Aetna®

Florida Small Group Business
Employer Application

FOR GROUP COVERAGE (GROUPS OF FEWER THAN 51 ELIGIBLE EMPLOYEES)

Life, Accidental Death & Dismemberment, Disability, Aetna Managed Choice, and Aetna PPO plans are underwritten by Aetna Life Insurance Company. Aetna HMO and Aetna POS plans are underwritten by Aetna Health Inc. 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 ☐ Corporation ☐ Non-Profit ☐ Partnership ☐ Sole Proprietor ☐ Other: _____

SIC Code or Industry Type: _____ Nature of Business: _____

Effective Date

Requested effective date (May be the 1st or 15th of the month only. The actual effective date will be assigned by the Aetna underwriting department if application is approved.)	

Medical Coverage Selection

(Groups with 2 – 4 eligible employees are limited to one selection. Groups with 5 – 50 eligible employees may offer any combination of two medical plans that are available in their service area.)

☐ **Aetna HMO Open Access – Plan Option** _____

☐ **Aetna HMO Gatekeeper – Plan Option** _____

☐ **Aetna POS Open Access – Plan Option** _____

☐ **Aetna Managed Choice Open Access – Plan Option** _____

☐ **Aetna PPO – Plan Option** _____

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

Dental Coverage Selection

Aetna Dental™ Plan (Plan Option 1 must be combined with Plan Options 4, 5, or 6 in a Dual Option offering. Plan Option V1 must be combined with Plan Option V4 in a Dual Option offering.)

Standard Plans:

☐ Option 1: Managed Dental
☐ Option 2: Freedom-of-Choice (Max)
☐ Option 3: Freedom-of-Choice (R&C)
☐ Option 4: PPO Max
☐ Option 5: Active PPO
☐ Option 6: PPO 2000
☐ Out-of-State PPO Plan (if applicable):
☐ $1,000 ☐ $1,500 ☐ $2,000

Voluntary Plans:

☐ Option V1: Managed Dental
☐ Option V2: Freedom-of-Choice (Max)
☐ Option V3: Freedom-of-Choice (R&C)
☐ Option V4: PPO Max
☐ Out-of-State Plan:
☐ $1,000

Orthodontic coverage for dependent children is included in Standard Options 1, 2, 3, and 5 and Voluntary Options V1, V2, and V3, and for Children and Adults in Standard Option 6. Orthodontic coverage is available only to groups with 10 or more eligible employees.

Life, Short Term Disability, and Packaged Life and Disability Coverage Selections

Groups with 10 to 50 eligible employees may select one, two or three options for Life, Short Term Disability and Packaged Life 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.) Premium Waiver For Totally Disabled Employees. ☐ Yes ☐ No

A waiver of premium for any insured who is totally disabled for a period of at least 6 months shall be made available to the policyholder as a part of the application for any group life insurance policy.

All Groups	☐ $10,000 ☐ $15,000 ☐ $20,000 ☐ $50,000		
Groups with 10 - 50 eligible employees	☐ $75,000 ☐ $100,000 ☐ $125,000		
Life & Disability Packaged Plan	☐ Low ☐ Low – 2 ☐ Medium ☐ Medium – 2 ☐ High		
STD	☐ Option 1 ☐ Option 2 ☐ $100 ☐ $200 ☐ $300 ☐ $400 ☐ $500		
Class Description	**Class 1**	**Class 2**	**Class 3**
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.

Employer Contribution(s)

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

Business Eligibility

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.
- 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.

Business Name	Tax Identification Number	Owner's Name	Percentage of Ownership	Number of Employees	Is group to be included?
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No

If you have answered "No" to "Is the 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 a location of one legal entity?	☐ Yes ☐ No
- How many branch offices are there?	

- Where is each branch located (list each branch business address separately)?	Number of Employees at each location

Are you currently a client company of a Professional Employer Organization (PEO)?	☐ Yes ☐ No
Do you use the services of a Payroll Company? If Yes, provide the name of the payroll company.	☐ Yes ☐ No
Has any business to be included for coverage under this group plan filed for Chapter 7, Chapter 11, or Chapter 13 bankruptcy? If Yes, provide details.	☐ Yes ☐ No
Has any business to be included been declined for coverage with Aetna or any other carrier in the past 12 months? If Yes, provide details.	☐ Yes ☐ No
Has your business been insured with Aetna within the past 12 months? If Yes, provide group number.	☐ Yes ☐ No
Are there any associated companies to be included with this group that are commonly owned?	☐ Yes ☐ No

Employer Eligibility/Employee Status

	Number of Employees						
Work Location (list by state)	Full-time	Part-time	Retired	COBRA	1099	Union	Other (i.e., temporary, substitute, seasonal, etc.)
Total							

Total number of eligible employees based on state law (must work a minimum of 25 hours per week). **Note:** An employer may not set eligibility rules that would require an employee to work more than 25 hours a week to obtain small group coverage. As long as the employee meets the 25 hour per week standard they are considered full-time for purposes of coverage.	
Of the total number of eligible employees as indicated above, how many are:	
- waiving Aetna health benefits coverage because they are covered through their spouse's health benefit plan?	
- waiving Aetna health benefits due to coverage under another health benefit plan offered by this employer?	
- waiving Aetna health benefits coverage but do not have coverage elsewhere?	
Total number of eligible employees enrolling in the Aetna health benefits plan.	
Total number of full-time employees who are currently in the waiting period and not eligible.	
Are there excluded classes of employees other than part-time and temporary employees (for example, Union employees)? If Yes, describe class(es) and/or the union local name and number.	☐ Yes ☐ No

COBRA/Tefra/Defra

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
How many employees have terminated in the last 90 days?	
To the best of your knowledge, will any of these employee(s)/dependent(s) exercise their COBRA option?	☐ Yes ☐ No
If Yes, is the employee/dependent presently disabled?	☐ Yes ☐ No
Is your group subject to Tefra/Defra? Under Tefra/Defra, Aetna is primary coverage for groups of 20 or more full-time and part-time employees (based on the total number of employees during 50% of the working days during the previous calendar year). Medicare is primary for groups of less than 20 full-time and part-time employees.	☐ Medicare Primary ☐ Aetna Primary

Benefit Waiting Period

The eligibility date will be the first day of the policy month following the waiting period.	
Waive the waiting period for present employees enrolling with the group (even those who have not met the full waiting period).	☐ Yes ☐ No
Waiting period for future employees: ☐ 0 Days ☐ 30 Days ☐ 60 Days ☐ 90 Days ☐ 120 Days ☐ 150 Days ☐ 180 Days ☐ 365 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 and Telephone Number				
Effective Date of Coverage				
Proposed Termination Date				
Is this total replacement?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
If prior carrier is Aetna, provide Group/Control Number				
Dental Only – Prior coverage included, check all that apply:		☐ Major Services ☐ Orthodontia		
Did your plan have a deductible?	☐ Yes ☐ No			
Prior Carrier Deductibles:	☐ Individual $_____ ☐ Family $_____	☐ Individual $_____ ☐ Family $_____ ☐ Ortho Maximum $_____		

Workers' Compensation

Aetna's coverage is not a substitute for Workers' Compensation coverage. Proof of coverage is required. Please provide a copy of the Declaration Page including effective date.		
Name of current Workers' Compensation carrier:	Effective Date:	Renewal Date:
Is Workers' Compensation coverage provided on all employees?		☐ Yes ☐ No
If No, 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.	

Florida Notice of Election or Rejection of Optional Medical Benefits

(If medical coverage has not been selected, this section does not apply.)

Florida law requires that the following optional benefits be offered to applicants having employees who are located in Florida. If elected, coverage will be provided to all employees under a Florida contract except as otherwise noted. Additional medical premium may be required for each option selected. Certain optional medical benefits may standardly be included in the HMO and POS plans.

1. **Mental and Nervous Disorders Coverage**
   Optional coverage offered for the treatment of Mental and Nervous Disorders is limited to Partial Hospitalization Services as follows: The calendar year maximum benefit for Partial Hospitalization Services or Combination of Partial Hospitalization and Inpatient Hospitalization Services is limited to the cost of 30 days of Inpatient Hospitalization for mental health services, including physician fees.
   ☐ Applicant accepts the optional Mental and Nervous Disorders Coverage.
   ☐ Applicant rejects the optional Mental and Nervous Disorders Coverage.
2. **Alcoholism and Substance Abuse Coverage**
   Optional coverage offered for the treatment of Alcoholism and Substance Abuse is limited to:
   - 44 Outpatient visits.
   - $35 Maximum payment for each Outpatient visit. $2,000 lifetime maximum for Inpatient and Outpatient Benefits.

   ☐ Applicant accepts the optional Outpatient Alcoholism and Substance Abuse Coverage.
   ☐ Applicant rejects the optional Outpatient Alcoholism and Substance Abuse Coverage.

Florida Supplement

Section 627.6699 of the Florida Statutes requires that each insurer offering one of the Florida mandated small employer plans must obtain from the prospective customer a signed written statement that the customer understands the limited nature of these plans and has chosen to accept or reject these plans based on an informed understanding of these plans.

I hereby certify and acknowledge that:

- I the plan sponsor meet the eligibility requirements for coverage under these plans as defined in Section 627.6699 of the Florida Statutes.
- These plans provide only limited benefits to covered persons. The benefits provided by the Standard and Basic Plans are intended to promote the availability of low-cost health insurance to small employers.
- These plans contain provisions for deductibles, as well as utilization review of certain covered services as methods of cost containment.
- If any misrepresentations are made regarding eligibility for coverage under these plans, the person making the misrepresentations forfeits the right to coverage provided under these plans.

I have been offered the opportunity to purchase one of the Florida mandated small employer plans and have chosen to:

☐ **Decline such coverage.**

☐ **Accept coverage under the:** ☐ **Standard Plan** ☐ **Basic Plan**

Dated At: _____ Date _____

Employer Business Name _____ Employer Signature _____

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.

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

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.

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 (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 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.

continued

Signature Section (Continued)

JOINDER AGREEMENT - REQUEST FOR PARTICIPATION (For life, disability, accidental death and dismemberment, out-of-state medical and out-of-state dental employee benefits): 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, as a Participating Employer in the Industry Trust corresponding to the standard industry classification ("SIC") code selected above: 1) agrees to be bound by the terms of the Agreement and the policy issued to the Trustee (including any amendments); 2) requests coverage for its eligible employees under the 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 to 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.

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

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 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: _____ Tax ID or SSN: _____
Agent Florida License ID Number: _____ Agency Name: _____ % of Credit: _____
Phone Number: (_____) _____ Fax Number: (_____) _____
Address: _____ City: _____ State: _____ ZIP: _____
Signature: _____ E-Mail Address: _____

Agent/Broker Name: _____ Tax ID or SSN: _____
Agent Florida License ID Number: _____ Agency Name: _____ % of Credit: _____
Phone Number: (_____) _____ Fax Number: (_____) _____
Address: _____ City: _____ State: _____ ZIP: _____
Signature: _____ E-Mail Address: _____

General Agent Name: _____ ID Number: _____
Phone Number: (_____) _____ Fax Number: (_____) _____
Address: _____ City: _____ State: _____ ZIP: _____
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 _____