

5. 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): _____

6. Employer Contribution(s)

	Employer's Contribution for Employee Coverage	Employer's Contribution for Dependent Coverage
Medical*	_____ %	_____ %
Medical**	\$ _____	\$ _____ or _____ %
Dental	_____ %	_____ %
Basic Employee Term Life (including AD&D)	_____ %	N/A
Optional Dependent Term Life	N/A	_____ %
Aetna Medicare Advantage Plan	_____ %	_____ %
Disability	_____ %	N/A

* Requires a minimum of 50% per employee per month (employee coverage only -- does not apply to dependent coverage).
 ** Only available to groups requesting Multi-Option-Requires a minimum of \$80.00 per employee per month or the actual cost of the plans (whichever is less)

7. Employer Eligibility Information

Please complete the chart below. Please note that Aetna Small Group Underwriting requires all small employers to provide documentation verifying the number of eligible employees for the last calendar quarter. Aetna Small Group Underwriting may request documentation for the last 12 months prior to the requested effective date should eligibility be a concern. Please enter current information regarding your company's eligible and non-eligible employees, retirees, and COBRA participants.

Work Location (By state)	Total* Number of Eligible Employees	Total Number of Non-eligible Employees	Total Number of Eligible COBRA or Cal-COBRA	Total Number of COBRA or Cal-COBRA not yet electing coverage	Medicare Eligible or Retired/Medicare Eligible
California					
Total:					

Total number of employees that are enrolling into an Aetna Medical Product: _____

Total number of medical waivers: _____

Total number of Medicare eligible employees:

Is your group subject to COBRA (20 or more total employees during at least 50% of the working days in the previous calendar year) or CAL-COBRA (less than 20 total employees during at least 50% of the working days in the previous calendar year or previous calendar quarter)? COBRA CAL-COBRA

Is your group subject to Medicare as Secondary Payor (20 or more employees for each working day in each of 20 or more calendar weeks in the current calendar year or the preceding calendar year)? Yes No

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

Does the group allow permanent employees who work 20-29 hours/week to be eligible for coverage? Yes No

Are there excluded classes of employees (i.e., Management/Non-management, Union/Non-union, Salary/Hourly): Yes No

If Yes, describe the excluded class(es): _____

Please list, if any, other medical carriers that will be offered alongside with Aetna's medical coverage. Also identify how many employees are enrolling with the other medical carrier:

Carrier 1: _____ Enrolled: _____; Carrier 2: _____ Enrolled: _____

Depending upon the group's effective date, the eligibility date will be the 1st or 15th day of the month following satisfaction of the waiting period. Waiting period for employees: 0 days 30 days 60 days 90 days 120 days 180 days

* Small employer eligibility will be determined based upon Total Eligible Employees listed here unless a signed and notarized affidavit is submitted along with this Verification Form attesting that you employed an average of 2 – 50 employees on 50% of your business days during the last calendar quarter or calendar year.

8. Prior Carrier Information

Health:

Will coverage be transferring from another carrier: Yes No

If Yes, name of the carrier: _____ Proposed Termination Date: _____

If prior carrier is Aetna, provide group or control #: _____ Total Replacement: Yes No

Dental:

Will coverage be transferring from another carrier: Yes No

If Yes, name of the carrier: _____ Proposed Termination Date: _____

If prior carrier is Aetna, provide group or control #: _____ Total Replacement: Yes No

Prior Coverage included coverage for (check all that apply) Major Services Orthodontia

Life and AD&D:

Will coverage be transferring from another carrier: Yes No

If Yes, name of the carrier: _____ Proposed Termination Date: _____

If prior carrier is Aetna, provide group or control #: _____ Total Replacement: Yes No

Disability:

Will coverage be transferring from another carrier: Yes No

If Yes, name of the carrier: _____ Proposed Termination Date: _____

If prior carrier is Aetna, provide group or control #: _____ Total Replacement: Yes No

9. Workers' Compensation Information

Aetna's coverage is not occupational in nature and, consequently, it is not a substitute for Workers' Compensation coverage.

Name of current Workers' Compensation carrier: _____ Renewal Date: _____

Is Workers' Compensation coverage provided on all employees? Yes No

If not, please provide a list of all employees enrolling that are NOT covered by Workers' Compensation or similar legislation (including title).

10. 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, permanent full-time employee (working 30 hours per week or more), or a permanent employee (working 20-29 hours per week, if coverage is offered).

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 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.

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 thereto commits a fraudulent insurance act, which is a crime and subjects 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. 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 affirm that all information provided in this application is accurate and complete to the best of my knowledge or 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 but only to the extent permitted by law.

(continued on back cover)



Small Group Business COBRA/CAL.COBRA Questionnaire

(For use in California only)

This form must be completed when replacing another group plan.

Does your group currently qualify for (choose one): <input type="checkbox"/> COBRA <input type="checkbox"/> Cal. COBRA
--

I. COBRA/Cal.COBRA Continuees – Complete for each employee currently on COBRA or Cal.COBRA

Name	Date of Birth	Social Security Number	Date of Qualifying Event	Qualifying Event
1.				<input type="checkbox"/> COBRA <input type="checkbox"/> Cal.COBRA
2.				<input type="checkbox"/> COBRA <input type="checkbox"/> Cal.COBRA
3.				<input type="checkbox"/> COBRA <input type="checkbox"/> Cal.COBRA
4.				<input type="checkbox"/> COBRA <input type="checkbox"/> Cal.COBRA

II. Terminated Employees – Complete for each employee terminated in the last 90 (COBRA) or 60 days (Cal.COBRA)

1. Name	Date of Termination	Social Security Number
To the best of your knowledge, will this employee/dependent(s) exercise their COBRA /Cal.COBRA Option? <input type="checkbox"/> Yes <input type="checkbox"/> No		
2. Name	Date of Termination	Social Security Number
To the best of your knowledge, will this employee/dependent(s) exercise their COBRA /Cal.COBRA Option? <input type="checkbox"/> Yes <input type="checkbox"/> No		
3. Name	Date of Termination	Social Security Number
To the best of your knowledge, will this employee/dependent(s) exercise their COBRA /Cal.COBRA Option? <input type="checkbox"/> Yes <input type="checkbox"/> No		
4. Name	Date of Termination	Social Security Number
To the best of your knowledge, will this employee/dependent(s) exercise their COBRA /Cal.COBRA Option? <input type="checkbox"/> Yes <input type="checkbox"/> No		

III. Misrepresentation

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 thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Employer Signature	Title	Date
Company Name		