Kentucky
Small Group Employer Application

Aetna Health Inc.
1425 Union Meeting Road
Blue Bell, Pennsylvania 19422

Aetna Life Insurance Company
151 Farmington Avenue
Hartford, Connecticut 06156

Company name (Legal name)	Doing business as (if applicable)		
Street address (PO box not acceptable)	City	State	ZIP code
Billing address (if different from above)	City	State	ZIP code
Phone number ( )	Fax number ( )		

Are there additional addresses or locations for this business? ☐ Yes ☐ No If **yes**, provide all addresses and locations.

Company contact – Name and title	Company contact email
Billing contact name (if different from company contact) *Online statements available. Activate access to your eBusiness account at* ***www.aetna.com/employersregister*** *when you get your approval letter.*	Billing contact email
Enrollment contact name (if different from company contact)	Enrollment contact email

SIC code	Nature of business	Federal tax ID number	Date business established (Month/Year):

Employer classification ☐ S Corp ☐ C Corp ☐ Nonprofit ☐ Partnership ☐ Sole proprietor
☐ LLC filing 1065 ☐ LLC filing 1120 ☐ LLP ☐ Other: _____

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

Requested effective date: _____

Medical coverage selection

☐ **Health Network Option (HNOption)** – Plan name _____

☐ **PPO** – Plan name _____

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

Are you a religious employer that meets the federal guidelines for qualification and would like to exclude coverage for contraceptive drugs and devices?
☐ **Yes** ☐ **No** **If yes, please complete the appropriate attestation form to confirm your religious exempt status.**

Aetna Health Inc., 1425 Union Meeting Road, Blue Bell, Pennsylvania 19422, underwrites Aetna Health Network Option (HNOption) plans.
Aetna Life Insurance Company, 151 Farmington Avenue, Hartford, Connecticut 06156, underwrites Aetna PPO plans.

Dental coverage selection

Aetna Dental® Plan

Non-voluntary plan – Plan option name _____ Option number _____

Voluntary plan – Plan option name _____ Option number _____

All dental plans are available with an Aetna medical plan. Non-voluntary plans are available with 2 or more eligible employees. Voluntary plans are available with 3 or more eligible employees.

Aetna Life Insurance Company, 151 Farmington Avenue, Hartford, Connecticut 06156, underwrites Aetna dental plans.

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.

Please keep a copy of this application for your records. If Aetna accepts the application, it becomes part of the issued Group Agreement and / or Group Policy.

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, 151 Farmington Avenue, Hartford, Connecticut 06156, underwrites Aetna Vision℠ Preferred plans. First American Administrators, Inc. provides certain claims administration services. Eyemed Vision Care, LLC ("Eyemed") provides certain network administration services.

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 (HIPPA) 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 associated companies to be included with this group that are commonly owned?	☐ Yes ☐ No

If you answered **yes** to any questions, complete the information below. *(If additional space is needed, attach a separate sheet.)*

- 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	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.

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 that 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

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Participation

How many hours a week must your employees work to be eligible for coverage?			
Number of employees eligible for coverage (employees 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 Kentucky List all states _____	
Number of part-time employees Are part-time employees to be covered? ☐ Yes ☐ No		Number of employees not actively at work	
Number of 1099 employees		Number of COBRA continuees	
Number of union employees		Number of employees in waiting period and not eligible	
Excluded classes: ☐ Union – Local number: _____			
Do you want to cover domestic partners as eligible dependents? ☐ Yes ☐ No If **yes**, coverage will include same and opposite sex domestic partners. Please notify Aetna in writing if you intend to have coverage apply differently.			

Total average number of employees

You MUST supply this number: To calculate average number of employees, determine the number of employees for each month, add each month's number to get an annual total, and then divide by 12. Round up or down to the nearest whole number. For example: 24.6 = 25. Do not spell out the number. For example: write 3, not three.

What is the average number of employees you employed for the entire previous calendar year regardless of whether or not they were eligible for coverage? An employee is defined as any person for whom the company issues a W-2, including full time, part time, and seasonal workers, and regardless of insurance eligibility. The determination of how to count employees of related corporate entities when calculating group size for medical loss ratio (MLR) purposes is based on whether the entities are considered a single employer under Section 414 of the Internal Revenue Code (subsection (b), (c), (m), or (o)) – and is not based on the multiple tax ID status of the related entities.	

Medicare primary versus secondary

How many full-time and part-time employees have you employed for at least 20 or more weeks during the current or prior calendar year? *Include: Full time, part time, seasonal, temporary, union, owners, partners, officers* *Exclude: Self-employed persons, independent contractors (1099), directors* If you employed fewer than 20 employees for 20 weeks in the current or prior year, your group is Medicare primary. If you employed 20 or more employees for 20 weeks in the current or prior year, your group is Aetna primary.	

COBRA / TEFRA / DEFRA

Is your employer group required to comply with COBRA?	☐ Yes ☐ No
How many full- and part-time employees did you employ 50 percent of the business days in the prior calendar year? *Include: Full time, part time, seasonal, temporary, union, owners, partners, officers* *Exclude: Self-employed persons, independent contractors (1099), directors* Each part-time employee counts as a fraction of an employee, with the fraction equal to the number of hours that the part-time employee worked divided by the hours an employee must work to be considered full time.	
Eligible: How many present or former employees / dependents are eligible to elect COBRA or state continuation? These present or former employees / dependents must be listed below. Attach a separate sheet, if needed.	
Enrolled: How many present or former employees / dependents are enrolled in COBRA? These present or former employees / dependents must be listed below. Attach a separate sheet, if needed.	

Name of applicant	Qualifying event (e.g., termination of employment, divorce, etc.)	Have they elected COBRA or state continuation?	Date of qualifying event	Date COBRA or state continuation coverage terminates
		☐ Yes ☐ No		
		☐ Yes ☐ No		
		☐ Yes ☐ No		

Eligibility waiting period

The eligibility date will be the first day of the policy month after the waiting period for 0, 30 or 60 days or *exactly* 90 days from date of hire. Policy month refers to the contract effective date of the first or fifteenth day of the month.

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 after the date of hire.

If the group has a fifteenth day of the month bill cycle, the new hire will be effective on the fifteenth day of the month after the waiting period chosen, except exactly 90 days after 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 policy month following: ☐ 0 days - A date of hire effective date is not allowed.
☐ 30 days ☐ 60 days
OR ☐ exactly 90 days from date of hire*

*Employees must be added to the group coverage no later than 90 days after their first day of employment.

Employer premium contribution(s)

Coverage	Medical	Dental
Employer premium contribution for employee	$ _____ or _____ %	%
Employer premium contribution for dependent	$ _____ or _____ %	%

Prior carrier information

Is this plan a total replacement for any existing group plans?	Carrier name	Phone number	Start date	End date
Current medical carrier ☐ Yes ☐ No				
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 maximum $ _____
Be sure to 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, is eligible for coverage, unless otherwise specifically provided in the Group Agreement / Group Policy.
- The Group Agreement / Group Policy determines the:
  - Contractual provisions
  - Procedures
  - Exclusions and limitations
- The Group Agreement / Group Policy 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.
- 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 **www.aetna.com**.

Continued on next page

Signature section *(Continued)*

- Participating physicians, hospitals and other health care providers are independent contractors. They are neither agents nor employees of Aetna.
- 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, dental or vision care services and it cannot guarantee any results or outcome.
- I hereby apply for the coverages indicated above. I certify that all information in this application is accurate and complete.
- I understand Aetna will rely on the information I provide to determine:
  - Eligibility for coverage
  - Setting premium rates
  - Compliance with applicable laws
  - Other purposes
- Any fraudulent statement may result in:
  - Rescission of coverage under the Group Agreement / Group Policy
  - Rescission of the Group Agreement / Group Policy
  - Termination of coverage
  - Increase in premiums
  - Fines
  - Civil damages
  - Imprisonment
  - Other consequences
- Aetna reserves the right to audit documentation as evidence of business activity at any time in order to:
  - Validate compliance with eligibility and underwriting guidelines
  - 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, or other consequences.

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

Continued on next page

Signature section *(Continued)*

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

SUMMARY OF BENEFITS AND COVERAGE (SBC) FOR GROUP HEALTH PLAN – PLEASE READ. YOU MUST CHECK BELOW TO CONFIRM:
In accordance with my contract with Aetna to distribute information related to enrollment / coverage information,

☐ I have ☐ I have not

received the Summary of Benefits and Coverage document (**https://www.aetna.com/sbcsearch/home**) associated with the plan information referenced in this application. I confirm I have provided SBCs to plan participants and beneficiaries in compliance with the federal regulations and guidance, including the requirements for timely delivery, on this date _____ (MM/DD/YYYY). For information on the SBC regulations and distribution requirements, please review the regulations at the HHS website: **https://cciio.cms.gov/resources/other/index.html#sbcug**.

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.

Signed at city, state	Applicant (company name)	
Authorized applicant signature	Official title	
Print name of authorized applicant		Date

Agent or broker certification

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