration that would terminate this Declaration (e.g., due to death of a partner, a change in residence of one partner, termination of the relationship, etc.). We will notify ___________________ (employer-print name) within thirty-one (31) days of such change.

2. We understand that termination of this coverage (obtained as a result of completion of this Declaration) will be effective on the date the relationship ends as indicated on the Declaration of Termination of Domestic Partnership, providing coverage has not otherwise terminated due to standard policy provisions.

I. ACKNOWLEDGMENTS:

1. We understand that a civil action may be brought against one or both of us for any losses (as well as attorneys' fees and costs) due to any false statement contained in this Declaration or for failure to notify _________________________ (employer-print name) of changed circumstances as required in Section IV above. I, the undersigned employee, further understand that falsification of information in this Declaration, or failure to notify __________________ (employer-print name), of changed circumstances pursuant to Section IV above, may lead to disciplinary action against me, including discharge from employment.

2. We have provided the information in this Declaration for use by ______________________ (employer-print name) for the sole purpose of determining our eligibility for certain domestic partner benefits. We understand and agree that _____________________ (employer-print name) is not legally required to extend any such benefits. We understand that this information provided in this Declaration will be treated as confidential by ______________________ (employer-print name) but will be subject to disclosure; a) upon the express written authorization of the undersigned

employee, b) upon request of the insurer or plan administrator, or c) if otherwise required by law.

3. We understand that this Declaration may have legal implications relating, for example, to our ownership of property or to taxability of benefits provided, and that before signing this Declaration we should seek competent legal advice concerning such matters.

We affirm, under penalty of perjury, that the statements in this Declaration are true and correct.

________________________	__/__/__	__/__/__
Employee Signature	DOB	Date
________________________	__/__/__	__/__/__
Domestic Partner Signature	DOB	Date

____

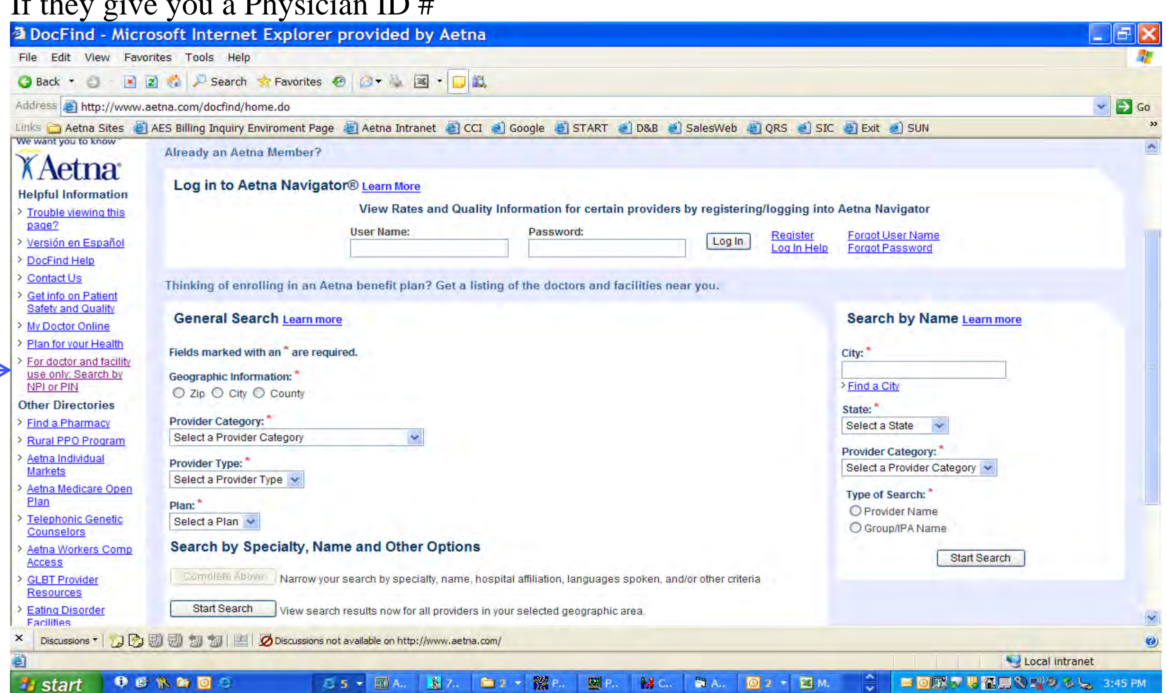
____

Employee & Domestic Partner Address

1. The group must be located in one of the 5 boroughs of New York City: Manhattan, Bronx, Queens, Staten Island and Brooklyn.
2. There is no minimum contribution.
3. There are no participation guidelines.
4. If the group is doing a dual option with MC or EPO you must follow the MC guidelines for both participation and contribution percentage.
5. Everyone enrolling in the NYC Community Plan must work or live and access health care in the five boroughs of NYC.
6. Every one enrolling must pick a NYC Community Plan Primary Care Physician and put the ID number on the enrollment form.
7. Management Carveouts are allowed for NYC Plans.
8. Waivers are not required but the NYS 45 must clearly indicating who is full time and waiving if not supplying waiver forms
9. If the broker wants to know how to find a NYC Community Plan Primary Care Physician;
   Go to Doc Find
   General Search
   Search by Zip, City or County
   Provider Category – Medical Providers
   Provider Type – Primary Care Physicians
   Plan NYC Community Plan(SM)

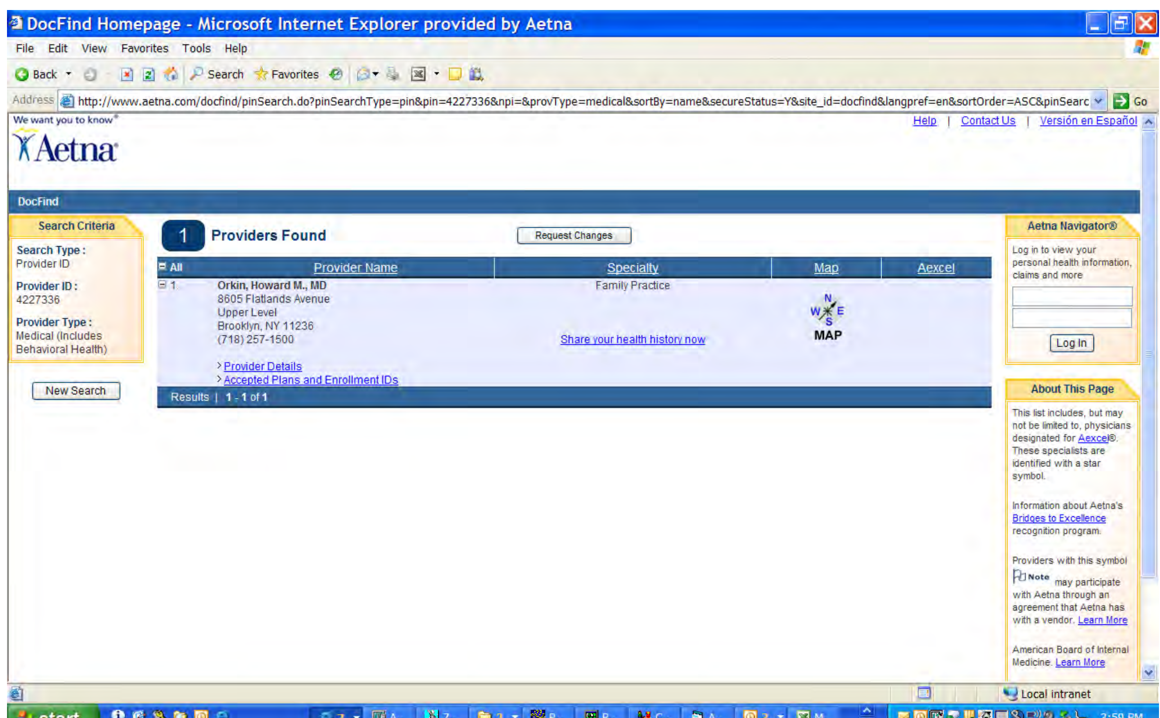
Below is how to look up a doctor in DOC FIND

If they give you a Physician ID #

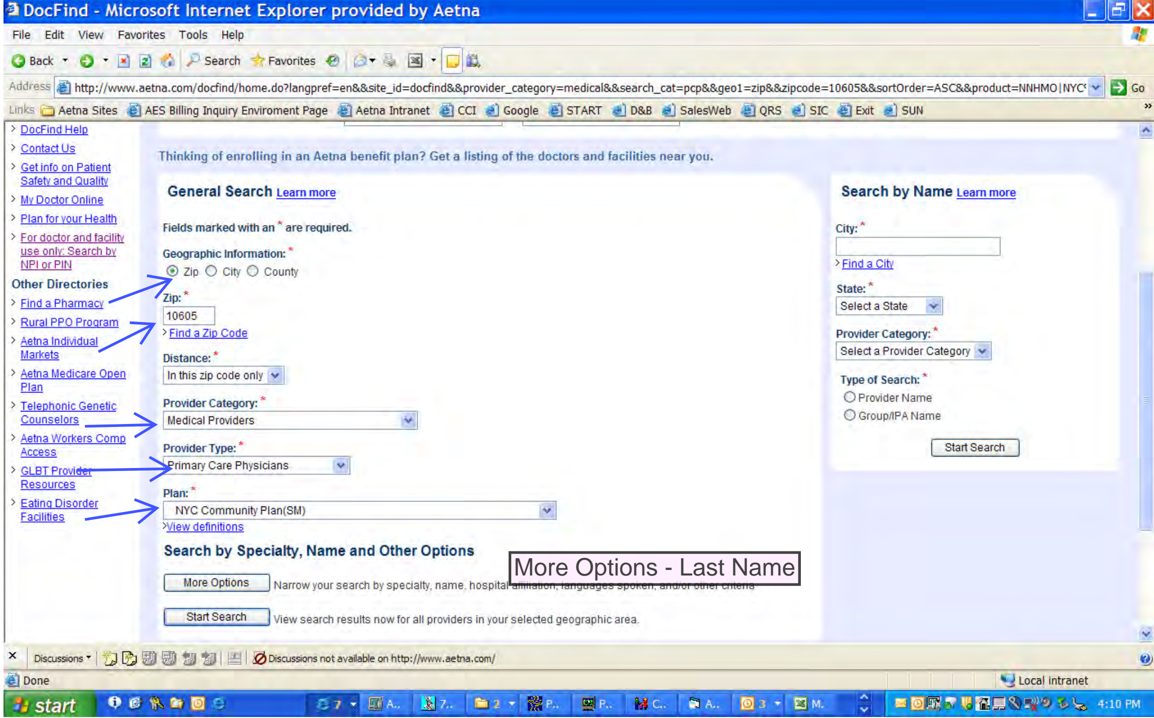


Go and search by the ID #

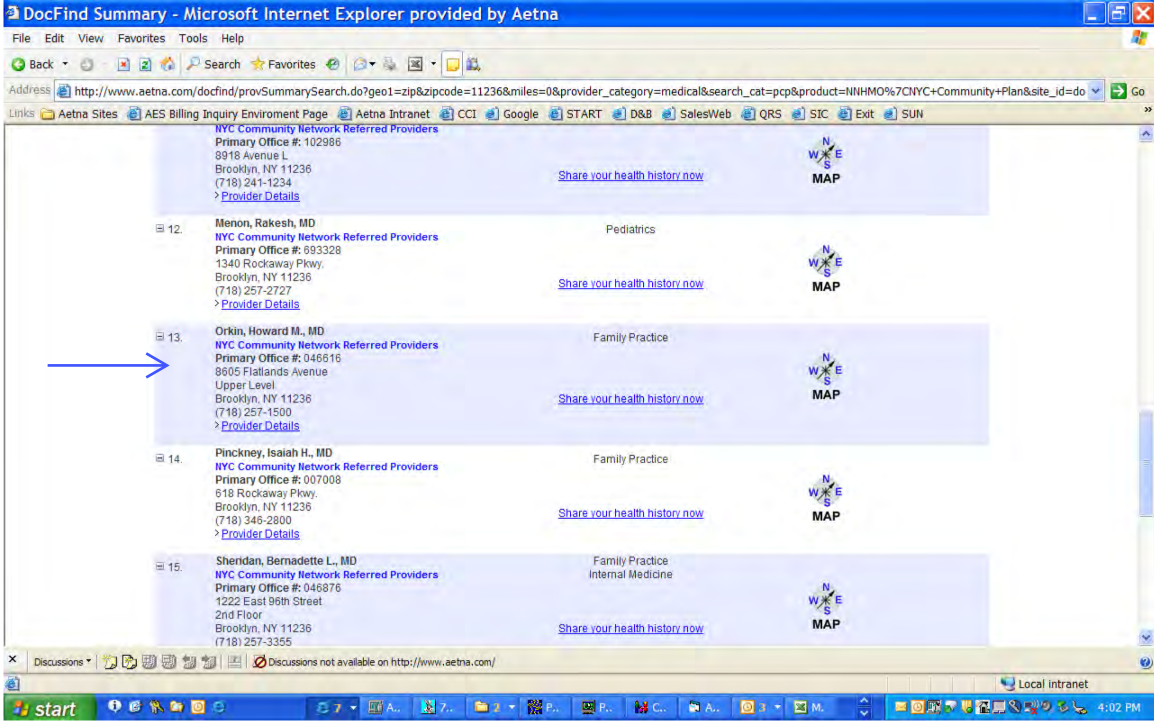
Start Search



You now have to search this physician to verify that they are a NYC Community Plan Primary Care Physician. It must come up when you do a general search.



Look to see if your Physician comes up.



Look who's in the network!

Aetna Provider Network

New York

You'll be impressed with all the choices.

Aetna Avenue® — Your Destination for Small Business Solutions℠

14.03.152.1-NY (9/09)

New York Provider Network

Great coverage begins with a solid network

It's true. Aetna offers your company the security of a large, well-known carrier with over 150 years of experience. But we also offer a large nationwide network, with a presence in all 50 states. To date, our national network includes over 921,000 heath care service providers.

With our New York Provider Network,* you get access to:

- More than 9,429 primary care physicians (PCPs), including internists, family practitioners and pediatricians
- More than 25,839 specialists, including 1,980 obstetricians and gynecologists
- More than 12,220 dental providers†
- Pharmacy participation from leading chains like Rite Aid, CVS, Eckerd, ShopRite and many supermarket pharmacies
- Over 116 hospitals
- Management of credentialing review, practice patterns and quality-of-care standards

Aetna's New York Provider Network

	NYC Community Plan℠	EPO/MC Network	
	5-Borough Network**	5 Boroughs	Statewide
Hospitals	42	63	116
PCPs	2,896	5,815	9,429
Specialists	6,774	15,479	25,839
Ob/Gyn	605	1,237	1,980

NETWORK COMPOSITION BY BOROUGH***

	NYC Community Plan	EPO/MC
Bronx	2,011	3,146
Kings	2,462	4,961
New York	3,948	9,102
Queens	1,533	4,368
Richmond	363	1,017

*Aetna Network data as of 8/18/09. Hospital Network data as of 9/21/09. Network subject to change.

**Queens, Manhattan, Brooklyn, Bronx and Staten Island.

***Total counts of PCPs, Specialists, Ob/Gyn and Hospitals by borough.

†Aetna Dental Providers data as of 9/1/09.

Health benefits and health insurance plans are offered, underwritten and/or administered by Aetna Health Inc., Aetna Health Insurance Company of New York and/or Aetna Life Insurance Company (Aetna).

EPO/MC Network	NYC Community Plan Network
BRONX	
Bronx VAMC (1360)	
Bronx-Lebanon Hospital Center	•
Calvary Hospital	
Jacobi Medical Center	•
Lincoln Medical and Mental Health Center	•
Montefiore Medical Center North Division	•
Montefiore Medical Center/Henry & Lucy Moses	•
Montefiore Medical Center/Jack D. Weiler Hospital	•
New York Westchester Square Medical Center	•
North Central Bronx Hospital	•
St. Barnabas Hospital	
DUTCHESS	
Department of Veterans Affairs Medical Center	
Northern Dutchess Hospital	
Saint Francis Hospital	
Vassar Brothers Medical Center	
KINGS	
Beth Israel Medical Center-Kings Highway Division	•
Brookdale Hospital Medical Center	•
Brooklyn Hospital Center-Caledonian Campus	
Brooklyn Hospital Center-Downtown Campus	•
Coney Island Hospital Center	•
Department of Veterans Affairs, New York	
Interfaith Medical Center	
Kings County Hospital Center	•
Long Island College Hospital	•
Lutheran Medical Center	•
Maimonides Medical Center	
New York Community Hospital of Brooklyn	•
New York Methodist Hospital	•
University Hospital of Brooklyn	•
Woodhull Medical and Mental Health Center	•
Wyckoff Heights Medical Center	•
NASSAU	
Franklin Hospital	
Glen Cove Hospital	
Long Beach Medical Center	
Mercy Medical Center	
Nassau University Medical Center	
New Island Hospital	
North Shore University Hospital at Manhasset	
Plainview Hospital	
South Nassau Communities Hospital	
St. Francis Hospital/The Heart Center	
Syosset Hospital	
Winthrop-University Hospital	
NEW YORK	
Bellevue Hospital Center	•
Beth Israel Medical Center - Petrie Division	•
Department of Veterans Affairs, New York	
Harlem Hospital Center	•
Hospital for Special Surgery	
Lenox Hill Hospital	•
Manhattan Eye, Ear and Throat Hospital	•
Memorial Sloan-Kettering Cancer Center	
Metropolitan Hospital Center	•
Mount Sinai Medical Center	
New York Downtown Hospital	•
New York Eye and Ear Infirmary	•
New York Presbyterian Hospital Columbia Presbyterian Campus	•
New York Presbyterian Hospital NY Cornell Campus	•
New York Presbyterian Hospital The Allen Pavilion	•
North General Diagnostic & Treatment Center	•
North General Hospital	•
NYU Hospitals Center HJD	
NYU Hospitals Center Tisch	
Saint Vincent Catholic Medical Centers	

EPO/MC Network	NYC Community Plan Network
NEW YORK (CONTINUED)	
St. Luke's-Roosevelt Hosp Ctr-Roosevelt Division	•
St. Luke's-Roosevelt Hosp Ctr-St. Luke's Division	•
ORANGE	
Bon Secours Community Hospital	
Orange Regional Medical Center-Arden Hill Campus	
Orange Regional Medical Center-Horton Campus	
St. Anthony Community Hospital	
St. Luke's Cornwall Hospital - Cornwall	
St. Luke's Cornwall Hospital - Newburgh	
PUTNAM	
Putnam Hospital Center	
QUEENS	
Elmhurst Hospital Center	•
Flushing Hospital Medical Center	•
Forest Hills Hospital	
Jamaica Hospital Medical Center	•
Long Island Jewish Medical Center	
Mount Sinai Hospital of Queens	
New York Hospital Medical Center of Queens	•
Peninsula Hospital Center	
Queens Hospital Center	•
St. John's Episcopal Hospital South Shore Division	•
RICHMOND	
Richmond University Medical Center	•
Richmond University Medical Center-Bayley Seton	
Staten Island University Hospital-North Site	
Staten Island University Hospital-South Site	
ROCKLAND	
Good Samaritan Hospital	
Helen Hayes Hospital	
Nyack Hospital	
SUFFOLK	
Brookhaven Memorial Hospital Medical Center	
Eastern Long Island Hospital	
Good Samaritan Hospital Medical Center	
Huntington Hospital	
John T. Mather Memorial Hospital	
Peconic Bay Medical Center	
Southampton Hospital	
Southside Hospital	
St. Catherine of Siena Medical Center	
St. Charles Hospital & Rehabilitation Center	
Stony Brook University Medical Center	
Veterans Affairs Medical Center	
SULLIVAN	
Catskill Regional Medical Center	
ULSTER	
Benedictine Hospital	
Ellenville Regional Hospital	
Kingston Hospital	
WESTCHESTER	
Dobbs Ferry Pavilion of St. John's Riverside	
Hudson Valley Hospital Center	
Hudson Valley VA Healthcare System	
Lawrence Hospital Center	
Mt. Vernon Hospital	
Northern Westchester Hospital Center	
Phelps Memorial Hospital Center	
Sound Shore Medical Center of Westchester	
St. John's Riverside Hospital	
St. Joseph's Medical Center	
Westchester Medical Center	

Follow these easy steps to find a provider in your area:

DocFind®

Locating a participating doctor has never been easier — with our DocFind online provider directory. You can search for participating doctors, hospitals, pharmacies, dentists and eyewear outlets. DocFind also lets you search by zip code, distance from home, city and state, or county and state.

Narrow your search by specialty, hospital affiliation and/or languages spoken — all with a few clicks of a mouse. Best of all, DocFind is updated regularly and is available 24 hours a day, 7 days a week.

To search for providers by city, zip or county:

- Go to **www.aetna.com** and select "Find a Doctor."
- Scroll down to "General Search" and enter the requested criteria. You can search by zip, city or county.
- Select the provider category.
- Select the provider type.
- Select the desired plan.

Select Aetna Standard Plans

- EC Network — select "Elect Choice® EPO"
- MC Network — select "Managed Choice® POS"

NYC Community Plan Network — select NYC Community Plan℠

Please note that:

- Referred providers will be designated with "NYC Community Network referred provider" displaying on the provider record.
- Only referred PCPs will be displayed when doing a search for PCPs.
- You may choose to narrow your search results. If not, select "Start Search." Your search results will contain:
  - >Provider name, address and phone number
  - >Provider specialty (if appropriate)
  - >Link to MapQuest website to access provider location
  - >Link to more provider details (such as hospital affiliation, languages spoken, etc.)
- From the Search Results page, you may select a "Printer Friendly Version." This option will consolidate your search results into a mini-directory and provide a printer-friendly PDF you may download or print.

Through Aetna's website (www.aetna.com), members have access to health information, resources and services designed to help them better manage their health.

This material is for information only and is not an offer or invitation to contract. An application must be completed to obtain coverage. Rates and benefits vary by location. Health benefits and health insurance plans contain exclusions and limitations. Providers are independent contractors and are not agents of Aetna. Provider participation may change without notice. Aetna does not provide care or guarantee access to health services. Not all health services are covered. See plan documents for a complete description of benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by location and are subject to change. Aetna receives rebates from drug manufacturers that may be taken into account in determining Aetna's Preferred Drug List. Rebates do not reduce the amount a member pays the pharmacy for covered prescriptions. Information is believed to be accurate as of the production date; however, it is subject to change. For more information about Aetna plans, refer to **www.aetna.com**.

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14.03.152.1-NY (9/09)