aetna®

Employer Acknowledgment – Employer Waiting Period

Dear Employer:

Starting with plan years on or after 1/1/14, the Affordable Care Act and subsequent federal regulations prohibit group health plans and health insurance issuers from requiring any otherwise eligible plan participants and beneficiaries (employees and dependents) to wait more than ninety (90) days before their health coverage is effective (states may permit maximum waiting periods that do not exceed a specified period that is less than ninety (90) days). The regulations define group health plan as the employer or plan administrator. The issuer is defined as the insurance company. Since the requirement applies to both the group health plan and the issuer, each party's obligation is satisfied if the ninety (90) day waiting period (or shorter state specified waiting period) is honored. However, if neither party complies, both are subject to penalty.

By signing below, Employer Group Policyholder ("Employer") represents that it provides to Aetna, effective date information regarding plan participants and beneficiaries that takes into account the eligiblity conditions and waiting period requirements required under applicable state and federal law, in order for such plan participants and beneficiaries to become eligible for coverage under the Employer's group health insurance coverage with Aetna. In compliance with the waiting period requirements, Aetna shall use the effective date information provided by Employer to enroll such plan participants and beneficiaries in the Employer's group health insurance coverage. In the event this information changes, the Employer shall inform Aetna so that this form can be updated accordingly.

By signing below, I acknowledge and represent that:

- I am an authorized representative of the plan(s) for which this information is being provided.
- I agree that the statement above is true and correct as it applies to Employer, and I agree that I will update Aetna upon any change to this statement as it applies to Employer.

PSUID: _____

Group Policyholder Numbers/Control Numbers: _____

Employer/Company Name: _____

Authorized Representative:_____

Title: _____

Signature:_____ Date: _____

Phone/Email:_____