New Jersey Employer Application

FOR GROUP COVERAGE (51 – 100 EMPLOYEES)

Aetna Life Insurance Company **Aetna Health Inc.**
Aetna Health Insurance Company **Aetna Dental Inc.**

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
Telephone number ( )			
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		
Nature of business	SIC code	Federal tax ID number	Date business established (Month/Year):
Employer classification ☐ Corporation ☐ Nonprofit ☐ Partnership ☐ Sole proprietor ☐ LLP ☐ LLC ☐ Other: _____			

Effective date

Requested effective date: _____ (may be the first or fifteenth of the month only). The actual effective date will be assigned by Aetna if this application is accepted. Do not cancel your current coverage until you receive written confirmation from Aetna that it accepted your application.

Medical plan selection

☐ Plan option 1	☐ Plan option 2	☐ Plan option 3	☐ Plan option 4
_____	_____	_____	_____

If offering a health plan with a deductible, is the employer or a third party funding any of the deductible? ☐ Yes ☐ No
If **yes**, how much? _____ %

Aetna Life Insurance Company, Aetna Health Inc., and/or Aetna Health Insurance Company provide or administer medical coverage.

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.

Dental coverage selection

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

Voluntary plan – Plan option name _____ Option number _____

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

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 Dental Inc. underwrites the Aetna DMO® dental plans. Aetna Life Insurance Company underwrites all other Aetna dental plans.

Vision coverage selection

Aetna Vision℠ Preferred – Plan option name _____

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

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

Benefit waiting period (BWP)

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 of the month following 0 days ☐ first of the month following 30 days ☐ first of the month following 60 days ☐ exactly 90 days

If "exactly 90 days" is selected, the enrollment eligibility date will begin 90 calendar days following the date of hire.

If "0" days is selected and the employee is hired on the first of the month, the effective date will be the date of hire.

Is a dual waiting period offered? If **yes**, provide the two classes of employees below: ☐ Yes ☐ No

Class 1 name _____ Class 1 waiting period _____

Class 2 name _____ Class 2 waiting period _____

Employer premium contributions

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

Employee information

Number of full-time eligible employees	Number of part time employees	Number of employees working outside New Jersey	Number of COBRA participants or individuals	Number of union members	Number of retirees
		List all states _____			

Normal work week a full-time employee is required to work to be eligible for coverage _____ hours a week

Total number of employees in benefit waiting period and not eligible

Classes excluded: ☐ None ☐ Union – Local # _____

Domestic partners: ☐ Same sex ☐ Opposite sex ☐ None

Full-time equivalents for the prior calendar year – The "full-time equivalent" (FTE) employee counting method in 26 U.S.C. 4980H(c)(2) must be utilized to determine group size for medical coverage. This method is the same calculation used to determine employer liability under the "Shared Responsibility for Employers" provisions of the Affordable Care Act (ACA) and Internal Revenue Code.

A. FTEs from full-time employees. Number of full-time employees working on average 30 hours or more a week (or 130 hours a month) for more than 120 days a year (even if they are neither eligible nor enrolling for health coverage).	
B. FTEs from part-time employees. Number of part-time employees who worked on average less than 30 hours a week. (Add up the total number of hours worked in a week by part-time employees and divide by 30. Example: 10 employees working 20 hours a week: 10 x 20 = 200 ÷ 30 = 6.66 = 6 (rounding down to the nearest whole number)	
C. Number of seasonal workers who worked 120 or fewer days If the seasonal count puts you over 50, you do not have to include them in your total count **below.**	
D. Total number of FTEs = A + B. Only include C if your total **with C** is fewer than 50.	

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.

What is the average number of employees 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, temporary, seasonal, salaried, and hourly workers. For newly formed business, calculate the prior year average using only those months the group was in business; or use reasonable expected total employees if the group was not in business the prior year. The determination of how to count employees of related corporate entities when calculating group size 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.	

Business eligibility

Our company is a subsidiary, affiliate, or under common control of 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
Our company files or is eligible to file state or federal taxes with another company(ies) on a combined or consolidated basis.	☐ Yes ☐ No
There are other entities associated with the group that are eligible to file a combined tax return under Section 414 of the Internal Revenue Code.	☐ Yes ☐ No
There are associated companies to be included with this group that are commonly owned.	☐ Yes ☐ No

Business name (Indicate all groups including the company the groups are being written under.)	**Tax identification number**	**Address**	**Owner's name(s)**	**Percentage of ownership**	**Number of employees**	**Is the group to be included?**
						☐ Yes ☐ No
						☐ Yes ☐ No
						☐ Yes ☐ No
						☐ Yes ☐ No
						☐ Yes ☐ No

If we have answered **no** to "Is the group to be included" above, the reason is provided here:

Continued on next page

Business eligibility *(Continued)*

Our company is a branch of another company or our company has 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
We are a professional employer organization (PEO).		☐ Yes ☐ No
If yes	We offer health coverage to our clients under our PEO plan.	☐ Yes ☐ No
	Our clients are enrolling under this health plan.	☐ Yes ☐ No
	We are only covering the administrative staff of the PEO.	☐ Yes ☐ No
We are currently a client of a professional employer organization (PEO) and have group health coverage available as a client of the PEO. If we have answered **yes**, the name of the PEO is provided here:		☐ Yes ☐ No

Medicare

Our company is Medicare primary (employed less than 20 employees for 20 or more weeks during this calendar year or prior calendar year) or group health plan primary (employed 20 or more employees for 20 weeks in the current or prior year). ***Include:*** Full time, part time, seasonal, temporary, union, owners, partners, officers ***Exclude:*** Self-employed persons, independent contractors (1099), directors, leased employees	☐ Medicare primary ☐ Group health plan primary
The number of full-time and part-time employees we have employed for 20 or more weeks during this calendar year or prior calendar year	

COBRA

The following is a list of **all** individuals we presently cover under COBRA. (Former employees and/or dependents must be included.) Attach a separate sheet if needed. Aetna needs this information to determine how long each of those members will continue to have COBRA coverage. We understand that we and Aetna have obligations to notify and terminate continuation coverage in accordance with COBRA regulations.

Name of applicant	Qualifying event (e.g., termination of employment, divorce, etc.)	Date of qualifying event	Date COBRA coverage terminates

Prior carrier information – Submit a copy of the current carrier bill with employee roster if replacing an existing medical and/or dental plan.

Carrier name	Start date	End date
Medical:		
Dental:		
Our business has been insured or administered with Aetna previously. If **yes**, provide group number: _____		☐ Yes ☐ No
Is this plan a total replacement of any existing group medical plans?		☐ Yes ☐ No

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

☐ Discount dental ☐ Preventive only ☐ Preventive and basic ☐ Major services ☐ Orthodontia – Ortho max $ _____

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

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 to contributory coverage for the current coverage period at a higher rate than shown in 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 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.
- 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 to the best of my knowledge and belief.
- 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 material misrepresentation or 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, increase in premiums, or other consequences.

Continued on next page

Signature section *(Continued)*

EMPLOYER ACKNOWLEDGMENT – EMPLOYER WAITING PERIOD

The Affordable Care Act and subsequent federal regulations prohibit group health plans and health insurance issuers from requiring any otherwise eligible plan participants and beneficiaries (employees and dependents) to wait more than ninety (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 ninety (90) day waiting period is honored. However, if neither party complies, both are subject to penalty.
- I agree to provide the following information of the employees and dependents to Aetna:
  - Effective date information
  - Eligibility
  - Waiting period required under federal law
- Aetna will use the information provided by the employer to enroll employees and dependents 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 a 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 or
   - Agree to incorporate the following four points into any 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 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)*

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 employees and dependents 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: **http://cciio.cms.gov/resources/other/index.html#sbcug**.

Misrepresentation: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

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

Agent or broker certification

I hereby certify that: 1) any information I am aware of that may have bearing on this risk has been disclosed in this application by the applicant, 2) I will advise Aetna immediately if I become aware of new information of this nature not previously disclosed, 3) I have explained the details of the coverage applied for to the applicant and have complied with underwriting rules and regulations applicable to the product, and, 4) that I have advised the applicant 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		National producer number
Agency name		Tax ID number
Address		Pay commissions to (check one) ☐ Broker ☐ Agency
City		Telephone number
State	ZIP	% of credit
Signature		Date
Broker admin assistant name		Broker email
Admin email		

I hereby certify that I am licensed to sell Aetna products in the state of New Jersey.

Broker name		National producer number
Agency name		Tax ID number
Address		Pay commissions to (check one) ☐ Broker ☐ Agency
City		Telephone number
State	ZIP	% of credit
Signature		Date
Broker admin assistant name		Broker email
Admin email		

I hereby certify that I am licensed to sell Aetna products in the state of New Jersey.

General agent name		Tax ID number	
Selling agent name		Email address	
Address		Telephone number	
City		State	ZIP
GA admin assistant name		General agent email	
Admin email			

I hereby certify that I am licensed to sell Aetna products in the state of New Jersey.