APPLICATION FOR A SMALL GROUP HEALTH BENEFITS POLICY

Please Print or Type	For Aetna Use Only
☐ New Policy ☐ Change in Policy Requested Effective Date _____ **NOTE:** The Effective Date will be on or after the date Aetna approves the application.	Policy Number _____

Section I: POLICYHOLDER INFORMATION

1. Policyholder (Full Legal Name of Company)		2. Tax Identification Number		
3. Main Address: Street		City	State	Zip
Mailing Address: Street		City	State	Zip
Telephone Number ( )	Facsimile Number ( )	Email Address		
4. Name of Correspondent			Telephone	

5. Type of Organization
☐ Corporation ☐ Partnership ☐ Proprietorship ☐ Other (explain):

6. Nature of Business (specify)	SIC Code

7. Number of eligible employees in your company

Refer to the New Jersey Small Employer Certification for the definition of an eligible employee

8. Number of eligible employees to be insured	9. Class or classes to be excluded

10. Insurance requested for
☐ Employees Only ☐ Employees and Dependents
Should the plan provide coverage for domestic partners as permitted by P.L. 2003, c.246? ☐ Yes ☐ No
If "Yes", should the plan provide coverage for children of a covered domestic partner? ☐ Yes ☐ No

11. Is the Employer subject to the requirements of COBRA?
☐ Yes ☐ No

12. Is the employer subject to the requirements of Medicare as Secondary Payor Rules for eligibility due to
age? ☐ Yes ☐ No
disability? ☐ Yes ☐ No

13. Waiting period before employees become insured (may not exceed 6 months):
Current Employees: _____
New or Rehired Employees: _____

14. What percentage of the premium will the employer pay?

15. Deposit $ _____ Premium Paid: Monthly	Premium will be due as of the effective date. The premium for the first month of coverage must be attached.

Affiliates, subsidiaries or branches (Must be included for the purposes of participation)

Legal Name and Location	No. Eligible Employees In This Company	No. Eligible Employees to Be Insured

Section II: SPECIFICATIONS FOR COVERAGE

Health Benefits:

☐ NJ HMO: Plan Option - _____ RX Option - _____

☐ NJ HMO No-Referral: Plan Option - _____ RX Option - _____

☐ NJ Cost-Sharing HMO: Plan Option - _____ RX Option - _____

☐ NJ Cost-Sharing HMO No Referral: Plan Option - _____ RX Option - _____

☐ NJ HMO HSA Compatible No Referral: Plan Option - _____ RX Option - _____

☐ NJ POS: Plan Option - _____ RX Option - _____

☐ NJ POS No-Referral: Plan Option - _____ RX Option - _____

☐ NJ Cost-Sharing POS No Referral: Plan Option - _____ RX Option - _____

☐ NJ POS HSA Compatible No Referral: Plan Option - _____ RX Option - _____

☐ NJ PPO Basic Hospital

☐ NJ PPO First Dollar

☐ NJ PPO HSA Compatible: Plan Option - _____

☐ Out-of-State/Situs PPO Plans:
☐ $250 (High) ☐ $500 (Medium) ☐ $1,000 (Low)

☐ Standard Health Benefits Plans:
☐ NJ HMO: Plan Option - _____ RX Option - _____
☐ NJ Indemnity: Plan Option - _____

☐ Other Plan _____

If you have selected an HSA-compatible plan:

- Do you plan on making contributions to your employee's HSA accounts? ☐ Yes ☐ No
- Do you plan to offer your employees payroll deductions to fund their HSA accounts? ☐ Yes ☐ No

Section III: ALL QUESTIONS MUST BE ANSWERED

1. Is there any Group Health Plan:
   - now in force and to be continued? ☐ Yes ☐ No
   - currently being applied for? ☐ Yes ☐ No

   If "Yes", identify the name of the Group Health Plan, give a description of the plan(s) and the name of insurance carrier(s):
   _____
2. Name of present or prior group carrier _____
   Effective date of prior coverage _____ Cancellation/Termination Date _____
   Is the coverage applied for in this application replacing other group insurance? ☐ Yes ☐ No
   If "Yes" give reason _____
   Plan being replaced ☐ A ☐ B ☐ C ☐ D ☐ E ☐ HMO ☐ HMO/POS ☐ Dual Contract POS
   ☐ Other _____
3. Has your firm been uninsured for 3 or more months prior to application? ☐ Yes ☐ No
4. What forms of Insurance are now or were in force? ☐ Health Benefits ☐ Prescription Drugs
   (Attach copies of Booklet/Certificate and most recent Billing Statement.)
5. Are extended benefits provided in case of termination of health benefits? ☐ Yes ☐ No
6. To the best of your knowledge, are there any current or former employees or their eligible dependents whose health insurance is being continued? ☐ Yes ☐ No

   Please provide the following information for each current/former employee or dependent on health continuations.
   If additional space is needed, attach a separate sheet, signed and dated.

Name of Employee/ Dependent	Date of Birth	Type of Continuation State/Federal/ Extended Benefits	Reason for Termination Disability/Other	Continuation Dates	
				Start	End

7. To the best of your knowledge:
   a. Are any employees or dependents presently incapacitated? ☐ Yes ☐ No
   b. Are any dependent children incapable of self-support due to a physical or mental disability? ☐ Yes ☐ No

Additional space to explain if items 1, 2 or 3 were answered "Yes". Refer to the question number, and give details, including names, where appropriate.

_____

_____

_____

_____

Section III: ALL QUESTIONS MUST BE ANSWERED (Continued)

8. Does the employer participate in an arrangement with a Professional Employer Organization? ☐ Yes ☐ No
(Refer to Advisory bulletin 00-SEH-02 if you need information concerning what constitutes a Professional Employer Organization.)

Section IV: AGENT/PRODUCER INFORMATION

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

Agent/Broker Name: _____ Aetna Agent Number/Tax ID/SSN: _____

Agency Name: _____ % of Credit: _____

Phone Number: (____) _____ Fax Number: (____) _____

Address: _____ City: _____ State: _____ Zip: _____

Signature: _____ Date: _____ E-Mail Address: _____

Agent/Broker Name: _____ Aetna Agent Number/Tax ID/SSN: _____

Agency Name: _____ % of Credit: _____

Phone Number: (____) _____ Fax Number: (____) _____

Address: _____ City: _____ State: _____ Zip: _____

Signature: _____ Date: _____ E-Mail Address: _____

General Agent Name: _____ Aetna Agent Number/ID Number: _____

Phone Number: (____) _____ Fax Number: (____) _____

Address: _____ City: _____ State: _____ Zip: _____

Signature: _____ Date: _____ E-Mail Address: _____

Section V: SIGNATURE

It is understood that, except as provided under applicable regulations, no individual shall become insured while not actively at work on a full-time basis, and only full-time employees are eligible. A full-time employee is one who regularly works at least 25 hours per week at his employer's place of business.

It is further understood that no agent has power on behalf of Aetna Health Inc. and Aetna Life Insurance Company to make or modify any request or application for insurance or to bind Aetna Health Inc. and Aetna Life Insurance Company by making any promise or representation or by giving or receiving any information.

It is further understood that no insurance will be effective unless and until the application is accepted in writing by Aetna Health Inc. and Aetna Life Insurance Company. Final rates will be based on enrollment data as of the Policy effective date. No contract of insurance is to be implied in any way on the basis of the completion and/or submission of this application.

Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

Date at _____ on _____

Print Name of Officer, Partner or Proprietor _____

Signature of Officer, Partner or Proprietor _____

Witness to Signature _____

Note: If there are any modifications to the statements and answers given in this application (i.e., crossed out, whited-out, erased information), the applicant must attest to the modifications by giving a complete signature in the margin near the modification.