

A. Policyholder Information (continued)

14. What percentage of the premium will the employer pay?
 Life ____% LTD ____% Dental ____%

Life/LTD: *Life:* 2-9 eligible employees - employer must contribute 100% of the total cost;
Life and LTD: 10-50 eligible employees - employer must contribute at least 50% of the total cost.

Dental: *Contributory Plans* - employer must contribute 25% of total premium or 50% of the employee premium - 75% participation applies;
Voluntary Plans - employer contributes less than 25% of total premium or less than 50% of employee premium - 30% participation applies. (Or, if 100% paid by the employee, coverage is deemed voluntary.)

15. Deposit \$ _____ Premium Paid: Monthly Premium will be due as of the effective date.
 The premium for the first month of coverage must be attached.

16. **Affiliates, subsidiaries or branches (must be included for the purposes of participation)**

Legal Name and Location	No. Eligible Employees in This Company	No. Eligible Employees to be Covered

B. Specifications for Coverage

Life and Disability Coverage Selection (Not available to groups of one. Groups of 2 to 9 eligible employees are limited to one class.)

Life Class Description	Class 1:	Class 2:	Class 3:
------------------------	----------	----------	----------

Basic Life (2 – 9 eligible employees)
 \$10,000 \$15,000 \$20,000 \$50,000

Basic Life and AD&D Ultra® (10 – 50 eligible employees)
 \$10,000 \$15,000 \$20,000 \$25,000 \$30,000 \$50,000 \$75,000 \$100,000
 \$125,000 \$150,000 \$175,000 \$200,000

OR
 Basic Annual Salary 1x 2x Maximum Amount \$ _____
 (Basic Annual Salary will be rounded to the next higher \$1000.)

Basic Life and AD&D Ultra® Reduction Schedule (10-50): ____ % at age ____ then ____ % at age ____ then ____ % at age ____

Supplemental Life and AD&D Ultra® (10 – 50 eligible employees)
 Amounts entered must be in increments of \$10,000 or \$25,000.
 Class 1 Amount: \$ _____ Maximum amount: \$ _____
 Class 2 Amount: \$ _____ Maximum amount: \$ _____
 Class 3 Amount: \$ _____ Maximum amount: \$ _____
 Reduction Schedule: (matches basic life benefit)

OR
 Basic Annual Salary 1x 2x 3x 4x 5x Maximum amount \$ _____
 Reduction Schedule: (matches Basic Life and AD&D Ultra® benefit)

Dependent Supplemental Life and AD&D Ultra® (10 – 50 eligible employees)
 (Employee must be insured for Supplemental Life to choose Dependent Supplemental Life)
 Spouse: Yes No Child: Yes No

Long Term Disability Class Description	Class 1:	Class 2:	Class 3:
--	----------	----------	----------

Long Term Disability (10 – 50 eligible employees)
 Monthly Benefit 50% 60%
 Maximum Benefit \$2000 \$3500 \$5000 \$6000 \$8000
 Elimination Period 30 days 90 days 180 days
 Benefit Duration 2 years 5 years 1983 Amended Social Security Normal Retirement Age (SSNRA)

Vision Coverage Selection (Not available to groups of one)

Aetna Vision Preferred Plan - Option Name _____
 All vision plans are available in addition to other Aetna coverage selections or standalone.

Dental Coverage Selection

Contributory Plans: Option Number: _____ Plan Option Name: _____
Voluntary Plans: Option Number: _____ Plan Option Name: _____
Orthodontic coverage for dependent children may be included for groups with 10 or more eligible employees with a minimum of 5 enrolled employees.

C. All Questions Must be Answered

Please indicate below the number of employees by work location/state. All employees must be included, regardless of whether or not they currently have medical coverage and through whom that coverage is provided.

Work Location (list by state)	Number of Employees				
	Full-time	Part-time	Retired	COBRA or State Continuees	Other

An Eligible Employee is one who works on a full-time basis with a normal work week of 25 or more hours for compensation. An employee who works less than 25 hours per week or works on a temporary or substitute basis, or participates in an employee welfare arrangement established pursuant to a collective bargaining agreement is not an eligible employee.

Total number of eligible employees _____

	Life/AD&D Ultra®	LTD	Dental
Total number of eligible employees enrolling for			
Total number of eligible employees waiving			
Total number of employees in an ineligible class or classes			

D. Prior Carrier Information

Is this plan total replacement of any existing group plans?	Carrier Name	Phone Number	Start Date	End Date
Vision Carrier <input type="checkbox"/> Yes <input type="checkbox"/> No				
Dental Carrier <input type="checkbox"/> Yes <input type="checkbox"/> No				
Life/AD&D Carrier <input type="checkbox"/> Yes <input type="checkbox"/> No				
LTD Carrier <input type="checkbox"/> Yes <input type="checkbox"/> 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 and submit a copy of the most recent dental benefit summary to verify Major, Ortho, and Preventive and Basic coverage.

Has your business ever been insured with Aetna? If "Yes," provide group number: _____ Yes No

E. Agent/Producer Information

Agent/Broker Name:			
SSN:		National Producer Number:	
Agency Name:		Tax ID Number:	
Address:		Pay Commissions To (check one): <input type="checkbox"/> Broker <input type="checkbox"/> Agency	
City:		Telephone Number: ()	
State:	ZIP:	% of Credit:	Fax Number: ()
Signature:		Date:	E-mail Address:
Broker Admin Assistant Name:		Broker Admin Assistant E-mail address:	
Agent/Broker Name:			
SSN:		National Producer Number:	
Agency Name:		Tax ID Number:	
Address:		Pay Commissions To (check one): <input type="checkbox"/> Broker <input type="checkbox"/> Agency	
City:		Telephone Number: ()	
State:	ZIP:	% of Credit:	Fax Number: ()
Signature:		Date:	E-mail Address:
Broker Admin Assistant Name:		Broker Admin Assistant E-mail address:	
General Agent Name:			
Selling Agent Name:		Tax ID Number:	
Address:		E-mail Address:	
City:		Telephone Number: ()	
State:	ZIP:	Fax Number: ()	
GA Admin Assistant Name:		GA Admin Assistant E-mail address:	

F. Signature

It is understood that except as provided under applicable regulations no individual shall become covered while not actively at work on a full time basis, and only full-time employees are eligible. A full-time employee is one who regularly works at least 25 hours per week at his employer's place of business.

It is further understood that no agent has power on behalf of Aetna Life Insurance Company and/or Aetna Dental Inc. to make or modify any request or application for coverage or to bind Aetna Life Insurance Company and/or Aetna Dental Inc. by making any promise or representation or by giving or receiving any information.

It is further understood that no coverage will be effective unless and until the application is accepted in writing by Aetna Life Insurance Company and/or Aetna Dental Inc. Final rates will be based on enrollment data as of the Policy effective date. No coverage is to be implied in any way on the basis of the completion and/or submission of this application.

Any person who includes any false or misleading information on an application for a policy is subject to criminal and civil penalties. I certify that all statements made on this application are true and complete to the best of my knowledge and belief.

New Jersey law requires that plan sponsors with 25 or more employees contributing to dental plan organization (DMO®) coverage also offer to covered persons the option of selecting alternative coverage which permits covered persons to obtain dental services from any licensed dentist.

State law also requires that Aetna Life Insurance Company and/or Aetna Dental Inc. provide affected plan sponsors with copies of the applicable statutes/regulations and that those plan sponsors furnish to us written verification of their compliance with the law.

Per your signature below, you certify your organization's receipt of and compliance with New Jersey Statutes 17:48D-9.1 and 9.2 and New Jersey Administrative Code 11:10-2.1 through 2.6 requiring selection of alternate coverage.

I understand that this application will form a part of the Group Agreement or Group Policy issued by Aetna, 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 at its discretion subject to any state requirements.

ELECTRONIC ENROLLMENT, BILLING/PAYMENT AND ACCESS AGREEMENT

Enrollment: As part of your participation date, the following terms and conditions apply:

1. You agree to keep copies (paper or electronic) of actual enrollment forms and 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. For electronic enrollment submissions or changes you agree to create and maintain the records on secure information systems that can generate hard copy records of enrollments or changes entered or maintained on those information systems. Any hard copy records generated pursuant to this provision shall meet reasonable standards of availability, authenticity, non-repudiation and integrity.
3. You represent that all enrollment and eligibility information presented to Aetna is accurate and timely updated. You acknowledge that Aetna can and will rely on such enrollment and eligibility information in determining whether an individual is eligible for benefits under the plan. In the event of a discrepancy between enrollee information (including salary data) submitted and information actually presented by the enrollee on any particular claim for benefits, and the result is that Aetna must pay a higher benefit to reflect the actual information presented by the enrollee, you agree to pay promptly to Aetna applicable back premiums accruing as of the date on which the enrollee's information changed.
4. Insured plans must either (1) use Aetna-supplied forms in paper format or electronic format or (2) agree to incorporate the following four points into your enrollment materials.
 - a. Names(s) of the Aetna company offering the insurance coverage
 - b. State-specific fraud warning statement
 - c. A statement that the terms of the insurance documents will govern the member's rights and responsibilities
 - d. An acknowledgment that participating providers are not agents or employees of Aetna and that network composition can change.
5. You are 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, we will regard the submission as verification that no premium/contribution was paid by the member/dependent for that period.

Billing/Payment: You agree to receive your bill online each month. Any contractual provisions related to non-payment of premium continue to be applicable. I/we 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: Plan sponsor agrees that each employee will agree to terms associated with the issuance and use of his/her 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. If an individual to whom a password has been issued becomes aware of a security breach (an incident in which there occurs attempted or unauthorized access, use, disclosure, modification, or destruction of information or interface with system operations), they agree to contact Aetna.

Date at _____ on _____

Print Name of Officer, Partner or Proprietor _____

Signature of Officer, Partner or Proprietor _____

Witness to Signature _____

Note: If there are any modifications to the statements and answers given in this application (i.e., crossed out, whited-out, erased information), the applicant must attest to the modifications by giving a complete signature in the margin near the modification.

G. FOR AETNA USE ONLY

Effective Date	Billing	Coverage Code	Type	Pre-Ex	Continuous Coverage	Transcode

New Jersey – Code and Statutes

New Jersey Administrative Code

11:10-2.1 Purpose

P.L. 1983, Chapters 142 through 145, require that each employer or other organization subject thereto offer its employees or members the option of selecting alternate coverage which permits covered persons to obtain dental services from any dentist of their choice whenever the employer is contributing to a dental plan contract (as described in N.J.A.C. 11:10-2.2(a)). These statutes also direct the Commissioner to promulgate rules and regulations to effectuate their purposes. This subchapter is being promulgated to meet this statutory mandate and to implement the notification requirements of the statutes.

11:10-2.2 Scope and Application

- (a) This subchapter applies to each employer or other organization which:
1. Employs or has 25 or more employees or members during the full preceding calendar year; and,
 2. Contributes to a dental plan contract.
- (b) Insurers, dental plan organizations, and dental service corporations which are authorized to enter into contracts providing dental coverage are also subject to this subchapter.

11:10-2.3 Definitions

The following words and terms, when used in this subchapter, have the following meanings unless the context clearly indicates otherwise:

"Alternative coverage" means a plan that permits covered persons to obtain dental services from any licensed dentist.

"Dental plan contract" means any contract issued by a health insurer, dental plan organization, or dental service corporation which restricts covered persons in selecting the providers of dental services to a single provider or a limited number of providers.

"Enrollment period" means a period of time, of not less than one month's duration, prior to the renewal of a dental plan contract during which employees (Publication page references are not available for this document.) or members are afforded the option to be covered under the dental plan contract or alternative coverage.

"Other organization" means a group of 25 or more members to which a dental plan contract has been or is to be issued including, but not limited to, labor unions and associations.

"Renewal" means to begin a new term of the contract or to add an amendment to the contract.

11:10-2.4 Notification of affected parties

- (a) An insurer, dental plan organization and dental service corporation shall provide to each employer or other organization to which this subchapter applies a copy of N.J.S.A. 17:48D-9.1 and 9.2 (as appropriate) and this subchapter at the time of offering a dental plan contract as defined in this subchapter.
- (b) Every employer and other organization subject to this subchapter, shall offer in writing to its employees or members and their eligible dependents the option of selecting coverage which permits dental services to be obtained from any licensed dentist as an alternative to the coverage provided under a dental plan contract. For new dental plan contracts being provided for the first time, this option shall be offered during the period for enrolling the employees or members in the new plan. For existing dental plan contracts, this option shall be offered during an enrollment period preceding the renewal date of the contract. Employers and other organizations which have offered this option to existing employees or members shall also offer this option to new employees or members at the time they are enrolled in a dental plan contract.
- (c) Employers and other organizations to which this subchapter applies, shall post in a conspicuous manner, written notice of the coverage option and the text of P.L. 1983, Chapters 142- 145, whichever chapter is applicable.

11:10-2.5 General rules

- (a) Each health insurer, dental service corporation, or dental plan organization shall, at the time a dental plan contract is offered or at the time of renewal, obtain written verification from each employer or other organization of compliance with P.L. 1983, c.142 through 145, and this subchapter.
- (b) Each employer or other organization, at the time of offering or renewal of a dental plan contract shall furnish to the health insurer, dental service corporation, or dental plan organization written verification of compliance with P.L. 1983, c.142 through 145 and this subchapter.
- (c) Each employer or other organization at the time of offering or renewal of a dental plan contract shall provide in the written notice required by N.J.A.C. 11:10-2.4(b) and (c) an outline of the differences in coverages and cost to the employee or members and their eligible dependents between a dental plan contract and the alternative coverage.
- (d) The alternative coverage may be provided through an insurance contract, on a self-funded basis, or by any means which meets the approval of the Commissioner.
- (e) Each employer or other organization shall contribute to the alternative coverage an amount equal to the premium or cost which it pays or contributes to the dental plan contract. Such contribution shall be adjusted when the premium or cost which it pays or contributes to the dental plan changes.

11:10-2.6 Separability

If any provision of this subchapter, or its application to any person or circumstances, is held invalid, the remainder of this subchapter and its application to other persons or circumstances shall not be affected.

New Jersey – Code and Statutes (continued)

New Jersey Statutes

17:48D-9.1 Employer must offer alternative dental coverage

Each employer or other organization which employs or has 25 or more employees or members during the full preceding calendar year and which contributes to a dental plan organization contract which restricts the covered persons in selecting the providers of dental services to a single provider or limited number of providers, shall also offer its employees and their eligible dependents and members and members' eligible dependents at the time a dental benefits plan is offered or renewed the option of selecting alternative coverage which permits covered persons to obtain dental services from any licensed dentist.

17:48D-9.2 Employer contributions

An employer or other organization shall be required to pay for or contribute towards the provision of alternative coverage an amount equal to the premium or cost which it pays or contributes to the dental plan organization contract which limits the number of providers of dental service.

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.