aetna®

APPLICATION FOR A SMALL GROUP HEALTH BENEFITS POLICY

Aetna HMO, HNOnly, HNOption and QPOS plans are underwritten by Aetna Health Inc. Aetna Indemnity, OA EPO, OA MC and MC plans are underwritten by Aetna Life Insurance Company.

Please Print or Type	**For Aetna Use Only**
☐ New Policy ☐ Change in Policy Requested Effective Date _____ **NOTE:** The Effective Date will be on or after the date Aetna approves the application.	Policy Number _____

Section I: POLICYHOLDER INFORMATION

1. Policyholder (Full Legal Name of Company)		2. Tax Identification Number		
3. Main Address: Street		City	State	ZIP
Mailing Address: Street		City	State	ZIP
Telephone Number ( )	Facsimile Number ( )	Email Address		
Name of Correspondent			Telephone ( )	

4. Type of Organization
☐ Corporation ☐ Partnership ☐ Proprietorship ☐ Other (explain):

5. Nature of Business (specify)	SIC Code

6. Number of full-time employees in your company

Refer to the New Jersey Small Employer Certification for the definition of a full-time employee.

7. Number of full-time employees to be insured	8. Class or classes to be excluded

9. Insurance requested for ☐ Employees Only ☐ Employees and Dependents including Spouse ☐ Employees and Dependents excluding Spouse
Should the plan provide coverage for domestic partners as permitted by P.L. 2003, c. 246? ☐ Yes ☐ No
If "Yes", should the plan provide coverage for children of a covered domestic partner? ☐ Yes ☐ No

10. Is the Employer subject to the requirements of COBRA? ☐ Yes ☐ No

11. Is the employer subject to the requirements of Medicare as Secondary Payor Rules for eligibility due to
age? ☐ Yes ☐ No
disability? ☐ Yes ☐ No

12. Orientation Period: ☐ Yes ☐ No

13. Waiting period before employees become insured (may not exceed 90 days):
The 1st ☐ or 15th ☐ of the month following the waiting period of:
☐ 0 days ☐ 30 days ☐ 60 days
☐ exactly 90 days
Present Employees: _____ New Employees: _____ Rehired Employees: _____

14. Period for Annual Employee Open Enrollment Period:

15. What percentage of the total premium will the employer pay?

16. Deposit
$ _____ Premium Paid: Monthly

Premium will be due as of the effective date.
The premium for the first month of coverage must be attached.

Affiliates, subsidiaries or branches (must be included for the purposes of participation)

Legal Name and Location	No. Eligible Employees In This Company	No. Eligible Employees to Be Insured

Section II: SPECIFICATIONS FOR COVERAGE

Health Benefits:

Check One.

- ☐ NJ HMO: Plan Option: _____ Rx Option: _____
- ☐ NJ HMO HSA Compatible: Plan Option: _____
  Plan Administration: ☐ Cal Yr ☐ Plan Yr
- ☐ NJ Savings Plus HMO: Plan Option: _____
- ☐ NJ Savings Plus HMO HSA Compatible: Plan Option: _____
  Plan Administration: ☐ Cal Yr ☐ Plan Yr
- ☐ NJ HNOnly: Plan Option: _____ Rx Option: _____
- ☐ NJ HNOnly HSA Compatible:
  Plan Option: _____ Rx Option: _____
  Plan Administration: ☐ Cal Yr ☐ Plan Yr
- ☐ NJ Savings Plus HNOnly: Plan Option: _____
- ☐ NJ Savings Plus HNOnly HSA Compatible: Plan Option: _____
  Plan Administration: ☐ Cal Yr ☐ Plan Yr
- ☐ NJ QPOS: Plan Option: _____
- ☐ NJ HNOption: Plan Option: _____
- ☐ NJ HNOption HSA Compatible:
  Plan Option: _____ Rx Option: _____
  Plan Administration: ☐ Cal Yr ☐ Plan Yr
- ☐ NJ OA EPO: Plan Option: _____
- ☐ NJ OA EPO HSA Compatible: Plan Option: _____
  Plan Administration: ☐ Cal Yr ☐ Plan Yr
- ☐ NJ Aetna Whole Health (AWH) OA EPO Plan Option: _____
- ☐ NJ MC: Plan Option: _____
- ☐ NJ OA MC: Plan Option: _____
- ☐ NJ OA MC HSA Compatible: Plan Option: _____
  Plan Administration: ☐ Cal Yr ☐ Plan Yr
- ☐ NJ Indemnity: Plan Option: _____
- ☐ Other Plan: _____

Section III: ALL QUESTIONS MUST BE ANSWERED

1. Is there any Group Health Plan:
   - now in force and to be continued? ☐ Yes ☐ No
   - currently being applied for? ☐ Yes ☐ No

   If "Yes", identify the name of the Group Health Plan, give a description of the plan(s) and the name of insurance carrier(s):

   _____

2. Name of present or prior group carrier _____
   Effective date of prior coverage _____ Cancellation/Termination Date _____
   Is the coverage applied for in this application replacing other group insurance? ☐ Yes ☐ No
   If "Yes" give reason _____
   Plan being replaced _____
3. Are extended benefits provided in case of termination of health benefits? ☐ Yes ☐ No
4. To the best of your knowledge, are there any current or former employees or their eligible dependents whose health coverage is being continued? ☐ Yes ☐ No

   Please provide the following information for each current/former employee or dependent on health continuations.
   If additional space is needed, attach a separate sheet, signed and dated.

Name of Employee/ Dependent	Date of Birth	Type of Continuation State/Federal/ Extended Benefits	Reason for Termination Disability/Other	Continuation Dates	
				Start	End

5. To the best of your knowledge:
   a. Are any employees or dependents presently incapacitated? ☐ Yes ☐ No
   b. Are any dependent children incapable of self-support due to a physical or mental disability? ☐ Yes ☐ No

Additional space to explain if items 1, 2 or 3 were answered "Yes". Refer to the question number, and give details, including names, where appropriate.

6. Does the employer participate in an arrangement with a Professional Employer Organization? ☐ Yes ☐ No
   If yes, is health coverage available as a client of the PEO? ☐ Yes ☐ No
   (Refer to Advisory bulletin 00-SEH-02 if you need information concerning what constitutes a Professional Employer Organization.)

Section IV: AGENT/PRODUCER INFORMATION

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, for all products being applied for. I hereby represent that I am licensed and appointed to sell Aetna Group products in the state of New Jersey.
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.

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

Agent/Broker Name:				
National Producer Number:		SSN:		
Agency Name:		TIN:		
Pay commissions to (check one): ☐ Broker ☐ Agency		Phone:	Fax:	
Address:		City:	State:	ZIP:
Signature:	Date:	Email Address:		% of credit:
Broker Admin Assistant Name:		Broker Admin Assistant Email address:		

Agent/Broker Name:				
National Producer Number:		SSN:		
Agency Name:		TIN:		
Pay commissions to (check one): ☐ Broker ☐ Agency		Phone:	Fax:	
Address:		City:	State:	ZIP:
Signature:	Date:	Email Address:		% of credit:
Broker Admin Assistant Name:		Broker Admin Assistant Email address:		

General Agency Name:		Email Address:	
TIN:		Selling Agent Name:	
Phone:		Fax:	
Address:		City:	State:	ZIP:
GA Admin Assistant Name:		GA Admin Assistant Email address:	

Section V: SIGNATURE

It is understood that, except as provided under applicable regulations, no individual shall become insured while not actively at work on a full-time basis, and only full-time employees are eligible. (Refer to the definition on the New Jersey Employer Certification.)

It is further understood that no agent has power on behalf of Aetna Health Inc. and/or Aetna Life Insurance Company to make or modify any request or application for insurance or to bind Aetna Health Inc. and/or Aetna Life Insurance Company by making any promise or representation or by giving or receiving any information.

It is further understood that no insurance will be effective unless and until the application is accepted in writing by Aetna Health Inc. and/or Aetna Life Insurance Company. Final rates will be based on enrollment data as of the Policy effective date. No contract of insurance is to be implied in any way on the basis of the completion and/or submission of this application.

☐ Please read this statement and check to confirm. I confirm that I have received the Summary of Benefits and Coverage (SBC) documents associated with the plan or plans I selected on this application. I confirm I will provide SBCs to plan participants and beneficiaries as required by federal regulations and guidance related to the distribution of the SBC, including the requiring for timing and delivery.

Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

Date at _____ on _____

Print Name of Officer, Partner or Proprietor _____

Signature of Officer, Partner or Proprietor _____

Witness to Signature _____

Note: If there are any modifications to the statements and answers given in this application (i.e., crossed out, whited-out, erased information), the applicant must attest to the modifications by giving a complete signature in the margin near the modification.