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 ☐ Corporation ☐ Non-Profit ☐ Partnership ☐ Sole Proprietor ☐ 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

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	☐ 10,000 ☐ 15,000 ☐ 20,000 ☐ 50,000	☐ Low ☐ Medium ☐ High	☐ 10,000 ☐ 15,000 ☐ 20,000 ☐ 50,000	☐ Low ☐ Medium ☐ High	☐ 10,000 ☐ 15,000 ☐ 20,000 ☐ 50,000	☐ Low ☐ Medium ☐ High
Additional options for Groups with 10 – 50 eligible employees	☐ 75,000 ☐ 100,000 ☐ 125,000		☐ 75,000 ☐ 100,000 ☐ 125,000		☐ 75,000 ☐ 100,000 ☐ 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 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

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?
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ 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 ☐ No
If 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 ☐ No
Are 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 ☐ No

Waiting 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 Information

Is any person to be covered unable to work due to illness or injury? ☐ Yes ☐ No
Is 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): _____	☐ Yes ☐ 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?)	☐ Yes ☐ No
☐ 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?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
If Yes, provide Carrier Name and Telephone Number				
Renewal Date of Current Coverage				
Is this total replacement?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Dental Only – Prior coverage included, check all that apply:		☐ Major Services ☐ 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 thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

continued on next page

Signature Section (Continued)

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.

I understand 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.

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 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 subject to any state requirements.

JOINDER AGREEMENT - REQUEST FOR PARTICIPATION (for Life, Disability, Accidental Death and Dismemberment and Out-of-State Dental Employee Coverage): 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.

Signed at (Location):	City, State	Applicant (Company Name)
By:	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, including my knowledge that replacement life insurance is ☐ is not ☐ (check one) a part of this transaction.

I hereby certify that I am licensed and appointed to sell Aetna Small Group products in the state of Pennsylvania.

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.

Broker Name:		SSN:		
Agency Name:		TIN:		
Pay commissions to: (check one) ☐ Broker ☐ Agency		Phone:	Fax:	
Address:		City:	State:	ZIP:
Signature:	Date:	E-mail Address:		% of credit:

Broker Name:		SSN:		
Agency Name:		TIN:		
Pay commissions to: (check one) ☐ Broker ☐ Agency		Phone:	Fax:	
Address:		City:	State:	ZIP:
Signature:	Date:	E-mail Address:		% of credit:

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