



Wisconsin Employer Application

FOR GROUP COVERAGE (51-100 EMPLOYEES)

Aetna VisionSM Preferred plan, Aetna PPO plans and Aetna Indemnity plans are underwritten by Aetna Life Insurance Company. Dental plans are underwritten Aetna Life Insurance Company. For Vision coverage, certain claims administration services are provided by First American Administrators, Inc. and certain network administration services are provided through EyeMed Vision Care LLC ("EyeMed").

IMPORTANT FOR INTERNAL PROCESSING: Check applicable box if submitting through:

Private exchange: Digital Fidelity Liazon Benefits MBA-Buck Private Exchange Member Benefits Inc.
 Other: _____

Third party administrator: Bankers Cooperative Group Benefitmall Crawford Advisors GBS Kelly Paychex
 PPI CoBiz Other: _____

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
Phone number ()		Fax number ()	
Are there additional addresses or locations for this business? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes , provide all addresses and locations.			
Company contact – Name and title		Company contact email	
Billing contact name (if different from company contact) <i>Online statements available. Activate access to your eBusiness account at www.aetna.com/employersregister when you get your approval letter.</i>		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 <input type="checkbox"/> S Corp <input type="checkbox"/> C Corp <input type="checkbox"/> Nonprofit <input type="checkbox"/> Partnership <input type="checkbox"/> Sole proprietor <input type="checkbox"/> LLC <input type="checkbox"/> LLP <input type="checkbox"/> Other: _____			

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

Requested effective date (may be the first or fifteenth of the month only): _____

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.

Medical coverage selection

PPO – Plan option: _____

PPO HSA Compatible – Plan option: _____

Indemnity (only available if PPO networks are not available) – Plan option: _____

Do you, or any third party on your behalf, in any way fund or subsidize any portion of the member's cost sharing responsibilities (deductibles, coinsurance or copays) under a high deductible health plan (HSA or HRA)? Yes No If **yes**, how much? _____

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 an Aetna medical plan.

Vision coverage selection

Aetna VisionSM Preferred – Plan option name _____

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

Life, STD and LTD plans - for quote requests or questions send to: 51-100Groupinsurancesmallgroup@aetna.com

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.	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does your company file state or federal taxes with another company or other companies on a combined or consolidated basis?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are there any associated companies to be included with this group that are commonly owned?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are multiple companies or multiple addresses to be included under this plan?	<input type="checkbox"/> Yes <input type="checkbox"/> No

If you answered **yes** to any of these 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	Owner's name	Percentage of ownership	Number of employees	Is group to be included?
					<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No

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

Does your company have branch offices? Is your office a branch location?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes	- Is each branch office a separate legal entity?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	- Is each branch a location of one legal entity?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	- How many branch offices are there?	
	- Are taxes filed separately or as one common filing?	<input type="checkbox"/> Separately <input type="checkbox"/> One common filing
	- Where is each branch located? (List each branch business address separately.)	Number of Employees at each location

Continued on next page

Business eligibility (Continued)

Do you use the services of a payroll company?		<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes	- Provide the name of the payroll company:	
	- Is group health coverage available to you as a client of the payroll company?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you a professional employer organization (PEO)?		<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes	- Is this an Aetna PEO? Aetna group #: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
	- Do you offer health coverage to your clients under your PEO plan?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	- Are any of your clients enrolling under this health plan?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	- Are you only covering the administrative staff of the PEO?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you currently a client of a professional employer organization (PEO)?		<input type="checkbox"/> Yes <input type="checkbox"/> 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.	<input type="checkbox"/> Yes <input type="checkbox"/> No
	- If yes , you are not eligible for small group coverage.	

Participation

Number of employees eligible for coverage (employees working the minimum hours to be eligible for coverage - must be at least 25 hours a week)		
Number of employees enrolling		Number of employees waiving Aetna coverage
Number of full-time employees excluding union employees		Number of employees working outside Wisconsin List all states _____
Number of part-time employees		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: <input type="checkbox"/> Union – Local number: _____		
Are domestic partners to be included? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes , it is assumed this applies to both same sex and opposite sex partners unless you notify Aetna 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.

<p>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.</p> <p>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.</p>	
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Medicare primary versus secondary

<p>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?</p> <p><i>Include: Full time, part time, seasonal, temporary, union, owners, partners, officers</i> <i>Exclude: Self-employed persons, independent contractors (1099), directors</i></p> <p>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.</p>	
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COBRA / TEFRA / DEFRA

Is your employer group required to comply with COBRA?				<input type="checkbox"/> Yes <input type="checkbox"/> No
How many full- and part-time employees did you employ 50 percent of the business days in the prior calendar year? <i>Include: Full time, part time, seasonal, temporary, union, owners, partners, officers</i> <i>Exclude: Self-employed persons, independent contractors (1099), directors</i> 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? 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. Any individuals eligible for COBRA who are still within their election period, but have not enrolled, and enroll in the future retroactive to the group effective date, will constitute a change in census, and your company's health benefits plan may be charged a different premium for this coverage.				
Name of applicant	Qualifying event (e.g., termination of employment, divorce, etc.)	Have they elected COBRA?	Date of qualifying event	Date COBRA coverage terminates
		<input type="checkbox"/> Yes <input type="checkbox"/> No		
		<input type="checkbox"/> Yes <input type="checkbox"/> No		
		<input type="checkbox"/> Yes <input type="checkbox"/> No		

Benefit waiting period (BWP)

The eligibility date for enrollment will be the first day of the policy month following the waiting period of 0, 30 or 60 days or 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. Policy month refers to the contract effective date of the first or fifteenth. If the group has a fifteenth of the month bill cycle, the new hire will be effective on the fifteenth of the month following the waiting period chosen, except exactly 90 days following date of hire.	
Would you like to waive the benefit waiting period for current employees enrolling with the group as of the initial contract effective date only?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Benefit waiting period for future employees – First day of policy month following: <input type="checkbox"/> 0 days A date of hire effective date is not allowed. <input type="checkbox"/> 30 days <input type="checkbox"/> 60 days Or <input type="checkbox"/> exactly 90 days following date of hire	

Employer premium contribution(s)

Employer premium contribution for employee	Medical \$ _____ or _____ %	Dental \$ _____ or _____ %
Employer premium contribution for dependent	Medical \$ _____ or _____ %	Dental \$ _____ 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 <input type="checkbox"/> Yes <input type="checkbox"/> No				
Current dental carrier <input type="checkbox"/> Yes <input type="checkbox"/> No				
My current group dental plan has the following (Check all that apply): <input type="checkbox"/> Discount dental <input type="checkbox"/> Preventive only <input type="checkbox"/> Preventive and basic <input type="checkbox"/> Major services <input type="checkbox"/> Orthodontia – Ortho max \$ _____ Be sure to submit a copy of the most recent dental benefit summary to receive credit for major and ortho coverage.				
Has your business ever been insured with Aetna? If yes , provide group number: _____ <input type="checkbox"/> Yes <input type="checkbox"/> No				

Workers' compensation / disability / leave of absence

Do you provide workers' compensation coverage?				<input type="checkbox"/> Yes <input type="checkbox"/> No
Is any person currently receiving workers' compensation benefits?				<input type="checkbox"/> Yes <input type="checkbox"/> No
Is any person to be covered unable to work due to illness or injury?				<input type="checkbox"/> Yes <input type="checkbox"/> No
Is any person currently on leave of absence?				<input type="checkbox"/> Yes <input type="checkbox"/> No
Name	Start date	Expected date of return	Details	

Signature section

The undersigned employer agrees that at no time shall any employee be permitted or required to contribute for non-contributory coverage; or, unless the change is approved in writing by an authorized representative of Aetna, to make contributions for contributory coverage at a rate higher than the initial contribution rate applicable for the employee's then current coverage.

It is agreed that no coverage shall become effective as to any person who is not then a bona fide, full-time employee, regularly performing the duties of his or her occupation (subject to applicable HIPAA requirements for Health coverage), unless otherwise specifically provided in the plan documents (which consist of the Group Policy and / or Booklet-Certificate).

All statements herein shall be deemed representations and not warranties.

The undersigned employer acknowledges that it has selected this plan based upon written information provided by Aetna and that no agent or consultant is 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.

The undersigned employer agrees to make payroll and other records directly related to employee's plan coverage available to Aetna for inspection, at Aetna's expense, at employer's office, during regular business hours, upon reasonable advance request. This provision shall survive termination of plan coverage and the applicable plan documents.

The undersigned employer has selected, in accordance with applicable state law, the plan to be offered to employer's employees and employer has solely determined any / all plan options for the employer's employees and the contribution amounts.

Information on agent's compensation is available from your agent or at Aetna.com.

In accordance with current IRS regulations and the 1986 Tax Reform Act, a life insurance position schedule may be deemed discriminatory and result in imputed income tax to certain employees and possibly an excise tax to employers. Employers should consult with legal counsel prior to electing a position schedule. Aetna disclaims any responsibility if the employer elects such a position schedule and it is later deemed discriminatory.

The plan documents will determine the contractual provisions, including procedures, exclusions and limitations relating to the plan and will govern in the event they conflict with any benefits comparison, summary or other description of the plan.

With the exception of Aetna Rx Home Delivery® and Aetna Specialty Pharmacy®, participating physicians, hospitals and other health care providers are independent contractors and are neither agents nor employees of Aetna. Undersigned employer agrees to deliver, or otherwise make available to enrollees, all Aetna paper or online member documents and other plan-related materials upon request by Aetna. Aetna Rx Home Delivery, LLC, and Aetna Specialty Pharmacy, LLC, are subsidiaries of Aetna Inc.

Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statements 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 and subjects such person to criminal and civil penalties.

All data that may have a bearing on coverage or premiums will be open for Aetna to inspect while the plan documents are in force.

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, therefore, cannot guarantee any results or outcome.

I hereby apply for the coverage(s) indicated above. I certify that all information provided in this Application is accurate and complete to the best of my knowledge and belief.

I understand that the Application will form a part of the Group Policy issued by Aetna (a sample of which may be available on request), and by my signature below I agree to be bound by the terms and conditions of that Group Policy. I understand that Aetna may choose not to accept this Joinder Agreement and Application subject to any state requirements. I understand that Aetna will rely on the information I provide in determining eligibility for coverage, setting premium rates, compliance with applicable laws, and other purposes, and that any intentional material misrepresentation or fraudulent statement may result in rescission of coverage under the group policy, rescission of the group policy, termination of coverage, increase in premiums, or other consequences. Aetna reserves the right to audit and to request documentation as evidence of business activity at any time and from time to time in order to validate my compliance with eligibility and underwriting guidelines as well as 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.

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.

Continued on next page

Signature section (Continued)

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: The undersigned employer 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.

EMPLOYER ACKNOWLEDGMENT – EMPLOYER WAITING PERIOD

Starting with plan years on or after January 1, 2014, 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 is effective. The regulations define group health plan as the employer or plan administrator. The issuer is defined 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.

The Employer Group Policyholder ("Employer") represents that it provides to Aetna, effective date information regarding plan participants and beneficiaries that takes into account the eligibility conditions and waiting period requirements required under federal law, in order for such plan participants and beneficiaries to become eligible for coverage under the Employer's group health insurance coverage with Aetna. In compliance with the waiting period requirements, Aetna shall use the effective date information provided by Employer to enroll such plan participants and beneficiaries in the Employer's group health insurance coverage. In the event this information changes, the Employer shall inform Aetna immediately.

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 will provide SBCs to plan participants and beneficiaries in compliance with the federal regulation and guidance related to SBCs, including the requirements for timely delivery. 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>.

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 being applied for.

I represent that I am licensed to sell Aetna products in the state of Wisconsin.

I certify that I have advised the client not to terminate any existing coverage until receiving written notice from Aetna that the coverage being 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): <input type="checkbox"/> Broker <input type="checkbox"/> Agency		Phone: ()	Fax: ()
Address:		City:	State: ZIP:
Signature:	Date:	Email:	% of credit:
Broker admin assistant name:		Broker admin assistant email:	
Agent or broker name:		National producer number:	
Agency name:		TIN:	
Pay commissions to (check one): <input type="checkbox"/> Broker <input type="checkbox"/> Agency		Phone: ()	Fax: ()
Address:		City:	State: ZIP:
Signature:	Date:	Email:	% of credit:
Broker admin assistant name:		Broker admin assistant email:	
General agent name:		TIN:	
Selling agent name:		Email:	
Phone: ()		Fax: ()	
Address:		City:	State: ZIP:
Signature:		Date:	
GA admin assistant name:		GA admin assistant email:	