Alaska Small Group Employer Application

Aetna Life Insurance Company

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? ☐ Yes ☐ No If **yes**, provide all addresses and locations.			

Company contact – Name and title		Company contact email	
Billing contact name (if different from company contact)		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 ☐ S Corp ☐ C Corp ☐ Nonprofit ☐ Partnership ☐ Sole proprietor
☐ LLC filing 1065 ☐ LLC filing 1120 ☐ LLP ☐ Other: _____

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

Requested effective date: _____

Dental coverage selection

Non-voluntary plan – Plan option name _____ Option number _____

Voluntary plan – Plan option name _____ Option number _____

Aetna Life Insurance Company underwrites Aetna dental plans.

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.

Prior carrier information

Is this plan a total replacement for any existing group plans?	Carrier name	Phone number	Start date	End date
Current dental carrier ☐ Yes ☐ No				
My current group dental plan has the following (Check all that apply): ☐ Discount dental ☐ Preventive only ☐ Preventive and basic ☐ Major services ☐ Orthodontia – Orthodontic max $ _____				
Has your business ever been insured with Aetna? If **yes**, provide group number: _____ ☐ Yes ☐ No				

Business eligibility

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.			
I certify my business(es) applying for coverage meets the IRS test for being a commonly-controlled group as defined under subsection (b), (c), (m), or (o) of section 414 of the Internal Revenue Code of 1986.			☐ Yes ☐ No
If yes, I further certify by checking the box to the right that there are no other affiliated entities, other than the ones listed below, that are part of the commonly-controlled or affiliated group that includes my business.			☐
Business names of ALL groups including the company the groups are being written under	**Tax identification number**	**Owner's name**	**Number of eligible employees**

Does your company have branch offices or is your office a branch location?		☐ 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
Do you use the services of a payroll company?		☐ Yes ☐ No
If yes	- Provide the name of the payroll company:	
Are you currently a client of a professional employer organization (PEO)?		☐ Yes ☐ No
If yes	- Provide the name of the PEO:	
Are you a professional employer organization (PEO)?		☐ Yes ☐ No

Participation

How many hours a week must your employees work to be eligible for coverage?			
Number of employees eligible for coverage (employees working the minimum hours to be eligible for coverage)			
Number of employees enrolling		Number of employees waiving Aetna coverage	
Number of full-time employees excluding union employees		Number of employees working outside Alaska 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: ☐ Union – Local number: _____			
Are domestic partners to be included? ☐ Yes ☐ No			

COBRA / TEFRA / DEFRA

Is your employer group required to comply with COBRA?	☐ Yes ☐ No
How many full- and part-time employees did you employ 50 percent of the business days in the prior calendar year? *Include: Full time, part time, seasonal, temporary, union, owners, partners, officers* *Exclude: Self-employed persons, independent contractors (1099), directors* 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.	

Name of applicant	Qualifying event (e.g., termination of employment, divorce, etc.)	Have they elected COBRA?	Date of qualifying event	Date COBRA coverage terminates
		☐ Yes ☐ No		
		☐ Yes ☐ No		
		☐ Yes ☐ No		

Eligibility waiting period (BWP)

The eligibility date for enrollment will be the first day of the month following the waiting period. If "0" days is selected and the employee is hired on the first of the month, the effective date will be the date of hire.	
Do you want to waive the waiting period for present employees enrolling with the group (even those who have not met the full waiting period) as of the initial contract effective date only?	☐ Yes ☐ No
Waiting period for future employees: First day of month following:	☐ 0 days - A date of hire effective date is not allowed. ☐ 30 days ☐ 60 days

Employer premium contribution(s)

Employer premium contribution for employee	_____ %
Employer premium contribution for dependent	_____ %

Signature section

The Applicant agrees to the following:

- An employee cannot contribute to non-contributory coverage, unless an authorized representative of Aetna approves the change in writing.
- An employee cannot contribute for contributory coverage for the current coverage period at a higher rate than shown on this application.
- Only a person who is a bona fide, full-time employee, regularly performing the duties of their occupation, is eligible for coverage, 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 in the event they conflict with any:
  - Benefits comparison
  - Summary
  - Other description of the plan
- All statements in this application are representations and not warranties.
- I acknowledge that Aetna provided written information that I used in selecting 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 set forth in the plan documents.
- I agree to make all Aetna plan related paper or online member documents available to my employees.
- I agree to make payroll and other records, directly related to the employee's plan coverage, available to Aetna for inspection. This will occur after a reasonably advanced request at:
  - Aetna's expense
  - My office during regular business hours

  This provision shall survive termination of plan coverage and the applicable plan documents.
- Aetna may inspect all data that has bearing on coverage or premiums while the plan coverage is in force.
- I am responsible to select, in accordance with applicable state law, the plans offered to my employees and the contribution amounts.
- Information on agent's compensation is available from my agent or at **www.aetna.com**.
- I understand and agree that, with the exception of members of the CVS Health family of companies (which includes CVS Pharmacy, CVS Caremark Mail Service Pharmacy**,** MinuteClinic and CVS Specialty Infusion Services)**,** all other participating providers and vendors are independent contractors and are neither agents nor employees of Aetna or its affiliates. We cannot guarantee the availability of any particular provider outside of our corporate family and the providers in our network may change. We also do not guarantee any results or outcome of a health or dental care service. Notice of any change shall be provided in accordance with applicable state law.
- 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 it cannot guarantee any results or outcome.
- I hereby apply for the coverages indicated above. I certify that all information in this application is accurate and complete to the best of my knowledge.

Continued on next page

Signature section *(Continued)*

- I understand Aetna will rely on the information I provide to determine:
  - Eligibility for coverage
  - Setting premium rates
  - Compliance with applicable laws
  - Other purposes
- Any material misrepresentation or fraudulent statement may result in:
  - Rescission of coverage under the Group Agreement / Group Policy
  - Rescission of the Group Agreement / Group Policy
  - Termination of coverage
  - Increase in premiums
  - Fines
  - Civil damages
  - Imprisonment
  - Other consequences
- Aetna reserves the right to audit documentation as evidence of business activity at any time in order to:
  - Validate compliance with eligibility and underwriting guidelines
  - 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.

EMPLOYER ACKNOWLEDGMENT – Employer waiting period

The Affordable Care Act and subsequent federal regulations prohibit group health plans and health insurance issuers from requiring any eligible plan participants and beneficiaries (employees and dependents) to wait no more than 90 days before their health coverage goes into effect.

- 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. However, if either party doesn't comply, both are subject to a penalty.
- I agree to provide the following information of the plan participants and beneficiaries to Aetna:
  - Effective date information
  - Eligibility
  - Waiting period required under federal law
- Aetna will use the information provided by the employer to enroll plan participants and beneficiaries in the employer's group health insurance coverage. In the event this information changes, the employer shall inform Aetna immediately.

ELECTRONIC ENROLLMENT, BILLING / PAYMENT AND ACCESS AGREEMENT

Enrollment: As of my participation date:

1. I agree to keep copies (paper or electronic) of actual enrollment forms. I 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. I agree to create and maintain records on secure information systems that can generate hard copies of enrollments or changes maintained on electronic information systems. Any hard copy records generated pursuant to this provision shall meet reasonable standards of availability, authenticity, non-repudiation and integrity.
3. I agree that all enrollment and eligibility information presented to Aetna is accurate and timely updated. I acknowledge that Aetna can and will rely on such information in determining whether an individual is eligible for benefits under the plan. I agree to pay Aetna promptly any applicable back premiums as the result of a discrepancy between the enrollee information and the actual information presented by the enrollee. The premium due to Aetna starts accruing as of the date on which the enrollee's information changed.
4. Insured plans must either:
   - Use Aetna-supplied forms in paper format or electronic format or
   - Agree to incorporate the following four points into any enrollment materials
     - Names of the Aetna company offering the insurance coverage
     - State-specific fraud warning statement
     - A statement that the terms of the insurance documents will govern the member's rights and responsibilities
     - An acknowledgment that participating providers are not agents or employees of Aetna and that network composition can change
5. I am 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, Aetna will regard the submission as verification that no premium / contribution was paid by the member / dependent for that period.

Continued on next page

Signature section *(Continued)*

Billing / payment: I agree to receive my bill online each month. Any contractual provisions related to non-payment of premium continue to be applicable. I 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: I agree that each employee will agree to terms associated with the issuance and use of their 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. Any individual to whom a password has been issued agrees to contact Aetna immediately if they become aware 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

Misrepresentation: Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement 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.

Signed at city, state	Applicant (company name)	
Authorized applicant signature	Official title	
Print name of authorized applicant		Date

Agent or broker certification

I hereby represent 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 applied for in this application.
I hereby represent that I have advised the client not to terminate any existing coverage until receiving written notice from Aetna that the coverage 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): ☐ Broker ☐ Agency		Phone: ( )		
Address:		City:	State:	ZIP:
Signature*:	Date:	Email:		% of credit:
Broker admin assistant name:		Broker admin assistant email:		
*I hereby certify that I am licensed to sell Aetna products in the state of Alaska.				
Agent or broker name:		National producer number:		
Agency name:		TIN:		
Pay commissions to (check one): ☐ Broker ☐ Agency		Phone: ( )		
Address:		City:	State:	ZIP:
Signature*:	Date:	Email:		% of credit:
Broker admin assistant name:		Broker admin assistant email:		
*I hereby certify that I am licensed to sell Aetna products in the state of Alaska.				
General agent name:		TIN:		
Selling agent name:		Email:		
Phone: ( )				
Address:		City:	State:	ZIP:
Signature*:			Date:	
GA admin assistant name:		GA admin assistant email:		
*I hereby certify that I am licensed to sell Aetna products in the state of Alaska.				