APPLICATION FOR A SMALL GROUP HEALTH BENEFITS POLICY

Please Print or Type

☐ New Policy ☐ Change in Policy

Requested Effective Date ______________________

NOTE: The Effective Date will be on or after the date Aetna approves the application.

For Aetna Use Only

Policy Number ______________________

Section I: POLICYHOLDER INFORMATION

1. Policyholder (Full Legal Name of Company)
2. Tax Identification Number
3. Main Address: Street | City | State | Zip

   Mailing Address: Street | City | State | Zip

   Telephone Number ( ) | Facsimile Number ( )
4. Name of Correspondent | Telephone
5. Type of Organization

   ☐ Corporation ☐ Partnership ☐ Proprietorship ☐ Other (explain):
6. Nature of Business (specify) | SIC Code
7. Number of eligible employees in your company

   Refer to the New Jersey Small Employer Certification for the definition of an eligible employee
8. Number of eligible employees to be insured
9. Class or classes to be excluded
10. Insurance requested for

    ☐ Employees Only ☐ Employees and Dependents

    Should the plan provide coverage for domestic partners as permitted by P.L. 2003, c.246? ☐ Yes ☐ No

    If "Yes", should the plan provide coverage for children of a covered domestic partner? ☐ Yes ☐ No
11. Is the Employer subject to the requirements of COBRA?

    ☐ Yes ☐ No
12. Is the employer subject to the requirements of Medicare as Secondary Payor Rules for eligibility due to

    age? ☐ Yes ☐ No

    disability? ☐ Yes ☐ No
13. Waiting period before employees become insured (may not exceed 6 months):

    Current Employees: ______________

    New or Rehired Employees: ______________
14. What percentage of the premium will the employer pay?
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.

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 Insured

Section II: SPECIFICATIONS FOR COVERAGE

Health Benefits: Plan number (1, 2, etc.) and suffix (N or S) must be completed below.

- ☐ NJ HMO: Plan Option - ___________ Suffix *(please circle one)*: N or S
- ☐ NJ HMO No-Referral: Plan Option - ___________ Suffix *(please circle one)*: N or S
- ☐ NJ Cost-Sharing HMO: Plan Option - ___________ Suffix *(please circle one)*: N or S
- ☐ NJ POS No-Referral: Plan Option - ___________ Suffix *(please circle one)*: N or S
- ☐ NJ PPO Basic Hospital Plan
- ☐ NJ PPO First Dollar Plan
- ☐ NJ PPO HSA Compatible: ☐ Plan 1 ☐ Plan 2

- ☐ Out-of-State/Situs PPO: ☐ $250 (High) ☐ $500 (Medium) ☐ $1000 (Low)
- ☐ Standard Health Benefits Plans:
  - – NJ HMO: ☐ $5 Plan ☐ $10 Plan ☐ $15 Plan ☐ $20 Plan ☐ $30 Plan ☐ With RX Rider ($15/$25/$40) ☐ Without RX Rider (50%)
  - – NJ Indemnity: ☐ Plan A1 ☐ Plan A2 ☐ Plan B ☐ Plan C ☐ Plan D ☐ Plan E1 ☐ Plan E2
- ☐ Other Plan ____________

If you have selected an HSA-compatible plan:

- Do you plan on making contributions to your employee's HSA accounts? ☐ Yes ☐ No
- Do you plan to offer your employees payroll deductions to fund their HSA accounts? ☐ Yes ☐ No

Section III: ALL QUESTIONS MUST BE ANSWERED

1. Is there any Group Health Plan:
   - now in force and to be continued? ☐ Yes ☐ No
   - currently being applied for? ☐ Yes ☐ No

   If "Yes", identify the name of the Group Health Plan, give a description of the plan(s) and the name of insurance carrier(s):

   ____
2. Name of present or prior group carrier ________________________________

   Effective date of prior coverage ____________________ Cancellation/Termination Date ____________________

   Is the coverage applied for in this application replacing other group insurance? ☐ Yes ☐ No

   If "Yes" give reason ________________________________

   Plan being replaced ☐ A ☐ B ☐ C ☐ D ☐ E ☐ HMO ☐ HMO/POS ☐ Dual Contract POS ☐ Other ____________________
3. Has your firm been uninsured for 3 or more months prior to application? ☐ Yes ☐ No
4. What forms of Insurance are now or were in force? ☐ Health Benefits ☐ Prescription Drugs

   (Attach copies of Booklet/Certificate and most recent Billing Statement.)
5. Are extended benefits provided in case of termination of health benefits? ☐ Yes ☐ No
6. To the best of your knowledge, are there any current or former employees or their eligible dependents whose health insurance is being continued? ☐ Yes ☐ No

   Please provide the following information for each current/former employee or dependent on health continuations.

   If additional space is needed, attach a separate sheet, signed and dated.

Name of Employee/ Dependent	Date of Birth	Type of Continuation State/Federal/ Extended Benefits	Reason for Termination Disability/Other	Continuation Dates	
				Start	End

7. To the best of your knowledge:
   a. Are any employees or dependents presently incapacitated? ☐ Yes ☐ No
   b. Are any dependent children incapable of self-support due to a physical or mental disability? ☐ Yes ☐ No

Additional space to explain if items 1, 2 or 3 were answered "Yes". Refer to the question number, and give details, including names, where appropriate.

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Section III: ALL QUESTIONS MUST BE ANSWERED (Continued)

8. Does the employer participate in an arrangement with a Professional Employer Organization? ☐ Yes ☐ No
   (Refer to Advisory bulletin 00-SEH-02 if you need information concerning what constitutes a Professional Employer Organization.)

Section IV: AGENT/PRODUCER INFORMATION

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

Agent/Broker Name: ______________________ Aetna Agent Number/Tax ID/SSN: ______________

Agency Name: ______________________ % of Credit: ______________

Phone Number: (____) ______________________ Fax Number: (____) ______________

Address: ______________________ City: ______________ State: ______ Zip: ______

Signature: ______________ Date: ________ E-Mail Address: ______________

Agent/Broker Name: ______________________ Aetna Agent Number/Tax ID/SSN: ______________

Agency Name: ______________________ % of Credit: ______________

Phone Number: (____) ______________________ Fax Number: (____) ______________

Address: ______________________ City: ______________ State: ______ Zip: ______

Signature: ______________ Date: ________ E-Mail Address: ______________

General Agent Name: ______________________ Aetna Agent Number/ID Number: ______________

Phone Number: (____) ______________________ Fax Number: (____) ______________

Address: ______________________ City: ______________ State: ______ Zip: ______

Signature: ______________ Date: ________ E-Mail Address: ______________

Section V: SIGNATURE

It is understood that, except as provided under applicable regulations, no individual shall become insured 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 Health Inc. and Aetna Life Insurance Company to make or modify any request or application for insurance or to bind Aetna Health Inc. and Aetna Life Insurance Company by making any promise or representation or by giving or receiving any information.

It is further understood that no insurance will be effective unless and until the application is accepted in writing by Aetna Health Inc. and Aetna Life Insurance Company. Final rates will be based on enrollment data as of the Policy effective date. No contract of insurance 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 an insurance policy is subject to criminal and civil penalties.

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.