aetna®

Nevada

Employer Application and Joinder Agreement

FOR GROUP COVERAGE (2 – 100 ELIGIBLE EMPLOYEES)

Life, Accidental Death & Personal Loss, Disability, Indemnity and Aetna PPO plans are underwritten by Aetna Life Insurance Company. Aetna Value Network HMO plans and Aetna HNOption plans are underwritten by Aetna Health Inc., Aetna Life Insurance Company and/or Aetna Health Insurance Company. Dental plans are underwritten by 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 all addresses and locations.			
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: _____			

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 (Please select all plans in which your employees have enrolled.)

☐ **PPO** – Plan Option _____

☐ **Aetna Value Network HMO** – Plan Option _____

☐ **Aetna HNOption** – Plan Option _____

☐ **Indemnity** – Plan Option _____

1. For 51-100 eligible employees: 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)? Types of funding arrangements include (but not limited to): Gap, Wrap, HSA, HRA, etc. If "Yes," how much? _____	☐ Yes ☐ No
2. Does this group have a flex plan under Section 125 of the Internal Revenue Service Code?	☐ Yes ☐ No

Dental Coverage Selection - **Aetna Dental® Plan**

Standard Plans:
Option: _____

Voluntary Plans:
Option: _____

Orthodontia coverage is available in some plans for dependent children in groups with 10 or more eligible employees with a minimum of 5 enrolled employees.

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, and Packaged Life & Disability Coverage Selections

- Groups of 2 to 9 eligible employees are limited to one class.
- Groups with 10 to 50 eligible employees may elect 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.
- Dependent Life for groups with 10 to 50 eligible employees: 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 51 to 100: Contact your Aetna Sales Executive.

Groups with 2 to 9	☐ 10,000	☐ 15,000	☐ 20,000	☐ 50,000			
Groups with 10 to 50	☐ 10,000	☐ 15,000	☐ 20,000	☐ 50,000	☐ 75,000	☐ 100,000	☐ 125,000
Life & Disability Packaged Plan (limit one selection)	☐ Low	☐ Low 2	☐ Medium	☐ Medium 2	☐ High		

Class Description	**Class 1**	**Class 2**	**Class 3**

Optional Dependent Term Life (10 to 50 eligible employees only): ☐ Yes ☐ No

Benefit Waiting Period

Eligibility date for enrollment 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:

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

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.

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

Class 1 Name: _____ Class 1 Waiting Period: _____

Class 2 Name: _____ Class 2 Waiting Period: _____

Employer/Employee Contribution(s)

Coverage	**Medical**	**Dental**	**Employee Life**	**Dependent Life**	**Packaged Life & Disability**
Employer Contribution for Employee	$ or %	%	%	NA	%
Employer Contribution for Dependent	$ or %	%	%	NA	NA

Employee Disability Tax Contribution – check one: ☐ Pre-Tax ☐ Post-Tax

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 that are commonly owned?	☐ Yes ☐ No
Are multiple companies or multiple addresses to be included under this plan?	☐ Yes ☐ No
If "Yes" to any of the above questions, complete the Common Ownership Form.	
Is your company a branch of another company, or does your company have branch offices? If "Yes," complete the Common Ownership Form – Branch questions.	☐ Yes ☐ No

Employer Eligibility/Employee Status

Work Location (list by state)	**Number of Employees**						
	Full-time	**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?	

Employees must work a minimum of 30 hours per week to be eligible for coverage.

Classes Excluded: ☐ None ☐ Union (Local Number: _____)

Do you want to cover Domestic Partners as eligible dependents? ☐ Yes ☐ No

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?	

Affordable Care Act (ACA) Medical Loss Ratio Requirements

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.	

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					
Number of carriers within past 5 years? _____					
Has your business ever been insured with Aetna? If "Yes," provide group number: _____ ☐ Yes ☐ No					

Workers' Compensation

Does company offer Workers' Compensation?	☐ 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. 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 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)***

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.

With the exception of Aetna Rx Home Delivery®, participating physicians, hospitals and other health care providers are independent contractors and are neither agents nor employees of Aetna. Aetna Rx Home Delivery, LLC, is a subsidiary of Aetna Inc.

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.

I understand that if it is determined that I have committed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact, my company's group health coverage may be terminated or my company may be charged a different premium for this coverage.

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 care services and, therefore, cannot guarantee any results or outcome.

This information, as well as other personal and privileged information, subsequently collected by the insurance institution or agent may, in certain circumstances, be disclosed to third parties without authorization.

A right of access and correction exists with respect to all personal information collected.

Further disclosures required by **Nevada** law will be furnished to the policyholder upon request.

Personal information may be collected from persons other than the individual or individuals proposed for coverage.

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 consistent with provision of **Nevada** law.

I understand that Aetna will rely on the information I provide in determining eligibility for coverage, setting premium rates, compliance with applicable laws, and other purposes, and that any material misrepresentation or fraudulent statement may result in rescission of the group policy, termination of coverage, increase in premiums, or other consequences. Aetna reserves the right to audit and to request documentation as evidence of business activity at any time and from time to time in order to validate my compliance with eligibility and underwriting guidelines as well as validate the applicability of State and Federal laws. I understand that my failure to comply with any such request may also result in termination of coverage, increase in premiums, or other consequences.

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

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 ENROLLMENT, BILLING/PAYMENT AND ACCESS AGREEMENT

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.

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Signature Section *(Continued)*

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 either (1) use Aetna-supplied forms in paper format or electronic format or (2) agree to incorporate the following four points into your enrollment materials.
   a. Names(s) of the Aetna company offering the insurance coverage
   b. State-specific fraud warning statement
   c. A statement that the terms of the insurance documents will govern the member's rights and responsibilities
   d. An acknowledgment that participating providers are not agents or employees of Aetna and that network composition can change.
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/Payment: You agree to receive your bill online each month. 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.

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.

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, or all products being applied for including life insurance, if applicable. I hereby certify that I am licensed and appointed to sell Aetna products in the state of Nevada. 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:		