Colorado

Small Group Employer Application

FOR DENTAL AND VISION BENEFITS

AETNA LIFE INSURANCE COMPANY

<table>
<tr><td colspan="3">Company name (legal name)</td><td colspan="3">Doing business as (if applicable)</td></tr>
<tr><td colspan="3">Street address (PO box not acceptable)</td><td>City</td><td>State</td><td>ZIP code</td></tr>
<tr><td colspan="3">Billing address (if different than above)</td><td>City</td><td>State</td><td>ZIP code</td></tr>
<tr><td colspan="3">Phone number ( )</td><td colspan="3">Fax number ( )</td></tr>
<tr><td colspan="6">Are there additional addresses or locations for this business? ☐ Yes ☐ No If yes, provide all addresses and locations.</td></tr>
<tr><td colspan="3">Company contact – name and title</td><td colspan="3">Company contact email</td></tr>
<tr><td colspan="3">Billing contact name (if different from company contact)
Online statements are available. Activate access to your eBusiness account at www.aetna.com/employersregister upon receipt of your approval letter.</td><td colspan="3">Billing contact email</td></tr>
<tr><td colspan="3">Enrollment contact name (if different from company contact)</td><td colspan="3">Enrollment contact email</td></tr>
<tr><td>SIC code</td><td colspan="2">Nature of business</td><td>Federal tax ID number</td><td colspan="2">Date business established (Month/Year):</td></tr>
<tr><td colspan="6">Employer classification ☐ S Corp ☐ C Corp ☐ Nonprofit ☐ Partnership ☐ Sole proprietor
☐ LLC filing 1065 ☐ LLC filing 1120 ☐ LLP ☐ Other: ____________________</td></tr>
</table>

Effective date of group plan – The actual effective date will be assigned by the Aetna underwriting department if the application is approved.

Requested effective date: ______________________

Dental coverage selection – Aetna Dental® Plan

☐ Non-voluntary plan option ______________________ ☐ Voluntary plan option ______________________

This policy DOES NOT include coverage of pediatric dental services as required under federal law. Coverage of pediatric dental services is available for purchase in the state of Colorado, and can be purchased as a stand-alone plan or as a covered benefit in another health plan. Please contact your insurance carrier, agent, or Connect for Health Colorado to purchase either a plan that includes pediatric dental coverage, or an Exchange-qualified stand-alone dental plan that includes pediatric dental coverage.

Employees in AZ, CA, GA, MA, MD, MO, NC, NJ and TX must either live or work within the approved DMO® service area to be eligible to enroll in the DMO®.

Aetna Life Insurance Company underwrites Aetna dental plans.

Vision coverage selection

Aetna Vision℠ Preferred - Plan option name ______________________________

All vision plans are available in addition to other Aetna coverage selections or standalone.

Aetna Life Insurance Company underwrites Aetna Vision℠ Preferred plans. First American Administrators, Inc. provides certain claims administration services. Eyemed Vision Care, LLC ("Eyemed") provides certain network administration services.

A group that has terminated with Aetna in the past 12 months for non-payment of premium must pay any premiums owed in full before Aetna will approve a group plan application and issue health benefits.

Eligibility waiting period

The eligibility date will be the first of the month following the waiting period, except exactly 90 days following date of hire.
Do you want to 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 month following: ☐ 0 days* ☐ 30 days ☐ 60 days *A date of hire effective date is not allowed. ☐ exactly 90 days following date of hire If "0 days" is selected and the employee is hired on the first day of the month, the effective date will be the date of hire. If "exactly 90 days" is selected, the enrollment eligibility date will begin 90 calendar days following the date of hire.

Employer dental premium contributions

Employer premium contribution for employee	_____ % *or* $ ________
Employer premium contribution for dependent	_____ % *or* $ ________

Participation

How many hours a week must your employees work to be eligible for coverage?			
Number of employees eligible for coverage (working the minimum hours to be eligible for coverage)			
Number of employees enrolling		Number of employees waiving Aetna coverage	
Number of full-time employees excluding union employees		Number of employees working outside Colorado List all states ______________________	
Number of part-time employees		Number of employees not actively at work	
Number of 1099 employees		Number of COBRA or state continuees	
Number of union employees		Number of employees in waiting period and not eligible	
Classes Excluded: ☐ None ☐ Union – Local number ____________			
Are domestic partners to be included? ☐ Yes ☐ No If **yes**, it is assumed this applies to both same sex and opposite sex partners unless you notify Aetna differently.			
Do you wish to cover designated beneficiary dependents*, per Colo. Rev. Stat. § 15-22-105(3)(c) (IV): ☐ Yes ☐ No ***** Colorado law permits certain unmarried individuals to enter into a Designated Beneficiary Agreement for the purpose of designating each person as the beneficiary of the other person and for the purpose of ensuring that each person has certain rights and financial protections, including the right to be recognized as a dependent under health insurance policies if the employer elects to provide coverage for designated beneficiaries as dependents.			

Business eligibility

Is your company a subsidiary of another company, an affiliate of another company, or under common control with another company? The Health Insurance Portability and Accountability Act of 1996 (HIPAA) states that all persons treated as a single employer under subsection (b), (c), (m), or (o) of section 414 of the Internal Revenue Code of 1986 shall be treated as one employer.	☐ Yes ☐ No
Does your company file state or federal taxes with another company or other companies on a combined or consolidated basis?	☐ Yes ☐ No
Are there any other entities associated with the group that are eligible to file a combined tax return under section 414 of the IRS code? If **yes**, provide legal names of all companies below.	☐ 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 or are eligible to file multiple businesses under one tax ID number, all businesses must be included as one group.

Business names of ALL groups including the company the groups are being written under	Tax identification number	Address	Owner's name	Percentage of ownership	Number of employees	Is group to be included?
						☐ Yes ☐ No
						☐ Yes ☐ No
						☐ Yes ☐ No
						☐ Yes ☐ No
						☐ Yes ☐ No

If you have answered **no** to "Is the group to be included "above, explain why.

Continued on next page

Business eligibility *(Continued)*

Question		Answer
Does your company have branch offices, or is your office a branch location?		☐ 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
Do you use the services of a payroll company?		☐ Yes ☐ No
If yes	- Provide the name of the payroll company:	
	- Is group health coverage available to you as a client of the payroll company?	☐ Yes ☐ No
Are you a professional employer organization (PEO)?		☐ Yes ☐ No
If yes	- Are you an existing Aetna customer who is a PEO? Aetna group number: ___________________	☐ Yes ☐ No
	- Do you offer health coverage to your clients under your PEO plan?	☐ Yes ☐ No
	- Are any of your clients enrolling under this health plan?	☐ Yes ☐ No
	- Are you only covering the administrative staff of the PEO?	☐ 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 health coverage available to you as a client of the PEO? - If **no**, provide a letter from the PEO indicating health coverage is not offered to any employer groups. - If **yes**, you are not eligible for small group coverage.	☐ Yes ☐ No

Prior carrier information

Is this plan a total replacement for any existing group plans?	Carrier name	Phone number	Start date	End date
Current dental carrier ☐ Yes ☐ No				

My current group dental plan has the following (Check all that apply):

☐ Discount dental ☐ Preventive only ☐ Preventive and basic ☐ Major services ☐ Orthodontia – orthodontic max $ __________

Be sure and submit a copy of the most recent dental benefit summary to receive credit for major and orthodontic coverage.

Has your business ever been insured with Aetna? If **yes**, provide group number: ______________________ ☐ Yes ☐ No

Signature section

The Applicant agrees to the following:

- An employee cannot contribute to non-contributory coverage, unless an authorized representative of Aetna approves the change in writing.
- An employee cannot contribute for contributory coverage for the current coverage period at a higher rate than shown on this application.
- Only a person who is a bona fide, full-time employee, regularly performing the duties of their occupation (subject to applicable HIPPA requirements for Health coverage), is eligible for coverage, unless otherwise specifically provided in the plan documents. The plan documents consist of the group agreement and / or certificate of coverage.
- The plan documents determine the:
  - Contractual provisions
  - Procedures
  - Exclusions and limitations
- The plan documents will govern in the event they conflict with any:
  - Benefits comparison
  - Summary
  - Other description of the plan
- All statements in this application are representations and not warranties.
- I acknowledge that Aetna provided written information that I used in selecting this plan. Brokers, agents or consultants are not 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.
- I agree to make all Aetna plan related paper or online member documents available to my employees.

Continued on next page

- I agree to make payroll and other records, directly related to the employee's plan coverage, available to Aetna for inspection. This will occur after a reasonably advanced request at:
  - Aetna's expense
  - My office during regular business hours

  This provision shall survive termination of plan coverage and the applicable plan documents.
- Aetna may inspect all data that has bearing on coverage or premiums while the plan coverage is in force.
- I am responsible to select, in accordance with applicable state law, the plans offered to my employees and the contribution amounts. Information on agent's compensation is available from my agent or at Aetna.com.
- Participating physicians, hospitals and other health care providers are independent contractors. They are neither agents nor employees of Aetna.

EMPLOYER ACKNOWLEDGMENT – Employer waiting period

The Affordable Care Act and subsequent federal regulations prohibit group health plans and health insurance issuers from requiring any eligible plan participants and beneficiaries (employees and dependents) to wait no more than 90 days before their health coverage goes into effect.

- The regulations define the group health plan as the Employer or plan administrator.
- The regulations define the issuer 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 90 day waiting period is honored. However, if either party doesn't comply, both are subject to a penalty.
- I agree to provide the following information of the plan participants and beneficiaries to Aetna:
  - Effective date information
  - Eligibility
  - Waiting period required under federal law.
- Aetna will use the information provided by the employer to enroll 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 of my participation date:

1. I agree to keep copies (paper or electronic) of actual enrollment forms. I 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. I agree to create and maintain records on secure information systems that can generate hard copies of enrollments or changes maintained on electronic information systems. Any hard copy records generated pursuant to this provision shall meet reasonable standards of availability, authenticity, non-repudiation and integrity.
3. I agree that all enrollment and eligibility information presented to Aetna is accurate and timely updated. I acknowledge that Aetna can and will rely on such information in determining whether an individual is eligible for benefits under the plan. I agree to pay Aetna promptly any applicable back premiums as the result of a discrepancy between the enrollee information and the actual information presented by the enrollee. The premium due to Aetna starts accruing as of the date on which the enrollee's information changed.
4. Insured plans must either:
   - Use Aetna-supplied forms in paper format or electronic format
   - Agree to incorporate the following four points into my enrollment materials
     - Names of the Aetna company offering the insurance coverage
     - State-specific fraud warning statement
     - A statement that the terms of the insurance documents will govern the member's rights and responsibilities
     - An acknowledgment that participating providers are not agents or employees of Aetna and that network composition can change.
5. I am 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, Aetna will regard the submission as verification that no premium / contribution was paid by the member / dependent for that period.

Billing / payment: I agree to receive my bill online each month. Any contractual provisions related to non-payment of premium continue to be applicable. I 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: I agree that each employee will agree to terms associated with the issuance and use of their 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. Any individual to whom a password has been issued agrees to contact Aetna immediately if they become aware of a security breach.

A security breach is:

- An attempt to gain unauthorized access
- Actual unauthorized access
- Use of unauthorized information
- Disclosure of unauthorized information
- Modification of unauthorized information
- Destruction of unauthorized information
- Unauthorized interface with system operation

Continued on next page

Signature section *(Continued)*

ATTENTION: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.		
Signed at city, state	Applicant (company name)	
Authorized applicant signature	Official title	
Print name of authorized applicant		Date

Questions regarding any of the above information should be directed to your agent or broker or Aetna sales representative.

Agent or broker certification

I hereby certify that I am not aware of any information not disclosed in this application by the client that may have bearing on this risk, or all products applied for in this application.

I hereby certify that I have advised the client not to terminate any existing coverage until receiving written notice from Aetna that the coverage applied for by this application is accepted.

Appointment with Aetna: In order to receive commissions you must be appointed with Aetna. To become appointed with Aetna, apply online: **https://pangea.geninfo.com/Aetna/Apply/Default.aspx.** If you are not yet appointed and your state has a limited time to become appointed, you may want to include another broker from your office.

Agent or broker name:		National producer number:			
Agency name:		TIN:			
Pay commissions to: (check one) ☐ Broker ☐ Agency		Phone:	Fax:		
Address:		City:	State:	ZIP:	
Signature*:	Date:	Email:		% of credit:	
Broker admin assistant name:		Broker admin assistant email:			
*I hereby certify that I am licensed to sell Aetna products in the state of Colorado.					

Agent or broker name:		National producer number:			
Agency name:		TIN:			
Pay commissions to: (check one) ☐ Broker ☐ Agency		Phone:	Fax:		
Address:		City:	State:	ZIP:	
Signature*:	Date:	Email:		% of credit:	
Broker admin assistant name:		Broker admin assistant email:			
*I hereby certify that I am licensed to sell Aetna products in the state of Colorado.					

General agent name:	TIN:		
Selling agent name:	Email:		
Phone:	Fax:		
Address:	City:	State:	ZIP:
Signature*:	Date:		
GA admin assistant name:	GA admin assistant email:		
*I hereby certify that I am licensed to sell Aetna products in the state of Colorado.			