



# Pennsylvania Small Group Business Employer Application

**FOR GROUP COVERAGE (2 – 50 ELIGIBLE EMPLOYEES)**

Life, Accidental Death & Dismemberment, Disability, Aetna PPO and Aetna Indemnity plans are underwritten by Aetna Life Insurance Company. Aetna HMO plans and Aetna POS plans are underwritten by Aetna Health Inc., Corporate Health Insurance and/or Aetna Life Insurance Company. Dental plans are provided or administered 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
Bill 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 <input type="checkbox"/> Corporation <input type="checkbox"/> Non-Profit <input type="checkbox"/> Partnership <input type="checkbox"/> Sole Proprietor <input type="checkbox"/> Other:			SIC Code:

### Medical Coverage Selection

<b>PA HMO:</b> <input type="checkbox"/> Plan 1.1 <input type="checkbox"/> Plan 2.1 <input type="checkbox"/> Plan 3.1 <b>PA HMO No-Referral:</b> <input type="checkbox"/> Plan 1.1 <input type="checkbox"/> Plan 2.1 <input type="checkbox"/> Plan 3.1 <b>PA Cost-Sharing HMO:</b> <input type="checkbox"/> Plan 1.1 <b>PA POS:</b> <input type="checkbox"/> Plan 1.1 <input type="checkbox"/> Plan 2.1 <input type="checkbox"/> Plan 3.1 <b>PA POS No-Referral:</b> <input type="checkbox"/> Plan 1.1 <input type="checkbox"/> Plan 2.1 <input type="checkbox"/> Plan 3.1	<b>PA PPO:</b> <input type="checkbox"/> Plan 1.1 <input type="checkbox"/> Plan 2.1 <input type="checkbox"/> Plan 3.1 <b>PA PPO HSA Compatible*:</b> <input type="checkbox"/> Plan 1.1 <input type="checkbox"/> Plan 2.1 <input type="checkbox"/> Plan 3.1 <b>PA PPO Basic Hospital Plan:</b> <input type="checkbox"/> Plan 1.1 <b>PA PPO First Dollar Plan:</b> <input type="checkbox"/> Plan 1.1 <b>PA PPO HealthFund Plan</b> <input type="checkbox"/> Plan 1.1 (available 1/1/06)	<b>Out-of-State/Situs PPO Plan:</b> <input type="checkbox"/> \$250 (High) <input type="checkbox"/> \$500 (Medium) <input type="checkbox"/> \$1,000 (Low) <input type="checkbox"/> <b>Out-of-State/Situs Indemnity Plan – Traditional Choice</b> <input type="checkbox"/> <b>Other Plan:</b> _____  <small>*If you have selected an HSA-compatible plan –          - Do you plan on making contributions to your employees' HSA accounts? <input type="checkbox"/> Yes <input type="checkbox"/> No          - Do you plan to offer your employees payroll deductions to fund their HSA accounts? <input type="checkbox"/> Yes <input type="checkbox"/> No</small>
--	---	---

### Dental Coverage Selection

All dental plans available with an Aetna medical plan. Dental Options V2, V3 and V4 are only available to groups with 3 or more employees. Orthodontic coverage is available only to groups with 10 or more eligible employees and automatically included on Options 2, 3, 5, 6, V2, and V3.

<b>Aetna Dental™ Plans</b> <b>Contributory Plans:</b> <input type="checkbox"/> Option 2 DMO <input type="checkbox"/> Option 6 Passive PPO 1500 <input type="checkbox"/> Option 3 Freedom-of-Choice <input type="checkbox"/> Option 7 Consumer Directed Dental Fund <input type="checkbox"/> Option 4 PPO Max <input type="checkbox"/> Out-of-State/Situs PPO Plan: <input type="checkbox"/> Option 5 Active PPO – High Option <input type="checkbox"/> Low Option, No Ortho <input type="checkbox"/> Medium Option, No Ortho <input type="checkbox"/> Low Option, Ortho <input type="checkbox"/> Medium Option, Ortho	<b>Voluntary Plans:</b> <input type="checkbox"/> Voluntary Option V2 DMO <input type="checkbox"/> Voluntary Option V3 Freedom-of-Choice <input type="checkbox"/> Voluntary Option V4 PPO Max
---	---

### Life, Accidental Death & Dismemberment, & Disability Coverage Selections

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.)

All Groups	Class 1		Class 2		Class 3	
	Life	Life & Disability Packaged Plan	Life	Life & Disability Packaged Plan	Life	Life & Disability Packaged Plan
	<input type="checkbox"/> \$10,000 <input type="checkbox"/> \$15,000 <input type="checkbox"/> \$20,000 <input type="checkbox"/> \$50,000	<input type="checkbox"/> Low <input type="checkbox"/> Medium <input type="checkbox"/> High	<input type="checkbox"/> \$10,000 <input type="checkbox"/> \$15,000 <input type="checkbox"/> \$20,000 <input type="checkbox"/> \$50,000	<input type="checkbox"/> Low <input type="checkbox"/> Medium <input type="checkbox"/> High	<input type="checkbox"/> \$10,000 <input type="checkbox"/> \$15,000 <input type="checkbox"/> \$20,000 <input type="checkbox"/> \$50,000	<input type="checkbox"/> Low <input type="checkbox"/> Medium <input type="checkbox"/> High
<b>Additional options for Groups with 10 – 50 eligible employees</b>	<input type="checkbox"/> \$75,000 <input type="checkbox"/> \$100,000 <input type="checkbox"/> \$125,000		<input type="checkbox"/> \$75,000 <input type="checkbox"/> \$100,000 <input type="checkbox"/> \$125,000		<input type="checkbox"/> \$75,000 <input type="checkbox"/> \$100,000 <input type="checkbox"/> \$125,000	
<b>Class Description</b>						

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

Please keep a copy of this application for your records. If the application is accepted by Aetna it becomes part of the issued Group Agreement and/or Group Policy.

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

Requested effective date (may be the 1st or 15th of the month only): \_\_\_\_\_

**Business Eligibility**

Is your company a subsidiary of another company, an affiliate of another company, or under common control with another company?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does your company file state or federal taxes with any other company(ies) on a combined or consolidated basis?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If Yes is checked for any of the above questions, complete and submit Aetna's Associated Companies Form.	

**Employer Contribution(s)**

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

Groups with 2 to 50 eligible employees: The employer must contribute at least 50% of the employee-only annual medical premium. Coverage can be denied based on inadequate contributions. For basic life and disability, the employer must contribute 100% of premiums for groups with 2 to 9 eligible employees and at least 50% of premium for groups with 10 to 50 eligible employees.

**Section 125 Plan**

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

**Employer Eligibility/Employee Status**

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:					
Total number of eligible employees based on state law (must work a minimum of 25 hours per week)					
What is the normal work week you require a full-time employee to work to be eligible for coverage?					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 full-time employees who are currently in the waiting period and not eligible:					
Total number of employees covered under another health benefit plan offered by the employer:					
Are there excluded classes of employees other than part-time and temporary employees (for example, Union employees)?					<input type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, describe excluded class(es):					
Is your group to COBRA, as defined by federal regulations (Have you employed 20 or more employees during at least 50% of the preceding calendar year)?					<input type="checkbox"/> Yes <input type="checkbox"/> No
Eligibility date will be the first day of the policy month following the waiting period.					
Waiting period for future employees: <input type="checkbox"/> 0 Days <input type="checkbox"/> 30 Days <input type="checkbox"/> 60 Days <input type="checkbox"/> 90 Days <input type="checkbox"/> 120 Days <input type="checkbox"/> 180 Days					

**Medical Information**

Is any person to be covered unable to work due to illness or injury?  Yes  No

Is any person unable to perform the normal duties of another person in the same employment class of the same age and sex?  Yes  No

If yes is answered to either question, attach a sheet with the names of the individual(s), dates and degree of recovery.

## Prior Carrier Information

	Health	Dental	Life	Disability
Is this group transferring from another group carrier?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, provide Carrier Name and Telephone Number				
Effective Date of Coverage				
Proposed Termination Date				
Is this total replacement?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
If prior carrier Aetna, provide Group/Control Number				
Dental Only – Prior coverage included, check all that apply:		<input type="checkbox"/> Major Services <input type="checkbox"/> 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. It is agreed that no coverage shall become effective as to any person who is not then a bona fide, full-time employee, regularly performing the duties of his or her occupation, unless otherwise specifically provided in the plan documents (which consist of the Group Policy and/or Group Agreement). All statements herein shall be deemed representations and not warranties.

The Applicant acknowledges that it has selected this plan based upon written information provided by Aetna and that no broker, agent or consultant is authorized to modify the terms of the offer or to agree to changes. All material terms of plan coverage are set forth in the plan documents. Applicant agrees to make payroll and other records directly related to employee's coverage under the Group Agreement or Group Policy available to Aetna for inspection, at Aetna's expense, at Applicant's office, during regular business hours, upon reasonable advance request. This provision shall survive termination of the Group Agreement or Group Policy.

Applicant has selected, in accordance with applicable state law, the plan to be offered to Applicant's employees and Applicant has solely determined any/all health plan options for the Applicant's employees and the contribution amounts.

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

In accordance with current IRS regulations and the 1986 Tax Reform Act, a life insurance 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 schedule. Aetna disclaims any responsibility if the employer elects such a schedule and it is later deemed discriminatory.

The plan documents will determine the contractual provisions, including procedures, exclusions and limitations relating to the plan and will govern in the event they conflict with any benefits comparison, summary or other description of the plan.

Participating physicians, hospitals and other health care providers are independent contractors and are neither agents nor employees of Aetna.

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

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 may have violated state law.

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.

I understand 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 material 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.

The availability of a plan or program may vary by geographic service area. Some benefits are subject to limitations or maximums.

Aetna does not provide health or dental care services and, therefore, cannot guarantee any results or outcome.

I hereby apply for the coverage(s) indicated above. I certify that all information provided in this application is accurate and complete to the best of my knowledge and belief. I understand that this application will form a part of the Group Agreement or Group Policy issued by Aetna (a sample of which may be available on request), and by my signature below I agree to be bound by the terms and conditions of that Group Agreement or Group Policy. I understand that Aetna may choose not to accept this application at its sole discretion.

*continued on back*

