



Illinois Small Group Business Employer Application and Joinder Agreement

FOR GROUP COVERAGE (2 – 50 ELIGIBLE EMPLOYEES)

Life, Accidental Death & Dismemberment, Disability, Aetna Managed Choice® (Open Access) and Aetna PPO plans are underwritten by Aetna Life Insurance Company. Aetna HMO plans are underwritten by Aetna Health of Illinois Inc. Aetna POS plans are underwritten by Aetna Health of Illinois Inc. and Aetna Health Insurance Company. Dental plans are provided or administered by Aetna Life Insurance Company.

Company Name (Legal Name)		DBA/Doing Business As (if applicable)	
Street Address (P.O. Box not acceptable)		City	State ZIP
Bill Address (If different than above)		City	State ZIP
Company Contact Person - Title		Phone Number ()	Fax Number ()
E-Mail Address		Federal Tax ID Number	Date Business Established (Mo/Yr):
Employer Classification <input type="checkbox"/> Corporation <input type="checkbox"/> Non-Profit <input type="checkbox"/> Partnership <input type="checkbox"/> Sole Proprietor <input type="checkbox"/> LLC <input type="checkbox"/> LLP <input type="checkbox"/> Other: _____			
Nature of Business:		SIC Code: _____	

Effective Date

Requested effective date may be the 1 st or the 15 th of the month. The actual effective date will be assigned by the Aetna underwriting department if the Joinder Agreement/Application is approved.	
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Medical Coverage Selection - Groups with 5 or more enrolled employees may offer two or three medical plans.

<input type="checkbox"/> Managed Choice® (Open Access) Plan -- Plan Option: _____ <input type="checkbox"/> Open Choice® PPO Plan -- Plan Option: _____ <input type="checkbox"/> Indemnity Plan -- Plan Option: _____ <input type="checkbox"/> Out-of-State PPO Plan -- Plan Option: _____ <input type="checkbox"/> Other Plan -- Plan Option: _____	
Is employer, plan sponsor or a third party funding any of the deductible? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, how much? _____	
Does this group have a flex plan under Section 125 of the Internal Revenue Service Code? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Aetna Dental™ Plan Coverage Selection

Plan Option 2 must be combined with Plan Options 1, 4, 5, 6 or 7 in a Dual Option offering. Plan Option V1 must be combined with Plan Option V3 in a Dual Option Offering.	
Standard Plans:	
<input type="checkbox"/> Option 1: Scheduled <input type="checkbox"/> Option 2: DMO® <input type="checkbox"/> Option 3: Freedom-of-Choice <input type="checkbox"/> Option 4: PPO Max <input type="checkbox"/> Option 5: Active PPO <input type="checkbox"/> Option 6: PPO 1500 <input type="checkbox"/> Option 7: PPO 2000 <input type="checkbox"/> Out-of-State PPO (if applicable) <input type="checkbox"/> \$1000 <input type="checkbox"/> \$1500 <input type="checkbox"/> \$2000	
Voluntary Plans:	
<input type="checkbox"/> Option V1 <input type="checkbox"/> Option V2 <input type="checkbox"/> Option V3 <input type="checkbox"/> Out-of-State PPO	
<i>Orthodontic coverage is included in Standard Plan Options 2, 3, 5, 6 and 7 and Voluntary Plan Options 1 and 2 for dependent children in groups with 10 or more eligible employees with 5 enrolled employees.</i>	

Life, AD&D, Short Term Disability and Packaged Life & Disability Coverage Selections

Groups with 10 to 50 employees may select one, two or three options for Life and Short Term Disability, with a minimum requirement of three employees in each option. If more than one option is selected, describe each class of employees, indicate the amount selected for each class and attach a list of employee names with each class designation. (Limited to 3 classes. The highest option selected can be no more than 5 times the lowest option.)				
Life Options for All Group Sizes:	<input type="checkbox"/> \$10,000 <input type="checkbox"/> \$15,000 <input type="checkbox"/> \$20,000 <input type="checkbox"/> \$50,000			
Additional Life Options for Groups with 10-50 eligible employees:	<input type="checkbox"/> \$75,000 <input type="checkbox"/> \$100,000 <input type="checkbox"/> \$125,000			
Packaged Life & Disability: (limit one selection)	<input type="checkbox"/> Low Option <input type="checkbox"/> Low Option 2 <input type="checkbox"/> Medium Option <input type="checkbox"/> Medium Option 2 <input type="checkbox"/> High Option			
Short Term Disability:	<input type="checkbox"/> Option 1 <input type="checkbox"/> Option 2 <input type="checkbox"/> \$100 <input type="checkbox"/> \$200 <input type="checkbox"/> \$300 <input type="checkbox"/> \$400 <input type="checkbox"/> \$500			
Class Description:	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 33%; border: 1px solid black;">Class 1</td> <td style="width: 33%; border: 1px solid black;">Class 2</td> <td style="width: 33%; border: 1px solid black;">Class 3</td> </tr> </table>	Class 1	Class 2	Class 3
Class 1	Class 2	Class 3		
Optional Dependent Term Life (available only to groups with 10 to 50 eligible employees) <input type="checkbox"/> Yes <input type="checkbox"/> No				
Waiver of Premium for totally disabled insured employees (totally disabled for a period of at least 6 months): <input type="checkbox"/> Yes <input type="checkbox"/> No				

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.

Benefit Waiting Period (BWP)

The date will be the first day of the policy month following the waiting period.

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: 0 days 30 days 60 days 90 days 120 days 150 days 180 days

Group Ownership Information – Optional

(This information is designed for the purposes of data collection and will not be used for underwriting.)

Check one or both if applicable:

Woman Owned Business

Minority Owned Business (indicate status): African American or Black Hispanic or Latino Asian Other _____

Business Eligibility

Is your company a subsidiary of another company, an affiliate of another company, or under common control with another company? Yes No

Does your company file state or federal taxes with another company(ies) 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 Yes to any 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 Name	Tax Identification Number	Owner's Name	Ownership Percentage	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

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

Is your company a branch of another company, or does your company have 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 _____

Has your business been insured with Aetna within the past 12 months? If Yes, provide group number. _____ Yes No

Do you use the services of a Payroll Company? If Yes, provide the name of the payroll company. _____ 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 coverage available to you as a client of a PEO? Yes No

- Is group considered a Co-Employer with the PEO? Yes No

- By enrolling for coverage as a small employer I am not in violation of any contractual breach of contract with the PEO. Agree Disagree

Employer Eligibility/Employee Status

Work Location (list by state)	Number of Employees						
	Full-time	Part-time	Retired	COBRA	1099	Union	Other (Temporary, substitute, seasonal, etc.)

What is the normal work week you require a full-time employee to work to be eligible for coverage? _____ hours per week

Total number of eligible employees		Total number of employees enrolling		Total number of employees waiving		Total number of employees in benefit waiting period	
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Are there excluded classes of employees other than part-time and temporary employees (for example, Union employees)? If Yes, describe class(es) and/or the union local name and number. Yes No

Is your group Medicare Primary (employed less than 20 employees during at least 50% of the preceding calendar year) or Aetna Primary (employed 20 or more employees during at least 50% of the preceding calendar year)? Medicare Primary Aetna Primary

Employer Contribution(s)

Coverage	Medical	Dental	Employee Life	Dependent Life	Disability	Packaged Life & Disability
Employer Contribution for Employee				NA		
Employer Contribution for Dependent			NA		NA	NA

Prior Carrier Information

	Health	Dental	Life	STD
Is this group transferring from another group carrier?	<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 Yes, provide Carrier Name				
Effective Date of Coverage				
Proposed Termination Date				
Is this total replacement?	<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 prior carrier is Aetna, provide Group/Control Number				
Did your plan have a deductible?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Provide prior carrier deductibles:	<input type="checkbox"/> Individual \$ _____ <input type="checkbox"/> Family \$ _____	<input type="checkbox"/> Individual \$ _____ <input type="checkbox"/> Family \$ _____ <input type="checkbox"/> Ortho Max \$ _____		
Dental Only – Prior coverage included, check all that apply:		<input type="checkbox"/> Major Services <input type="checkbox"/> Orthodontia		

Signature Section

The Applicant 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 Group Agreement). All statements herein shall be deemed representations and not warranties.

The Applicant acknowledges that it has selected this plan based upon written information provided by Aetna and that no broker, 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. Applicant agrees to make payroll and other records directly related to employee's coverage under the Group Agreement or Group Policy available to Aetna for inspection, at Aetna's expense, at Applicant's office, during regular business hours, upon reasonable advance request. This provision shall survive termination of the Group Agreement or Group Policy.

Applicant has selected, in accordance with applicable state law, the plan to be offered to Applicant's employees and Applicant has solely determined any/all health plan options for the Applicant'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 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 schedule. Aetna disclaims any responsibility if the employer elects such a schedule and it is later deemed discriminatory.

The plan documents will determine the rights and responsibilities of member(s) and will govern in the event of conflicts with any benefits comparison, summary, or other description of the plan. Any direct conflict between this form and the plan documents will be resolved according to the terms which are most favorable to the member.

With the exception of Aetna Rx Home Delivery, participating physicians, hospitals and other health care providers are independent contractors and are neither agents nor employees of Aetna. Aetna Rx Home Delivery, LLC, is a subsidiary of Aetna Inc.

Applicant 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.

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

All data that may have a bearing on coverage or premiums will be open for Aetna to inspect while the Group Agreement or Group Policy is 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 or dental care services and, therefore, cannot guarantee any results or outcome.

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages.

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