Aetna™

California Small Group Business
Employer Application

FOR GROUP COVERAGE (2 - 50 ELIGIBLE EMPLOYEES)

Life, Accidental Death & Dismemberment, Aetna Choice PPO, and Aetna Choice POS are underwritten by Aetna Life Insurance Company of Hartford, Connecticut. Aetna Primary Care HMO is underwritten by Aetna California Inc. Dental plans are administered by Aetna Dental Plan of California, Inc., Aetna of California Inc. and Aetna Life Insurance Company of Hartford, Connecticut.

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 ☐ Corporation ☐ Non-Profit ☐ Partnership ☐ Sole Proprietor ☐ Other: _____			

Medical Coverage Selection

Aetna Primary Care™ Plan HMO
☐ Plan Option 1 ☐ Plan Option 2 ☐ Plan Option 3

Aetna Choice™ Plan PPO
☐ Plan Option 1 ☐ Plan Option 2 ☐ Plan Option 3
Substance Abuse rehabilitation coverage? ☐ Yes ☐ No

Aetna Choice™ Plan (MC)
☐ Plan Option 1 ☐ Plan Option 2 ☐ Plan Option 3
Substance Abuse rehabilitation coverage? ☐ Yes ☐ No

Dental Coverage Selection

(Limited to one selection)

Aetna Dental™ Plan
☐ Plan Option 1 ☐ Plan Option 2 ☐ Plan Option 3

Orthodontia coverage option for adults and dependent children available to groups with 10 to 50 eligible employees.
(available with Plan Option 2 and Plan Option 3 only):
☐ Yes ☐ No

Life and Accidental Death & Dismemberment Coverage Selection

Basic Employee Term Life and Basic Accidental Death & Dismemberment (AD&D)

☐ $15,000 ☐ $20,000 ☐ $30,000 ☐ $50,000

Available only to groups with 10 to 50 eligible employees.
☐ $75,000 ☐ $100,000 ☐ $125,000 ☐ $150,000 ☐ $200,000 ☐ $250,000

Groups with 10 to 50 eligible employees may select one, two or three options. If more than one option is selected, describe class of employees, indicate the amount selected for each class, and attach a list of employee names with each class designation. (The highest option selected can be no more than 5 times the lowest option.)

For example: Class 1 Description: Owners and Managers. Class 1 Amount: $100,000
Class 2 Description: All Other Employees. Class 2 Amount: $50,000

Class 1 Description: _____ _____
Class 1 Amount:
☐ $15,000 ☐ $20,000 ☐ $30,000 ☐ $50,000 ☐ $75,000
☐ $100,000 ☐ $125,000 ☐ $150,000 ☐ $200,000 ☐ $250,000

Class 2 Description: _____ _____
Class 2 Amount:
☐ $15,000 ☐ $20,000 ☐ $30,000 ☐ $50,000 ☐ $75,000
☐ $100,000 ☐ $125,000 ☐ $150,000 ☐ $200,000 ☐ $250,000

Class 3 Description: _____ _____
Class 3 Amount:
☐ $15,000 ☐ $20,000 ☐ $30,000 ☐ $50,000 ☐ $75,000
☐ $100,000 ☐ $125,000 ☐ $150,000 ☐ $200,000 ☐ $250,000

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

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 monthly only): _____

Employer Contribution(s)

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

Employee Eligibility

Please provide the following information regarding your employees

Total number of employees _____

Number of employees to be covered by an Aetna health benefit plan + _____

Number of employees waiving health benefits coverage for one of the following reasons:

- A spousal plan or a different employer's or other group plan + _____
- Without coverage elsewhere or with individual only coverage + _____
- Covered under another health benefit plan, (other than Aetna) offered by you, the employer + _____

Total* number of employees eligible for health benefits = _____

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 Cal-COBRA Continuees	Other (i.e., temporary, substitute, seasonal)

Please list all medical carriers, including Aetna, to be offered to all eligible employees at the time the Aetna coverage will be effective.

1. 2. 3. 4.

Will domestic partners be eligible for coverage? ☐ Yes ☐ No
(Subject to Aetna review and approval. Additional documentation required.)

Are part-time employees (20-29 hours/week) to be covered?
☐ Yes ☐ No

Are there excluded classes of employees other than part-time and temporary employees (for example, Union employees)?
☐ Yes ☐ No
If Yes, describe excluded class(es): _____

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

Is your group currently subject to Cal-COBRA (employed 2-19 eligible employees on at least 50% of your business days during the last calendar year or last calendar quarter)? ☐ Yes ☐ No

Have you employed 20 or less employees (including non-eligible employees) for the past 20 weeks? ☐ Yes ☐ No

Prior Carrier Information

Health:

Will coverage be transferring from another carrier: ☐ Yes ☐ No

If yes, name of the carrier: _____ Proposed Termination Date: _____

If prior carrier is Aetna, provide group or control #: _____ Total Replacement: ☐ Yes ☐ No

Has the group been uninsured for three or more months prior to the requested effective date: ☐ Yes ☐ No

(continued on next page)

* Small employer eligibility will be determined based upon Total Eligible Employees listed here unless a signed and notarized affidavit is submitted along with this Verification Form attesting that you employed an average of 2 – 50 employees on 50% of your business days during the last calendar quarter or calendar year.

** Sum of Full Time employees listed for each work location must equal Total number of employees eligible for health benefits. Permanent employees who work at lest 20 hours and meet criteria of *California Health and Safety* Code Section 1357*(b)*(1) may be considered "Full Time employees."

Prior Carrier Information *(Continued)*

Dental:

Will coverage be transferring from another carrier: ☐ Yes ☐ No

If yes, name of the carrier: _____ Proposed Termination Date: _____

If prior carrier is Aetna, provide group or control #: _____ Total Replacement: ☐ Yes ☐ No

Prior Coverage included coverage for (check all that apply) ☐ Major Services ☐ Orthodontia

Has the group been uninsured for three or more months prior to the requested effective date: ☐ Yes ☐ No

Life and AD&D:

Will coverage be transferring from another carrier: ☐ Yes ☐ No

If yes, name of the carrier: _____ Proposed Termination Date: _____

If prior carrier is Aetna, provide group or control #: _____ Total Replacement: ☐ Yes ☐ No

Workers' Compensation Information

Aetna's coverage is not occupational in nature and, consequently, it is not a substitute for Workers' Compensation coverage.

Name of current Workers' Compensation carrier: _____ Renewal Date: _____

Is Workers' Compensation coverage provided on all employees? ☐ Yes ☐ No

If not, please provide a list of all employees enrolling that are NOT covered by Workers' Compensation or similar legislation (including title).

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.

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.

In accordance with current IRS regulations and the 1986 Tax Reform Act, a life insurance position schedule may be deemed discriminatory and result in imputed income tax to certain employees and possibly an excise tax to employers. Employers should consult with legal counsel prior to electing a position schedule. Aetna disclaims any responsibility if the employer elects such a position schedule and it is later deemed discriminatory.

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

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.

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. I understand that this application will form a part of the Group Agreement or Group Policy issued by Aetna

(continued on back cover)

Signature Section *(Continued)*

(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.

CALIFORNIA HMO APPLICANTS — NOTICE OF BINDING ARBITRATION — Any dispute arising from or related to the Group Agreement will be determined by submission to binding arbitration, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. The agreement to arbitrate includes, but is not limited to, disputes involving alleged professional liability or medical malpractice, that is, whether any medical services covered by the Group Agreement were unnecessary or were unauthorized or were improperly, negligently or incompetently rendered. This agreement also limits certain remedies and precludes the award of punitive damages. See Sections "Binding Arbitration" and "Limitations on Remedies" of the Evidence of Coverage for further Information.

The undersigned representative of the Employer understands that the Employer and any Groups eligible through the Employer, if different from the Employer, and any Members who enroll under this health plan are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of binding arbitration. This means that the Employer, Groups, Members and other interested parties will not be able to try their case in court. The undersigned representative of the Employer further understands and accepts that the Employer, Groups and Members are giving up certain remedies and cannot recover punitive damages.

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.

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: _____ 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: _____ E-Mail Address: _____

General Agent Name: _____ Aetna Agent Number/ID Number: _____

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

Address: _____ City: _____ State: _____ Zip: _____

E-Mail Address: _____

Administration Kits

Send Administration Kits to: ☐ Group ☐ Agent/Broker ☐ General Agent

For Aetna Use Only

Group Number _____ Control Number _____ SCD _____ Effective Date _____