SNJ Small Group Health Carrier Identification Request

(To be completed by Broker of Record)

Today's Date	Agency Name
Tax ID Number	Effective/Renewal Month
Broker Name:	

Please list the groups below and answer the questions in columns 4 and 5 accordingly. Sign, date, and return the form to **MASMALLGROUPRENEWALSPECIALISTS@aetna.com** by **renewal date** to assure correct processing of your commissions. If we do not receive this form back by the date indicated, the commission for your groups will be set to 0%.

	Group Number	**Customer Name**	**Is another carrier offered?**	**If Yes, indicate below the # enrolled across all non-Aetna carriers.***
1			☐ Yes ☐ No	
2			☐ Yes ☐ No	
3			☐ Yes ☐ No	
4			☐ Yes ☐ No	
5			☐ Yes ☐ No	
6			☐ Yes ☐ No	
7			☐ Yes ☐ No	
8			☐ Yes ☐ No	

* For any group with a "Yes," indicate the total number of employees enrolled in coverage sponsored by the employer with other company(ies). The number can be pulled off the premium invoice or commission statement received from the other company(ies).

- Only include employees with work locations in NJ, NY, CT, PA, DE, VA, MD, and DC.
- Exclude union employees if union employees are carved-out under a separate collective-bargaining arrangement.
- Do not include employees enrolled in spouse's health benefits plans, Medicare, Medicaid or NJ Family Care.

Broker Signature	Date (MM/DD/YYYY)