Virginia Employer Application

FOR GROUP COVERAGE (51 – 100 EMPLOYEES)

☐ **Aetna Health Inc.**
1425 Union Meeting Road
Blue Bell, PA 19422

☐ **Aetna Life Insurance Company**
151 Farmington Avenue
Hartford, CT 06156

☐ **Aetna Health Insurance Company**
1425 Union Meeting Road
Blue Bell, PA 19422

We refer to Aetna Life Insurance Company, Aetna Health Inc. and Aetna Health Insurance Company as "Aetna."

IMPORTANT FOR INTERNAL PROCESSING: Check applicable box if submitting through:
Third party administrator: ☐ BenefitMall ☐ GBS ☐ Kelly ☐ Hamilton
☐ **Not applicable to this group**

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) *You can get online statements. Just activate 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: _____

Start date

Requested start date: _____ (may be the first or fifteenth of the month only). We will assign the actual start date if we accept your application. Don't cancel your current coverage until you get written confirmation from us that we accepted your application.

Medical plan selection

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

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

Aetna HMO and EPO plans provide network benefits only. We cannot offer HMO/EPO plans to your enrollees unless we also offer a POS/PPO plan with both in- and out-of-network benefits. The enrollee can choose to accept or reject ***at their option****.*

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 we accept 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 by themselves. Or in addition to other Aetna coverage.

DNO (Dental Network Only) in Virginia is not an HMO. To get the most from your benefits, you must choose a participating primary dentist (PPD). The PPD will coordinate your care with network providers.

Aetna Life Insurance Company underwrites Aetna dental plans.

Vision coverage selection

Aetna Vision℠ Preferred – Plan option name _____

You can buy all vision plans separately. Or you can buy them in addition to our other plans.

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)

You want to waive the benefit waiting period for all current employees enrolling with the company as of the initial contract start date. ☐ 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 you select "exactly 90 days," the enrollment eligibility date will begin 90 calendar days after the hire date.

If you select "0" days and the employee is hired on the first of the month, the start date will be the hire date.

Is a dual waiting period offered? If **yes**, list 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
You'll contribute this much for each employee premium.	$ _____ or _____ %	%
You'll contribute this much for each dependent premium.	$ _____ or _____ %	%

Employee information

Number of full-time	Number of part time	Number working outside Virginia	Number of COBRA	Number of union	Number of retirees
		List all states _____			

To be eligible for coverage, a fulltime employee must work _____ hours a week

Your company has this many employees in benefit waiting period and not eligible: _____

Classes excluded: ☐ None ☐ Union – Local # _____

Domestic partners: ☐ Same sex ☐ Opposite sex ☐ None

Total average number of employees

You MUST supply this number: To calculate: first add the number of employees for each month. Then add all monthly totals to get an annual total. Then divide by 12. Round up or down to the nearest whole number. For example, you'd write "24.6" as "25."

What is the average number of employees employed for the entire previous calendar year, regardless of whether they were eligible for coverage? An employee is defined as any person issued a W-2 by the company. This includes full time, part time, temporary, seasonal, salaried and hourly workers. For a new business, calculate the prior year average using only those months your group was in business. If your group was not in business the year before, then list the total number of employees you expect. To count employees of related corporate entities when calculating group size, determine whether the entities are considered a single employer under Section 414 of the Internal Revenue Code (subsection (b), (c), (m) or (o)). It is not based on the multiple tax ID status of the related entities.	

Business eligibility

Your 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 are treated as one employer.	☐ Yes ☐ No
Your company files or is eligible to file state or federal taxes with another company(ies) on a combined or consolidated basis.	☐ Yes ☐ No
Other entities associated with your group are eligible to file a combined tax return under Section 414 of the Internal Revenue Code.	☐ Yes ☐ No
Associated companies with your group are commonly owned.	☐ Yes ☐ No

List the business name. Name 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 you answered **no** to "Is the group to be included" above, give the reason here:

Your company is a branch of another company or your 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?	
	Do you file taxes separately or as one common filing?	☐ Separately ☐ One common filing
	Where is each branch? (List each branch business address.)	Number of employees at each location
You are a professional employer organization (PEO).		☐ Yes ☐ No
If yes	You offer health coverage to your clients under our PEO plan.	☐ Yes ☐ No
	Your clients enroll under this health plan.	☐ Yes ☐ No
	You only cover the administrative staff of the PEO.	☐ Yes ☐ No
You are a client of a professional employer organization (PEO). And you have group health coverage available as a client of the PEO. If **yes**, list the name of the PEO here:		☐ Yes ☐ No

Medicare

Your company is Medicare primary. This means it employed less than 20 employees for 20 or more weeks during this calendar year or prior calendar year. Or your company is group health plan primary. This means it employed 20 or more employees for 20 weeks in the current or prior year. **Include** all full time, part time, seasonal, temporary, union, owners, partners, and officers. **Exclude** all self-employed persons, independent contractors (1099), directors, and leased employees.	☐ Medicare primary ☐ Group health plan primary
List the number of full-time and part-time employees you employed for 20 or more weeks during this calendar year or the year before.	

COBRA

List **all** persons you now cover under COBRA. Include former employees and/or dependents. Attach an extra sheet if needed. We need this information to know how long each of these members will continue to have COBRA coverage. Under COBRA rules, both you and we must notify members and end continuation coverage.

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

Prior carrier – Send us a copy of the current carrier bill with employee roster if you are replacing an existing medical and/or dental plan.

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

Signature section

You as the applicant agrees to the following:

- An employee cannot contribute to non-contributory coverage, unless we approve 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 full-time employee, regularly performing the duties of their occupation, is eligible for coverage. This is true 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 if they conflict with any:
  - Benefits comparison
  - Summary
  - Other description of the plan
- All statements in this application are representations and not warranties.
- You acknowledge that we gave you written information that you used to select 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 in the plan documents.
- You agree to make all Aetna plan-related member documents available to your employees.
- You agree to make payroll and other records directly related to employee's plan coverage available to us. This will occur after a reasonably advanced request at:
  - Our expense
  - Your office during regular business hours

  This provision is in effect even if plan coverage ends.
- We may inspect all data that has bearing on coverage or premiums while the plan coverage is in force.
- You are responsible for choosing plans offered to your employees and the contribution amounts. You'll follow all applicable state laws when you do so.
- You can visit **aetna.com** for information on agent's compensation. Your agent can also give you this.
- Participating doctors, hospitals and other health care providers are independent contractors. They are neither agents nor employees of Aetna.
- Not all plans or programs are available in all service areas. Some benefits may have limits or maximums. We do not provide health, dental or vision care services nor can we guarantee any results or outcome.
- You are applying for the coverages above. You certify that all information in this application is accurate and complete.

Signature section *(Continued)*

- You understand we will rely on the information you provide to determine:
  - Eligibility for coverage
  - Setting premium rates
  - Compliance with applicable laws
  - Other purposes
- You understand that any misrepresentation or fraudulent statement may result in:
  - Ending coverage under the Group Agreement/Group Policy
  - Ending the Group Agreement/Group Policy
  - Ending coverage
  - Increasing premiums
  - Civil damages
  - Other consequences
- If we cancel coverage, we'll give at least 30 days' written or electronic notice to any covered person affected by this cancellation. We'll do this whether the cancellation applies to the whole group or just one member in the group.
- We reserve the right to audit your documentation as evidence of business activity at any time. We may do this for two reasons:
  - We may want to validate compliance with eligibility and underwriting guidelines.
  - We may want to validate the applicability of state and federal laws.

  If you fail to comply with any such request, we may cancel coverage, increase premiums, or impose other consequences.

EMPLOYER ACKNOWLEDGMENT – EMPLOYER WAITING PERIOD

The Affordable Care Act prohibits group health plans and health insurance issuers from requiring employees and dependents to wait more than 90 days before health coverage starts.

- 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. But if neither party complies, both are subject to penalty.
- You agree to give us the following information of plan participants and beneficiaries:
  - Start date information
  - Eligibility
  - Waiting period required under federal law
- We will use the information you give us to enroll plan participants and beneficiaries in your group health insurance coverage. If this information changes, you'll let us know right away.

ENROLLMENT, BILLING/PAYMENT AND ACCESS AGREEMENT

Enrollment: Here's what you agree to once your coverage starts.

1. You agree to keep copies of actual enrollment forms. These can be paper or electronic. You also agree to keep a record of enrollment and eligibility information. This can be by electronic, voice response technology and/or hard copy. This includes:
   - Evidence of coverage elections
   - Evidence of eligibility
   - Changes to such elections and terminations

   You must make records available to us if we ask for them. You must keep these records for seven years.
2. You agree to create and maintain records on secure electronic information systems. These systems must be able to generate hard copies of enrollments or changes. Any of these hard copy records must meet reasonable standards of availability and authenticity.
3. You agree that all enrollment and eligibility information given to us is accurate. You also agree to let us know about updates in a timely way since we rely on this information when making benefit decisions. You agree to promptly pay us any applicable back premiums if there's a discrepancy between the enrollee information you supply and the actual information given by the enrollee. The premium due to us starts accruing as of the date on which the enrollee's information changed.
4. You are responsible for following both state and federal laws when submitting terminations to us.
5. When you submit retro-terminations, we'll regard the submission as proof that the member paid no premium for that period.

Continued on next page

Signature section *(Continued)*

Billing/payment: I agree to receive my bill online or via U.S. Mail each month. For online billing, please visit: **http://www.aetna.com/pspregister**. Any contractual provisions related to non-payment of premium continue to apply. I understand and agree to the terms of this agreement. I am authorized to sign this agreement.

For online access: Each employee will agree to our terms on passwords and system access. Passwords may not be shared for any reason. Each employee is responsible for the information entered into the system. Anyone issued a password agrees to contact us right away if they learn 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

☐ I have ☐ I have not

received the Summary of Benefits and Coverage (SBC) document (**aetna.com/sbcsearch/home**) for this application. I confirm I have provided SBCs to plan participants and beneficiaries in compliance with the federal rules. This includes the requirements for timely delivery, on this date _____ (MM/DD/YYYY).

For information on the SBC rules and distribution requirements, go to the HHS website: **cciio.cms.gov/resources/other/index.html#sbcug**

Misrepresentation: Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false statement or deceptive statement, may have violated state law.

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: 1) The applicant has disclosed any information that may have bearing on risk. 2) I will advise Aetna right away if I become aware of new information of this nature. 3) I have explained coverage details to the applicant. I've also complied with underwriting rules. 4) I have told the applicant not to end any coverage until they get written notice that Aetna has accepted this application.			
TPA – vendor name: _____			
Broker name		National producer number	
Agency name		Tax ID number	
Address		Pay fees to (check one) ☐ Broker ☐ Agency	
City		Telephone number	
State	ZIP	% of credit	
Signature		Date	
Broker admin assistant name		Broker email	
Admin email			
I certify that I am licensed to sell Aetna products in the Commonwealth of Virginia.			
Broker name		National producer number	
Agency name		Tax ID number	
Address		Pay fees to (check one) ☐ Broker ☐ Agency	
City		Telephone number	
State	ZIP	% of credit	
Signature		Date	
Broker admin assistant name		Broker email	
Admin email			
I certify that I am licensed to sell Aetna products in the Commonwealth of Virginia.			
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 certify that I am licensed to sell Aetna products in the Commonwealth of Virginia.			