aetna®

Texas
Employer Application

FOR GROUP COVERAGE:
Large Employer – 51 or more employees
Small Employer – 2 – 50 employees

**** You have the option to choose this Consumer Choice of Benefits Health Insurance Plan or Health Maintenance Organization health care plan that, either in whole or in part, does not provide state-mandated health benefits normally required in accident and sickness insurance policies or evidences of coverage in Texas. This standard health benefit plan may provide a more affordable health insurance policy or health plan for you although, at the same time, it may provide you with fewer health or health plan benefits than those normally included as state-mandated health benefits in Texas. If you choose this standard health benefit plan, please consult with your insurance agent to discover which state-mandated health benefits are excluded in this Policy or evidence of coverage.**

Life, Accidental Death & Personal Loss, Disability and Aetna PPO Plan, Aetna Savings Plus Plan, Aetna OAMC Plan, Aetna EPO Plan, Aetna Whole Health EPO Plan and Aetna Indemnity Plan are underwritten by Aetna Life Insurance Company. Aetna HNOnly Plans are underwritten by Aetna Health Inc. Dental plans are provided or administered by Aetna Dental Inc. and Aetna Life Insurance Company.

Company Name (Legal Name)	DBA/Doing Business As (if applicable)		
Street Address (PO Box not acceptable)	City	State	ZIP
Billing Address (if different than above)	City	State	ZIP
Phone Number ( )	Fax Number ( )		
Are there additional addresses/locations for this business? ☐ Yes ☐ No If "Yes," provide details.			
Company Contact – Name and Title	Company Contact E-mail Address		
Billing Contact Name (if different from Company Contact) *Go green – online statements available. Activate access to your eBusiness account at www.aetna.com/employersregister upon receipt of your approval letter.*	Billing Contact E-mail Address		
Enrollment Contact Name (if different from Company Contact)	Enrollment Contact E-mail Address		
SIC Code / Nature of Business		Federal Tax ID Number	Date Business Established (Mo/Yr):
Employer Classification ☐ Corporation ☐ Non-Profit ☐ Partnership ☐ Sole Proprietor ☐ LLC ☐ LLP ☐ Other: _____ Number of years in business: _____ Number of years with current carrier: _____ Number of carriers within the past 5 years: _____			

Effective Date of Group Plan Actual effective date will be assigned by the Aetna underwriting department if application is approved.

Requested effective date (may be the 1st or 15th of the month only): _____

Medical Coverage Selection

☐ **Aetna OAMC Plan**** _____ ☐ **Aetna HNOnly Plan**** _____
☐ **Aetna PPO Plan**** _____ ☐ **Aetna EPO Plan**** _____
☐ **Aetna Savings Plus Plan**** _____ ☐ **Aetna Indemnity Plan**** _____
☐ **Aetna Whole Health EPO Plan**** _____

51-100 Group Size: Is employer, plan sponsor, or a third party funding any of the deductible? If "Yes," how much? _____ ☐ Yes ☐ No

NOTE: OAMC 500 80/50, Savings Plus 500 80/60/50, AWH EPO 500 80/60, PPO 2000 70, Indemnity 2000 80 and EPO 70 plans are NOT offered under the Consumer Choice of Benefits Health Insurance Plan.

Dental Coverage Selection

☐ **Aetna Dental® Plan** _____ **Voluntary Dental:** ☐ Yes ☐ No

Orthodontia coverage is available for groups with 10 or more eligible employees with 5 enrolled employees (see plan details for eligibility).

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.

Life, Accidental Death & Personal Loss, & Disability Coverage Selections

Groups of 2 to 9 eligible employees are limited to one class. Groups with 10 to 50 eligible employees may select one, two, or three options for Life, Accidental Death & Personal Loss, and Disability. 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.) **Groups of 51 to 100: contact your Aetna Sales Executive.**

Life – Groups with 2 -9 eligible employees	☐ 10,000	☐ 15,000	☐ 20,000	☐ 50,000
Life – Groups with 10 to 50 eligible employees	☐ 10,000 ☐ 75,000	☐ 15,000 ☐ 100,000	☐ 20,000 ☐ 125,000	☐ 50,000
All Groups - Life & Disability Packaged Plan	☐ Low	☐ Medium	☐ High	
Class Description **Class 1:**	**Class 2:**		**Class 3:**	
Optional Dependent Term Life (Available only to groups with 10 to 50 eligible employees.) ☐ Yes ☐ No				

Employer Contribution(s)

Coverage	Medical	Dental	Employee Life	Dependent Life	Disability
Employer Contribution for Employee	%	%	%	NA	%
Employer Contribution for Dependent	%	%	N/A	%	N/A

Employee Disability Contribution

Employee's disability contribution percent – check one: ☐ Pre-Tax ☐ Post-Tax

Section 125 Plan

Does the group have a flex plan under Section 125 of the Internal Revenue Service code? ☐ Yes ☐ No

Employer Eligibility/Employee Status

Work Location (list by state) Please note if locations are a work site or "work-at-home".	**Number of Employees**						
	Full-time (i.e., usually at least 30 hours per week)	**Part-time**	**Retired**	**COBRA**	**1099**	**Union**	**Other** (e.g., temporary, substitute, seasonal)
TOTAL							

Of the total number of eligible employees indicated above, how many are:	
- currently in the waiting period and not eligible?	
- currently waiving medical coverage?	
What is the normal work week you require a full-time employee to work to be eligible for coverage?	____ hrs per week
2-50 Group Size: Do you wish to cover part-time employees who work a normal work week of 10-29 hours? If "Yes," enter the total number of these employees: _____	☐ Yes ☐ No
Excluded Classes: ☐ None ☐ Union – Local # _____ Domestic Partners: ☐ Same Sex ☐ Opposite Sex ☐ Both	
Do you use the services of a Payroll Company? If "Yes," provide the name of the company.	☐ Yes ☐ No
Are you currently a client company of a Professional Employer Organization (PEO)?	☐ Yes ☐ No

Benefit Waiting Period (BWP)

The eligibility date for enrollment will be the first day of the policy month following the waiting period of 0, 30 or 60 days or exactly 90 days following date of hire. If "0 days" is selected and the employee is hired on the 1st day of the month, the effective date will be the date of hire. If "Exactly 90 days" is selected, the enrollment eligibility date will begin 90 calendar days following the date of hire. Policy month refers to the contract effective date of the 1st or 15th.

Would you like to waive the benefit waiting period for current employees enrolling with the group as of the initial contract effective date only? ☐ Yes ☐ No

Waiting Period for future employees:

☐ First day of policy month following: ☐ 0 Days ☐ 30 Days ☐ 60 Days

☐ Exactly 90 Days following Date of Hire

Is a dual waiting period offered? ☐ Yes ☐ No If "Yes," provide the two classes of employees below:

Class 1 Waiting Period: _____ Class 1 Name: _____

Class 2 Waiting Period: _____ Class 2 Name: _____

Affordable Care Act (ACA) Medical Loss Ratio Requirement

What is the average number of employees you employed for the entire previous calendar year regardless of whether or not they were eligible for coverage? An employee is defined as any person for whom the company issues a W-2, including full time, part-time, and seasonal workers, and regardless of insurance eligibility.	

Medicare Primary versus Secondary

Is your group Medicare Primary (employed less than 20 employees for 20 consecutive weeks in the current or prior year) or Aetna Primary (employed 20 or more employees for 20 consecutive weeks in the current or prior year)? *Include:* Full-time, Part-time, Seasonal, Temporary, Union, Owners, Partners, Officers *Exclude:* Self-employed persons, Independent contractors (1099), Directors, Leased employees	☐ Medicare Primary ☐ Aetna Primary
How many full-time and part-time employees have you employed for 20 or more weeks during this calendar year or prior calendar year?	
100 or More Employees – Disabled Provision: How many full-time and part-time employees did you employ on 50% or more of your business days during the prior calendar year?	

COBRA/TEFRA/DEFRA

Is your employer group required to comply with COBRA regulation?	☐ Yes ☐ No
How many full and part-time employees did you employ 50% of the business days in the prior calendar year? *Include: Full-time, Part-time, Seasonal, Temporary, Union, Owners, Partners, Officers* *Exclude: Self-employed persons, Independent contractors (1099), Directors* Each part-time employee counts as a fraction of an employee, with the fraction equal to the number of hours that the part-time employee worked divided by the hours an employee must work to be considered full-time.	
Are any present or former employees/dependents currently on or eligible to elect COBRA/State Continuation? If "Yes," enter information below. Attach a separate sheet, if necessary.	☐ Yes ☐ No

Name of Applicant	Qualifying Event (e.g., termination of employment, divorce, etc.)	Date of Qualifying Event	Date of COBRA or State Continuation Coverage Terminates

Prior Carrier Information - If the Aetna plan is replacing an existing medical and/or dental plan, be sure to submit a copy of the most recent bill with employee roster. For dental, also include the benefit summary.

Is this plan total replacement of any existing group plans?		Carrier Name	Phone Number	Start Date	End Date
Current Medical Carrier	☐ Yes ☐ No				
Current Life Carrier	☐ Yes ☐ No				
Current Disability Carrier	☐ Yes ☐ No				
Current Dental Carrier	☐ Yes ☐ No				
Current Dental Coverage, check all that apply: ☐ Major Services ☐ Orthodontia – Ortho Max $ _____ ☐ Discount Dental					
Has your business ever been insured with Aetna? If "Yes," provide group number: _____					☐ Yes ☐ No

Medical Information for groups with 51 to 100 eligible employees

Is any person to be covered unable to work due to illness or injury?	☐ Yes ☐ No
Is any person currently receiving Workers' Compensation benefits?	☐ Yes ☐ No
Is any person currently on leave of absence? If "Yes," provide start date and expected date of return below.	☐ Yes ☐ No
If "Yes" is answered to any of the above, provide name(s) of the individual(s) and details.	

Workers' Compensation

Does company offer Workers' Compensation?	☐ Yes ☐ No

Texas Notice of Election or Rejection of Optional Medical Benefit - If medical coverage **has not been** selected or a Consumer Choice of Benefits Health Insurance Plan **has been** selected, this section does not apply.

Texas law requires that the following optional benefit be offered to applicants having employees who are located in Texas. If elected, coverage will be provided to all employees covered under a Texas contract except as otherwise noted. Additional medical premium will be required if option is selected.

1. **In Vitro Fertilization Coverage**
   Coverage includes expenses incurred by the subscriber or the subscriber's covered spouse for outpatient in vitro fertilization procedures subject to the provisions of the Texas Insurance Code.
   ☐ Applicant accepts the optional In Vitro Fertilization benefit.
   ☐ Applicant rejects the optional In Vitro Fertilization benefit.
   In rejecting coverage, I understand that it will not be provided at a future date unless I request it at policy renewal.
   Signature _____ Title _____ Date _____

Texas Notice of Election or Rejection of Optional Dental Benefits

To provide flexibility to covered persons, dental coverage can be obtained through either the Dental Plan Coverage (DPC Plan), offered by Aetna Dental Inc., or the Comprehensive Dental Expense Coverage plan (Point of Service Plan), offered by Aetna Life Insurance Company. The Point of Service Plan (POS Plan) provides out-of-network coverage for covered dental expenses and includes deductible and coinsurance percentage provisions. This plan must be offered to every customer who purchases a DMO plan and has 25 or more employees. If dental coverage has not been selected or the group does not meet the criteria indicated above, this section does not apply.

If any covered services or supplies are performed or received from a Member Dental Provider or a Member Specialty Dental Provider, benefits will be considered to have been paid for such services and supplies under the DPC Plan. The covered person will be responsible for the payment of the copayment amounts specified in the Certificate of Coverage describing his/her DPC Plan.

Except for Emergency Care, if any covered services or supplies are performed or received from a Non-Member Dental Provider, benefits will be considered to have been paid for such services and supplies under the POS Plan. The covered person will be responsible for the payment of the deductible and coinsurance percentage amounts specified in the Certificate of Coverage describing his/her POS Plan.

All the terms and conditions of the plan under which the services or supplies are provided will apply.

If you live and work outside of the Service Area, you will not be eligible for the DPC Plan Coverage.

Additional dental premium will be required if the Point of Service Option is accepted.

☐ Applicant accepts the Point of Service Option. ☐ Applicant rejects the Point of Service Option.

Signature _____ Title _____ Date _____

Signature Section

APPLICABLE TO ALL COVERAGES:

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 full-time employee, usually working at least 30 hours per week, regularly performing the duties of his or her occupation (except for health-related factors and subject to applicable HIPAA requirements for health coverage), 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 determined any/all health plan options for the Applicant's employees and the contribution amounts.

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.

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.

Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any intentional misrepresentation of material fact or conceals, for the purpose of misleading, information concerning any fact material thereto may commit a fraudulent insurance act, which may be a crime and may subject such person to criminal and civil penalties.

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.

APPLICABLE TO LIFE INSURANCE COVERAGE ONLY: 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.

continued on next page

Signature Section (Continued)

APPLICABLE TO HEALTH AND DENTAL COVERAGE ONLY:

Participating physicians, hospitals and other health care providers are independent contractors and are neither agents nor employees of Aetna. 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 may choose not to accept this application subject to Texas small employer laws.

JOINDER AGREEMENT - REQUEST FOR PARTICIPATION (For life, disability, accidental death and personal loss, 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 group size and minimum participation 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 upon the first renewal date following the first day of the next month after six consecutive months during which time the group failed to meet minimum group size or participation requirements.

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 authority pursuant to all applicable state and Federal laws, to review all denied claims for benefits under the Plan, and to construe disputed/doubtful Plan terms.

Employer Acknowledgment – Employer Waiting Period

Starting with plan years on or after 1/1/2014, 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. 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 is honored. However, if neither party complies, both are subject to penalty.

The Employer Group Policyholder ("Employer") represents that it provides to Aetna, effective date information regarding plan participants and beneficiaries that takes into account the eligibility conditions and waiting period requirements required under 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 immediately.

Electronic Access, Enrollment, and Billing Agreement

Access: Plan sponsor agrees that each employee will agree to terms associated with the issuance and use of his/her password and system access. An individual's password may be used only by that individual to access the system and may not be shared for any reason. Each individual is personally responsible for the information entered into the system. If an individual to whom a password has been issued becomes aware of a security breach (an incident in which there occurs attempted or unauthorized access, use, disclosure, modification, or destruction of information or interface with system operations), they agree to contact Aetna.

Enrollment: As part of your participation date, the following terms and conditions apply:

1. You agree to keep copies (paper or electronic) of actual enrollment forms and agree to maintain a reasonably complete record of enrollment and eligibility information (via electronic, interactive voice response technology and/or hard copy format), including evidence of coverage elections, evidence of eligibility, changes to such elections and terminations. Records must be available to Aetna upon request and retained for seven years.
2. For electronic enrollment submissions or changes you agree to create and maintain the records on secure information systems that can generate hard copy records of enrollments or changes entered or maintained on those information systems. Any hard copy records generated pursuant to this provision shall meet reasonable standards of availability, authenticity, non-repudiation and integrity.
3. You represent that all enrollment and eligibility information presented to Aetna is accurate and timely updated. You acknowledge that Aetna can and will rely on such enrollment and eligibility information in determining whether an individual is eligible for benefits under the plan. In the event of a discrepancy between enrollee information (including salary data) submitted and information actually presented by the enrollee on any particular claim for benefits, and the result is that Aetna must pay a higher benefit to reflect the actual information presented by the enrollee, you agree to pay promptly to Aetna applicable back premiums accruing as of the date on which the enrollee's information changed.
4. Insured plans must use Aetna-supplied forms in paper format or Aetna supplied electronic format (e.list).
5. You are responsible for adhering to both state and federal laws and regulations when submitting terminations to Aetna.
6. If otherwise permitted, when retro-terminations are submitted, we will regard the submission as verification that no premium/contribution was paid by the member/dependent for that period.

Billing Agreement: Any contractual provisions related to non-payment of premium continue to be applicable. I/we understand and agree to the terms set forth in this Agreement. By signing below, I represent that I am authorized to sign this Agreement.

SUMMARY OF BENEFITS - PLEASE READ AND CHECK BELOW TO CONFIRM:

☐ In accordance with my contract with Aetna to distribute information related to enrollment/coverage information, I have received the Summary of Benefits and Coverage document associated with the plan information referenced in this application. I confirm I will provide SBCs to plan participants and beneficiaries in compliance with the federal regulation and guidance related to SBCs, including the requirements for timing and delivery.

Signed at City, State	Applicant (Company Name)	
Authorized Applicant Signature	Official Title	
Print Name of Authorized Applicant		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.

I hereby certify that I am licensed and appointed to sell Aetna Group products in the state of Texas.

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:				
SSN:		National Producer Number:		
Agency Name:		TIN:		
Pay Commissions To (check one): ☐ Broker ☐ Agency		Phone: ( )	Fax: ( )	
Address:		City:	State:	ZIP:
Signature:	Date:	E-mail Address:		% of Credit:
Broker Admin Assistant Name:		Broker Admin Assistant E-mail Address:		
Agent/Broker Name:				
SSN:		National Producer Number:		
Agency Name:		TIN:		
Pay Commissions To (check one): ☐ Broker ☐ Agency		Phone: ( )	Fax: ( )	
Address:		City:	State:	ZIP:
Signature:	Date:	E-mail Address:		% of Credit:
Broker Admin Assistant Name:		Broker Admin Assistant E-mail Address:		
General Agent Name:		TIN:		
Selling Agent Name:		E-mail Address:		
Phone: ( )		Fax: ( )		
Address:		City:	State:	ZIP:
GA Admin Assistant Name:		GA Admin Assistant E-mail Address:		