



Pennsylvania Small Group Business Employer Application and Joinder Agreement

FOR GROUP COVERAGE (2 – 50 ELIGIBLE EMPLOYEES)

Life, Accidental Death & Dismemberment, Disability, Aetna PPO and Aetna Indemnity plans are underwritten by Aetna Life Insurance Company. Aetna HMO plans and Aetna POS plans are underwritten by Aetna Health Inc. and Aetna Health Insurance Company. Dental plans are provided or administered by Aetna Life Insurance Company.

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
Company Contact Person - Title	Phone Number ()	Fax Number ()	
E-Mail Address	Federal Tax ID Number	Date Business Established (Mo/Yr):	
Employer Classification <input type="checkbox"/> Corporation <input type="checkbox"/> Non-Profit <input type="checkbox"/> Partnership <input type="checkbox"/> Sole Proprietor <input type="checkbox"/> Other: _____			
SIC Code: _____ Nature of Business: _____			

Medical Coverage Selection

- PA POS – Plan Option: _____
Rx Option: _____
- PA POS No-Referral – Plan Option: _____
- PA POS Cost-Sharing – Plan Option: _____
- PA POS Cost-Sharing No Referral – Plan Option: _____
- PA POS Consumer-Directed No Referral – Plan Option: _____
- PA POS HSA Compatible No Referral – Plan Option: _____
- PA PPO – Plan Option: _____
- PA PPO Cost-Sharing – Plan Option: _____
- PA PPO HSA Compatible – Plan Option: _____
- PA Health Network Option AHF HRA – Plan Option: _____
- PA Indemnity – Plan Option: _____
- Other Plan – Plan Option: _____

Does this group qualify for the small employer exemption under Federal Mental Health Parity? Yes No

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

Is employer, plan sponsor or a third party funding any of the deductible?
 Yes No If yes, how much? _____

Dental Coverage Selection

Aetna Dental™ Plans

Contributory Plans:

Option Number _____

Plan Option Name _____

Voluntary Plans:

Option Number _____

Plan Option Name _____

Out-of-State PPO Plans:

Plan Option Name: _____

All dental plans available with an Aetna medical plan. Dental Options V2, V3, V4 and V7 are only available to groups with 3 or more employees. Orthodontic coverage is available only to groups with 10 or more eligible employees and automatically included on Options 2, 3, 5, 6, V2, and V3.

Life, Accidental Death & Dismemberment, and 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 with 10 to 50 eligible employees may offer up to 3 classes of coverage, with a minimum requirement of 3 employees in each class. If more than one class is selected, describe each class of employee, the amount selected for each class, and attach a list of employee names with each class designation. The highest life option selected can be no more than 5 times the lowest option.

	Class 1		Class 2		Class 3	
	Life	or Packaged Life & Disability Plan	Life	or Packaged Life & Disability Plan	Life	or Packaged Life & Disability Plan
All Groups	<input type="checkbox"/> 10,000 <input type="checkbox"/> 15,000 <input type="checkbox"/> 20,000 <input type="checkbox"/> 50,000	<input type="checkbox"/> Low <input type="checkbox"/> Medium <input type="checkbox"/> High	<input type="checkbox"/> 10,000 <input type="checkbox"/> 15,000 <input type="checkbox"/> 20,000 <input type="checkbox"/> 50,000	<input type="checkbox"/> Low <input type="checkbox"/> Medium <input type="checkbox"/> High	<input type="checkbox"/> 10,000 <input type="checkbox"/> 15,000 <input type="checkbox"/> 20,000 <input type="checkbox"/> 50,000	<input type="checkbox"/> Low <input type="checkbox"/> Medium <input type="checkbox"/> High
Additional options for Groups with 10 – 50 eligible employees	<input type="checkbox"/> 75,000 <input type="checkbox"/> 100,000 <input type="checkbox"/> 125,000		<input type="checkbox"/> 75,000 <input type="checkbox"/> 100,000 <input type="checkbox"/> 125,000		<input type="checkbox"/> 75,000 <input type="checkbox"/> 100,000 <input type="checkbox"/> 125,000	
Class Description						

Optional Dependent Term Life (Available only to groups with 10 to 50 eligible employees.) 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): _____

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.

Group Ownership Information – OPTIONAL

(This information is designed for the purposes of data collection and will not be used for underwriting.)

Check one or more, if applicable:

- Woman Owned Business Minority Owned Business (indicate status below):
 African American or Black Hispanic or Latino Asian Other _____

Business EligibilityIs your company a subsidiary of another company, an affiliate of another company, or under common control with another company? Yes NoDoes your company file state or federal taxes with another company(ies) on a combined or consolidated basis? Yes NoAre there any associated companies to be included with this group that are commonly owned? Yes No

If Yes to any questions, complete the information below.

- A copy of the Quarterly Wage and Tax Statement must be provided for each group to be included for coverage.
- If you file multiple businesses under one tax ID number, all businesses must be included as one group.

Business Name	Tax Identification Number	Owner's Name	Ownership Percentage	Number of Employees	Is group to be included?
					<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No

If you have answered "No" to "Is group to be included" above, please explain why.

Is your company a branch of another company, or does your company have branch offices? Yes NoIf Yes - Is each branch office a separate legal entity? Yes No- Is each branch a location of one legal entity? Yes No

- How many branch offices are there? _____

- Are taxes filed separately or as one common filing? Separately One common filing

- Where is each branch located? (List each branch business address separately.) _____ Number of Employees at each location _____

Has your business been insured with Aetna within the past 25 months? If Yes, provide group number. _____ Yes NoAre you currently a client of a Professional Employer Organization (PEO)? Yes No

If Yes - Provide the name of the PEO. _____

- 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 contract with the PEO. Agree Disagree**Employer Contribution(s)**

Coverage	Medical	Dental	Employee Life	Dependent Life	Life/Disability
Employer's Contribution for Employee	%	%	%	NA	%
Employer's Contribution for Dependent	%	%	NA	%	NA

Groups with 2 to 50 eligible employees: The employer must contribute at least 50% of the employee-only annual medical premium. Coverage can be denied based on inadequate contributions. For all life and disability products, the employer must contribute 100% of premiums for groups with 2 to 9 eligible employees and at least 50% of premium for groups with 10 to 50 eligible employees.

Benefit Waiting Period (BWP)

The eligibility date will be first day of the policy month following the waiting period.

Waive the waiting period for present employees enrolling with the group (even those who have not met the full waiting period). Yes NoWaiting period for future employees: 0 days 30 days 60 days 90 days 120 days 150 days 180 days**Overage Dependent Extension**

Aetna's standard limiting age for dependents is up to 26. Indicate below if you elect to extend this group health insurance coverage to eligible dependent children up to age 30.

- Yes, I elect to extend coverage to eligible dependent children up to age 30. I understand: 1) these dependents must satisfy state-mandated eligibility criteria; 2) these dependents must apply in writing; and 3) the dependent is responsible for the full premium cost of the continued coverage. Please provide employees with Pennsylvania DU30 Supplemental Enrollment Form.

- No, I do not elect to extend this group coverage to overage dependents.

Medical InformationIs any person to be covered unable to work due to illness or injury? Yes NoIs any person unable to perform the normal duties of another person in the same employment class of the same age and sex? Yes No

If yes is answered to either question, attach a sheet with the names of the individual(s), dates and degree of recovery.

Employer Eligibility/Employee Status

Work Location (list by state)	Number of Employees				
	Full-time (based on number of minimum hours allowed by state law)	Part-time	Retired	COBRA or State Continuees	Other (i.e., temporary, substitute, seasonal)
Total number of employees:					
Total number of eligible employees based on state law (must work a minimum of 25 hours per week)					
Total number of employees waiving Aetna health benefits but covered through their spouse's health benefit plan:					
Total number of employees waiving Aetna health benefits coverage without coverage elsewhere:					
Total number of full-time employees who are currently in the waiting period and not eligible:					
Total number of employees covered under another health benefit plan offered by the employer:					
Are there excluded classes of employees other than part-time and temporary employees (for example, Union employees)? If Yes, describe excluded class(es): _____					<input type="checkbox"/> Yes <input type="checkbox"/> No
Is your group subject to COBRA, as defined by federal regulations? (Have you employed 20 or more employees during at least 50% of the preceding calendar year?)					<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Check here if you want to cover Domestic Partners as eligible dependents.					

Prior Carrier Information

	Health	Dental	Life	Disability
Is this group transferring from another group carrier?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, provide Carrier Name and Telephone Number				
Renewal Date of Current Coverage				
Is this total replacement?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dental Only – Prior coverage included, check all that apply:		<input type="checkbox"/> Major Services <input type="checkbox"/> Orthodontia		

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 knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material or which would have affected the carrier's rating, offering, issuing of coverage thereto may have violated state law. Failure to disclose all health information encompassed by the questionnaire will be deemed to be material omissions for rating purposes.

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