aetna℠

Aetna Life Insurance Company
Aetna Health Inc.
Aetna Health Insurance Company

Virginia
Employer Application and Joinder Agreement

FOR GROUP COVERAGE (2 - 100 ELIGIBLE EMPLOYEES)

Life, Accidental Death & Dismemberment, Disability, Aetna PPO, Aetna Managed Choice POS (Open Access) and Aetna Indemnity plans are underwritten by **Aetna Life Insurance Company**. Aetna HMO and Health Network Only plans are underwritten by **Aetna Health Inc.** Aetna Health Network Option plans are underwritten by **Aetna Health Inc.** and **Aetna Health Insurance Company.** Dental plans are underwritten by **Aetna Life Insurance Company**. "Aetna" is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies.

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
Phone Number ( )	Fax Number ( )		
Company Contact Name, Title & DOB (DOB needed for eBilling setup and authentication)	Company Contact E-mail Address		
Billing Contact Name (if different from Company Contact)	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: _____

Medical Coverage Selection

☐ **VA Health Network Only** – Plan Option: _____ Rx Option: _____
☐ Morbid Obesity Rider

☐ **VA Health Network Only** – **Consumer Directed (CD)** – Plan Option: _____
☐ Morbid Obesity Rider

☐ **VA Health Network Only** – **HSA Compatible** – Plan Option: _____
☐ Morbid Obesity Rider

☐ **VA Health Network Option** – Plan Option: _____ Rx Option: _____
☐ Morbid Obesity Rider

☐ **VA Health Network Option AHF HRA** – Plan Option: _____ ☐ Morbid Obesity Rider

☐ **VA PPO** – Plan Option: _____ Rx Option: _____
☐ Morbid Obesity Rider

☐ **VA PPO HSA Compatible** – Plan Option: _____ ☐ Morbid Obesity Rider

☐ **VA OAMC Consumer Directed** – Plan Option: _____ ☐ Morbid Obesity Rider

☐ **VA Indemnity** – Plan Option: _____ ☐ Morbid Obesity Rider

☐ **VA Standard**
☐ HMO ☐ PPO ☐ Indemnity ☐ With Dental ☐ Without Dental
☐ With Mental Health Parity ☐ Without Mental Health Parity

☐ **VA Essential**
☐ HMO ☐ PPO ☐ Indemnity ☐ With Dental ☐ Without Dental
☐ With Mental Health Parity ☐ Without Mental Health Parity

☐ **Other Plan** – Plan Option: _____ ☐ Morbid Obesity Rider

1. Do you, or any third party on your behalf, in any way fund or subsidize any portion of the member's cost sharing responsibilities (deductibles, coinsurance or copays) under a high deductible health plan (HSA or HRA)?
☐ Yes ☐ No If "Yes," how much? _____ %
2. Does this group have a flex plan under Section 125 of the Internal Revenue Service Code? ☐ 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.

Dental Coverage Selection

Contributory Plan: Plan Option Name _____ Option Number _____

Voluntary Plan: Plan Option Name _____ Option Number _____

All dental plans are available with an Aetna medical plan. Voluntary Dental Options are only available to groups with 3 or more eligible employees. Orthodontic coverage for dependent children is optional to groups with 10 or more eligible employees.

Life, Accidental Death & Dismemberment, & Disability Coverage Selections – For Dependent Life, dependents are eligible from 14 days of age up to their 19th birthday or up to their 23rd birthday, if a full-time student.

- Groups of 2 to 9 eligible employees are limited to one class.
- Groups with 10 to 50 eligible employees may select up to 3 classes of coverage, with a minimum requirement of three employees in each class. 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. The highest option selected can be no more than 5 times the lowest option.
- Groups of 51 to 100: contact your Aetna Account Executive.

Groups with 2 to 50	☐ 10,000	☐ 15,000	☐ 20,000	☐ 50,000
Groups with 10 to 50	☐ 75,000	☐ 100,000	☐ 125,000	
Life & Disability Packaged Plan (limit one selection)	☐ Low	☐ Medium	☐ High	
Class Description	**Class 1:**	**Class 2:**	**Class 3:**	
Optional Dependent Term Life	(10 to 50 eligible employees only) ☐ Yes ☐ No			

Effective Date 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): _____.

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
Are there any associated companies to be included with this group that are commonly owned?	☐ Yes ☐ No
Are multiple companies or multiple addresses to be included under this plan?	☐ Yes ☐ No
If "Yes" to any questions, complete and submit Aetna's Multiple Companies form and provide a copy of the Quarterly Wage and Tax Statement for each group to be included for coverage.	
Is your company a branch of another company, or does your company have branch offices?	☐ Yes ☐ No
Do you use the services of a Payroll Company? If "Yes," provide the name of the payroll company.	☐ Yes ☐ No
Are you currently a client company of a Professional Employer Organization (PEO)?	☐ Yes ☐ No
Is group coverage available to you as a client of a PEO?	☐ Yes ☐ No
Is the group considered a Co-Employer with the PEO?	☐ Yes ☐ No
By enrolling for coverage as a small employer I am not in violation of any contractual breach of contract with the PEO.	☐ I am ☐ I am not

Employer Contribution(s)

	Medical	**Dental**	**Employee Life**	**Dependent Life**	**Packaged Life and Disability**
Employer Contribution for Employee	%	%	%	N/A	%
Employer Contribution for Dependent	%	%	N/A	%	N/A

Benefit Waiting Period

Eligibility date will be the first day of the policy month following the waiting period. Policy month refers to the contract effective date of the 1st or 15th.

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 ☐ 1 month ☐ 2 months ☐ 3 months ☐ 4 months ☐ 5 months ☐ 6 months

Employer Eligibility/Employee Status

Work Location (list by state)	**Number of Employees**						
	Full-time	**Part-time**	**Retired**	**COBRA or State Coninuees**	**1099**	**Union**	**Other** (i.e.,Temporary, substitute, seasonal, etc.)
TOTAL:							

Total number of employees _____	Total number of employees waiving _____
Total number of eligible employees _____	Total number of spousal waivers _____
Total number of employees enrolling _____	Total number of employees in benefit waiting period _____
Number of hours per week to be eligible for coverage _____	Are part time employees to be covered? ☐ Yes ☐ No
Classed Excluded ☐ None ☐ Union	
Do you want to cover Domestic Partners as eligible dependents? ☐ Yes ☐ No If "Yes," ☐ Same Sex ☐ Opposite Sex	

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)?	☐ Medicare Primary ☐ Aetna Primary
In total, how many full-time and part-time employees (including any seasonal employees, owners or partners) have you employed on 50% or more of your business days during the prior calendar year?	

COBRA versus Continuation

Is your employer group required to comply with COBRA regulation?	☐ Yes ☐ No
If you answered "Yes" to the above question but you currently employ less than 20 full-time and part-time employees, provide in total, how many full-time and part-time employees (including any seasonal employees, owners or partners) that you have employed for 20 or more weeks during this calendar year or prior calendar year.	
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**

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.	

Workers' Compensation

Does company offer Workers' Compensation?	☐ Yes ☐ No

Medical Information

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.	

Prior Carrier Information – If the Aetna plan is replacing an existing medical and/or dental plan, be sure to submit a copy of the current bill with employee roster.

	Carrier Name	Phone Number	Start Date	End Date
Current Medical Carrier				
Current Dental Carrier				
Current Life Carrier				
Current Disability Carrier				

Current Dental Coverage, check all that apply: ☐ Major Services ☐ Orthodontia

Has business ever been insured with Aetna in the past? If "Yes," provide group number: _____ ☐ Yes ☐ No

Number of carriers within past 5 years? _____

Is this plan total replacement of any existing group plans? ☐ Yes ☐ No

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.

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

In accordance with current IRS regulations and the 1986 Tax Reform Act, a life insurance 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 schedule. Aetna disclaims any responsibility if the employer elects such a schedule and it is later deemed discriminatory.

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.

Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false statement or deceptive statement, may have violated state law.

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.

Continued on next page

Signature Section *(Continued)*

JOINDER AGREEMENT - REQUEST FOR PARTICIPATION (For life, disability, accidental death and dismemberment 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.

I hereby apply for the coverage(s) indicated above. I certify that all information provided in this application is accurate and complete to the best of my knowledge and belief. 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 at its sole discretion.

Signed at (Location)	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, or all products being applied for including life insurance, if applicable. I hereby certify that I am licensed and appointed to sell Aetna Group products in the Commonwealth of Virginia. 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:

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:

General Agent Name:		TIN:	
Selling Agent Name:		E-mail Address:	
Phone:		Fax:	
Address:		City:	State: ZIP:
Signature:		Date:	