



Texas Small Group Business Employer Application

FOR GROUP COVERAGE (2 – 50 ELIGIBLE EMPLOYEES)

** You have the option to choose this Consumer Choice of Benefits Health Insurance Plan or Health Maintenance Organization health care plan that, either in whole or in part, does not provide state-mandated health benefits normally required in accident and sickness insurance policies or evidences of coverage in Texas. This standard health benefit plan may provide a more affordable health insurance policy or health plan for you although, at the same time, it may provide you with fewer health or health plan benefits than those normally included as state-mandated health benefits in Texas. If you choose this standard health benefit plan, please consult with your insurance agent to discover which state-mandated health benefits are excluded in this Policy or evidence of coverage.

Life, Accidental Death & Dismemberment, Disability and Aetna PPO Plan are underwritten by Aetna Life Insurance Company. In-Network Aetna QPOS and POS Plans are underwritten by Aetna Health Inc. Out-of-Network Aetna QPOS and POS Plans are underwritten by Corporate Health Insurance Company. Dental plans are provided or administered by Aetna Dental Inc. and 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"/> Other: | | | SIC Code: |

Medical Coverage Selection

| | |
|--|---|
| Aetna QPOS Plan** <input type="checkbox"/> Plan _____ | Aetna PPO Plan** <input type="checkbox"/> Plan _____ |
| Aetna OA POS Plan** <input type="checkbox"/> Plan _____ | <input type="checkbox"/> Aetna Indemnity Plan** |
| Aetna OA MC Plan** <input type="checkbox"/> Plan _____ | <input type="checkbox"/> Medical Out-of-State (OOS) ** Plan _____ |
| 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? _____ | |
| NOTE: OA MC 500 plan and QPOS 30 plan are NOT offered under the Consumer Choice of Benefits Health Insurance Plan. | |

Other Coverage Selection

| |
|--|
| Aetna Dental™ Plans <input type="checkbox"/> Plan _____ |
| Voluntary Dental: <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Available only to groups with 10 to 50 eligible employees. Orthodontia coverage option for dependent children (not available with Standard Plan Options 1 and 4 and Voluntary Option 1): <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Packaged Dental/Life/Disability <input type="checkbox"/> Plan _____ |
| Dental Out-of-State (OOS) <input type="checkbox"/> Plan _____ |

Life, Accidental Death & Dismemberment, & Disability Coverage Selections

Groups with 10 to 50 eligible employees may select one, two, or three options for Life, Accidental Death & Dismemberment, and Disability. 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.)

| | | | | |
|--|---|------------------------------------|------------------------------------|-----------------------------------|
| All Groups - Life | <input type="checkbox"/> \$10,000 | <input type="checkbox"/> \$15,000 | <input type="checkbox"/> \$20,000 | <input type="checkbox"/> \$50,000 |
| All Groups - Life & Disability Packaged Plan | <input type="checkbox"/> Low | <input type="checkbox"/> Medium | <input type="checkbox"/> High | |
| Additional options for Groups with 10 – 50 eligible employees | <input type="checkbox"/> \$75,000 | <input type="checkbox"/> \$100,000 | <input type="checkbox"/> \$125,000 | |
| Class Description | 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 | | | |

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.

Domestic Partner Option

Please indicate whether you will provide Domestic Partner coverage to your employees:
 Yes, include Domestic Partner coverage for my employees No, decline Domestic Partner coverage for my employees

Effective Date Actual effective date will be assigned by Aetna.

Requested effective date (may be the 1st or 15th of the month only): _____

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 below):
 African American or Black Hispanic or Latino Asian Other _____

Employer Contribution(s)

| Coverage | Medical | Dental | Employee Life | Dependent Life | Disability |
|--|---------|--------|---------------|----------------|------------|
| Employer's Minimum Contribution for Employee | % | % | % | NA | % |

Section 125 Plan

Does the group have a flex plan under Section 125 of the Internal Revenue Service code? Yes No

Employee Eligibility

| Work Location (list by state) | Number of Employees | | | |
|----------------------------------|---|-----------|--------------------------|---|
| | Full-time (based on number of minimum hours allowed by state law) | Part-time | COBRA or State Continues | Other (i.e., temporary, substitute, seasonal) |
| | | | | |
| | | | | |
| | | | | |

Total number of employees: _____
 Is your group subject to COBRA? (20 or more total employees during at least 50% of the working days in the previous calendar year)
 Yes No
 Total number of independent contractors compensated via a 1099-Misc tax form applying for coverage: _____
 (Requires Underwriting approval and additional documentation.)
 Total number of employees eligible for coverage (must usually work at least 30 hours per week): _____
 Total number of employees waiving Aetna health benefits but covered through their spouse's health benefit plan: _____
 Total number of employees waiving Aetna health benefits coverage without coverage elsewhere: _____
 Total number of employees covered under another health benefit plan offered by the employer: _____
 Are Union employees excluded for eligibility purposes? Yes No
 If Yes, how many union employees are to be excluded? _____
 Eligibility date will be the 1st of the policy month following the waiting period.
 Waiting period for all employees: 0 months 1 month 2 months 90 days
 Is the group waiving the waiting period at initial enrollment? Yes No
 Are you currently a client company of a Professional Employer Organization (PEO)? Yes No

Prior Carrier Information

| | Health | Dental | Life | Disability |
|---|--|---|--|--|
| 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 Aetna, provide Group/Control Number | | | | |
| Prior Carrier Deductible | | | | |
| Dental Only – Prior coverage included, check all that apply: | | <input type="checkbox"/> Major Services <input type="checkbox"/> Orthodontia | | |

Workers' Compensation Information

Aetna's coverage is not occupational in nature and, consequently, it is not a substitute for Workers' Compensation coverage.
 Name of current Workers' Compensation carrier: _____ Renewal Date: _____
 Is Workers' Compensation coverage provided on all employees? Yes No
 If not, please attach a list of all employees enrolling that are NOT covered by Workers' Compensation or similar legislation (including title).

Medical Information

Is any person to be covered unable to work due to illness or injury? Yes No

Is any person unable to perform the normal duties of another person in the same employment class of the same age and sex? Yes No

If Yes is answered to either question, attach a sheet with the names of the individual(s), dates and degree of recovery.

Texas Notice of Election or Rejection of Optional Medical Benefits

If medical coverage **has not been** selected or a Value Plan (Consumer Choice of Benefits Health Insurance Plan) **has been** selected, this section does not apply.

Texas law requires that the following optional benefits be offered to applicants having employees who are located in Texas. If elected, coverage will be provided to all employees covered under a Texas contract except as otherwise noted. Additional medical premium will be required for each option selected.

1. In Vitro Fertilization Coverage

Coverage includes expenses incurred by the subscriber or the subscriber's covered spouse for outpatient in vitro fertilization procedures subject to the provisions of the Texas Insurance Code.

- Applicant accepts the optional In Vitro Fertilization benefit.
 Applicant rejects the optional In Vitro Fertilization benefit.

2. Additional Speech and Hearing Impairment Coverage

The optional coverage would include benefits for the necessary care and treatment of loss or impairment of speech or hearing. Such coverage will not be less favorable than coverage under the plan for physical illness generally, subject to the same durational limits, dollar limits, deductibles and coinsurance factors that may apply.

- Applicant accepts the optional Speech and Hearing Impairment benefit.
 Applicant rejects the optional Speech and Hearing Impairment benefit.

In rejecting coverage, I understand that it will not be provided at a future date unless I request it at policy renewal.

Signature _____ Title _____ Date _____

3. Additional Coverage for Serious Mental Illness

Additional coverage offered for the treatment of "serious mental illness." A "serious mental illness" is defined as:

- Schizophrenia;
 - Paranoid and other psychotic disorders;
 - Bipolar disorders (hypomanic, manic, depressive and mixed);
 - Major depressive disorders (single episode or recurrent);
 - Schizo-affective disorders (bipolar or depressive);
 - Obsessive-compulsive disorders; and
 - Depression in childhood and adolescence.
- Applicant accepts the optional Serious Mental Illness benefit.
 Applicant rejects the optional Serious Mental Illness benefit.

Texas Notice of Election or Rejection of Optional Dental Benefits

To provide flexibility to covered persons, dental coverage can be obtained through either the Dental Plan Coverage (DPC Plan), offered by Aetna Dental Inc., or the Comprehensive Dental Expense Coverage plan (Point of Service Plan), offered by Aetna Life Insurance Company. The Point of Service Plan (POS Plan) provides out-of-network coverage for covered dental expenses and includes deductible and coinsurance percentage provisions. This plan must be offered to every customer who purchases a DMO plan and has 25 or more employees. If dental coverage has not been selected or the group does not meet the criteria indicated above, this section does not apply.

If any covered services or supplies are performed or received from a Member Dental Provider or a Member Specialty Dental Provider, benefits will be considered to have been paid for such services and supplies under the DPC Plan. The covered person will be responsible for the payment of the copayment amounts specified in the Certificate of Coverage describing his/her DPC Plan.

Except for Emergency Care, if any covered services or supplies are performed or received from a Non-Member Dental Provider, benefits will be considered to have been paid for such services and supplies under the POS Plan. The covered person will be responsible for the payment of the deductible and coinsurance percentage amounts specified in the Certificate of Coverage describing his/her POS Plan.

All the terms and conditions of the plan under which the services or supplies are provided will apply.

If you live and work outside of the Service Area, you will not be eligible for the DPC Plan Coverage.

Additional dental premium will be required if the Point of Service Option is accepted.

- Applicant accepts the Point of Service Option.
 Applicant rejects the Point of Service Option.

Signature _____ Title _____ Date _____

Signature Section

APPLICABLE TO ALL COVERAGES

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 full-time employee, regularly performing the duties of his or her occupation (except for health-related factors and 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.

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