



Attn. Small Group Renewal Underwriting Employer Verification
 11675 Great Oaks Way
 Alpharetta, GA 30022

<<Today's Date>>

«EMPLOYER_NAME _____»
 «ADDRESS_1 _____»
 «ADDRESS_2 _____»
 «CITY _____», «State» «ZIP9 _____»

Re: Policy Renewal Date: <<Renewal Date>>

Response Due Date: <<00/00/2004>>--Policy May not be Renewed if Complete Response is not Post-Marked by this Date.

Dear Customer:

It's time to renew your Aetna Small Group health plan coverage. As part of the renewal process each year, we verify your eligibility as a Florida Small Employer. The process is as simple as 1-2-3:

1. COMPLETE ALL SECTIONS OF THE ENCLOSED EMPLOYER VERIFICATION FORM (EVF).

- ✓ Indicate the total number of all employees in each category requested.
- ✓ The total number of employees includes those who may be covered under any other health benefits plan (including continuation coverage or Medicare).
- ✓ The total number of employees includes any employees of affiliated employers. (If you file a combined tax return, you are considered one employer.)
- ✓ If you are an Owner or Sole Proprietor and employ no one else, the total number of employees is one.

2. FURNISH PROOF OF WORKER'S COMPENSATION COVERAGE.

- ✓ Include a copy of your Worker's Compensation policy cover page indicating that you have coverage as of your renewal date of this policy; or
- ✓ If you do not furnish proof of Worker's Compensation coverage, your premium will be slightly higher; or
- ✓ If you are exempt from Worker's Compensation coverage, your premium will be slightly higher.

3. INCLUDE YOUR MOST RECENT UCT-6 TAX AND WAGE FORM.

- ✓ We consider this information in confirming your eligibility as a Florida Small Employer and to ensure compliance with community rating laws.
- ✓ If you are a Partnership, Owner, or S-Corporation, confirm your eligibility Schedule K-1, or IRS Form 1099 for each contracted employee.
- ✓ If you do not furnish one of the above, furnish either your previous month's Payroll, or a letter from your Attorney or CPA listing of the names of employees, their Dates of Hire, and the Hours worked.

IMPORTANT

- ✓ Verify that the preprinted name and address of your company are the legal name and address for your company. If the preprinted information is no longer correct, please write the correct address on the EVF.
- ✓ Do not risk non-renewal of your policy by leaving out any of the information requested in 1, 2, or 3.
- ✓ Do not risk non-renewal of your policy by delaying your response past the **Response Due Date** shown above.

We value your business and continue to look forward to providing your health plan coverage. If you have any questions about the enclosed EVF or the supporting documentation requirements, please contact . . .

Aetna Small Group Renewal Underwriting

1-888-422-2128 (Voice)

1-860-975-1528 (fax)

Sincerely,

Aetna

“Aetna” is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies. These companies include Aetna Health Inc.; Aetna Health of the Carolinas Inc; and/or Aetna Life Insurance Company.



Aetna™ Employer Verification Form

«EMPLOYER_NAME _____» «ADDRESS_1 _____» «ADDRESS_2 _____» «CITY _____», «State» «ZIP9 _____»	HMO Group Number: <<Group Number>> Control Number: <<Control Number>> Renewal Date: <<Renewal Date>> CFO: <<CFO>>
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PART I – EMPLOYEE CENSUS SURVEY

Employee Breakdown by State – Please provide a count, by state, for each category below for all employees eligible for coverage:

State	Full-Time Count	Part-Time** Count	Retiree Count	Continuation Count	Waiting Period Count	Total
Total Eligible Employees						

Employee Medical Coverage Summary – Please provide a count for each category below for all employees eligible for coverage:

Medical Benefits Plan (Aetna)	Medical Benefits Plan (Other Carrier)	Spouse / Partner’s Medical Benefits Plan	Other Employer’s Medical Benefits Plan	Waiving Medical Benefits Coverage

PART II – EMPLOYER SURVEY

- Please indicate the average number of eligible employees within the previous 12-month period: _____
- 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
- Please indicate your rate of contribution toward your employee’s health benefits:
Single: 0% 25% 50% 75% Other: _____%
Dependent: 0% 25% 50% 75% Other: _____%
- Do you, as an employer, cover your employees under Worker’s Compensation? (If responding yes, please provide documentation as proof of coverage in conjunction with your response.) If documentation is not supplied providing proof of coverage, we must assume that you do not have worker’s compensation coverage and an additional load will be applied to the rates.
 Yes No

PART III – SIGNATURE

I hereby attest to the accuracy and truthfulness of the above information. I understand that if the information I have provided is not accurate and complete, my company’s health benefits coverage may be rescinded or terminated or my company may be charged a different premium for this coverage. I understand that if my company does not meet Aetna’s participation and employer contribution requirements, Aetna may choose not to offer a renewal of coverage, and that Aetna will monitor ongoing adherence to participation and employer contribution requirements prior to subsequent renewals, subject to the requirements of state small group reform laws and the federal HIPAA law. Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Signature of Owner/Officer or Authorized Representative of the Company:	Telephone Number:
Print Name:	Date Signed:

** Part-Time is any employee who works fewer than 25 hours per week