



Oklahoma Small Group Business Employer Application and Joinder Agreement

FOR GROUP COVERAGE (2 – 50 ELIGIBLE EMPLOYEES)

Life, Accidental Death & Dismemberment, Disability and Aetna Choice Plan PPO are underwritten by Aetna Life Insurance Company. Aetna HMO Plans and Aetna Open Access POS Plans are underwritten by Aetna Health Inc., Aetna Life Insurance Company, and/or Corporate 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
Billing Address (If different than above)	City	State	Zip
Company Contact Person - Title	Phone Number ()	Fax Number ()	
Billing/Enrollment Contact (If different than above Company Contact Person)	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

Other Coverage Selection

Aetna HMO Plan - <input type="checkbox"/> Plan _____ Aetna Open Access POS Plan <input type="checkbox"/> Plan _____ Aetna Open Access MC Plan <input type="checkbox"/> Plan _____	Aetna PPO Plan <input type="checkbox"/> Plan _____ Aetna Indemnity Plan <input type="checkbox"/> Plan _____ Medical Out-of-State (OOS) <input type="checkbox"/> Plan _____	Aetna Dental™ Plans <input type="checkbox"/> Plan _____ Packaged Dental/Life/Disability <input type="checkbox"/> Plan _____ Dental Out-of-State (OOS) <input type="checkbox"/> Plan _____
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If you have selected an HSA-compatible plan:

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

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.)

	Class 1		Class 2		Class 3	
	Life	or Life & Disability Packaged Plan	Life	or Life & Disability Packaged Plan	Life	or Life & Disability Packaged Plan
All Groups	<input type="checkbox"/> \$10,000 <input type="checkbox"/> \$15,000 <input type="checkbox"/> \$20,000 <input type="checkbox"/> \$50,000	<input type="checkbox"/> Low <input type="checkbox"/> Medium <input type="checkbox"/> High	<input type="checkbox"/> \$10,000 <input type="checkbox"/> \$15,000 <input type="checkbox"/> \$20,000 <input type="checkbox"/> \$50,000	<input type="checkbox"/> Low <input type="checkbox"/> Medium <input type="checkbox"/> High	<input type="checkbox"/> \$10,000 <input type="checkbox"/> \$15,000 <input type="checkbox"/> \$20,000 <input type="checkbox"/> \$50,000	<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		<input type="checkbox"/> \$75,000 <input type="checkbox"/> \$100,000 <input type="checkbox"/> \$125,000		<input type="checkbox"/> \$75,000 <input type="checkbox"/> \$100,000 <input type="checkbox"/> \$125,000	
Class Description						

Optional Dependent Term Life (Available only to groups with 10 to 50 eligible employees.) Yes 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.

Employer Contribution(s)

	Employer's Contribution for Employee Coverage	Employer's Contribution for Dependent Coverage
	% Contribution	% Contribution
Medical	_____ %	_____ %
Dental	_____ %	_____ %
Basic Employee Term Life (including AD&D)	_____ %	N/A
Optional Dependent Term Life	N/A	_____ %
Disability	_____ %	N/A

Effective Date Actual effective date will be assigned by the Aetna underwriting department if application is approved.

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

Business Eligibility

Is your company a subsidiary of another company, an affiliate of another company, or under common control with another company?	<input type="checkbox"/> Yes <input type="checkbox"/> No				
Does your company file state or federal taxes with another company(ies) on a combined or consolidated basis?	<input type="checkbox"/> Yes <input type="checkbox"/> No				
If Yes to any questions, complete the information below.					
<ul style="list-style-type: none"> • 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(s)	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, please explain why.					
Is your company a branch of another company, or does your company have branch offices?	<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 tax filings prepared separately or as one common filing?					
- Where is each branch located (list each branch business address separately)?	Number of Employees at each location				
Has any business to be included for coverage under this group plan filed for Chapter 7 Bankruptcy?	<input type="checkbox"/> Yes <input type="checkbox"/> No				
If Yes, provide details.					
Are you currently a client company of a PEO?	<input type="checkbox"/> Yes <input type="checkbox"/> No				

Employer Eligibility/Employee Status

Work Location (list by state)	Number of Employees						
	Full-time	Part-time	Retired	COBRA	1099	Union	Other (i.e., temporary, substitute, seasonal, etc.)
TOTAL							
Total number of eligible employees based on state law (must work a minimum of 24 hours per week).							
Of the total number of eligible employees as indicated above, how many are:							
- waiving Aetna health benefits coverage because they are covered through their spouse's health benefit plan?							
- waiving Aetna health benefits due to coverage under another health benefit plan offered by this employer?							
- waiving Aetna health benefits coverage but do not have coverage elsewhere?							

Employer Eligibility/Employee Status (Continued)

Total number of eligible employees enrolling in the Aetna health benefits plan.	
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 full-time employees who are currently in the waiting period and not eligible.	
Are there excluded classes of employees other than part-time and temporary employees (for example, Union employees)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, describe class(es) and/or the union local name and number.	

COBRA/Tefra/Defra

Is your group subject to COBRA? (20 or more total employees during at least 50% of the working days in the previous calendar year)	<input type="checkbox"/> Yes <input type="checkbox"/> No
How many employees have terminated in the last 90 days?	
To the best of your knowledge, will any of these employee(s)/dependent(s) exercise their COBRA option?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, is the employee/dependent presently disabled?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is your group subject to Tefra/Defra? Under Tefra/Defra, Aetna is primary coverage for groups of 20 or more full-time and part-time employees (based on the total number of employees during 50% of the working days during the previous calendar year.) Medicare is primary for groups of less than 20 full-time and part-time employees.	<input type="checkbox"/> Medicare Primary <input type="checkbox"/> Aetna Primary

Benefit Waiting Period

Eligibility 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).	<input type="checkbox"/> Yes <input type="checkbox"/> No
Waiting period for future employees: <input type="checkbox"/> 0 days <input type="checkbox"/> 30 days <input type="checkbox"/> 60 days <input type="checkbox"/> 90 days <input type="checkbox"/> 120 days <input type="checkbox"/> 180 days	

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

Workers' Compensation

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:	Effective Date: Renewal Date:
Is Workers' Compensation coverage provided on all employees?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If No, please provide 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is any person unable to perform the normal duties of another person in the same employment class of the same age and gender?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If Yes is answered to either question, attach a sheet with the names of the individual(s), dates and degree of recovery.	

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, 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.

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

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.

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. Any direct conflict between this form and the plan documents will be resolved according to the terms which are most favorable to the member and are in compliance with Oklahoma law.

Participating physicians, hospitals and other health care providers are independent contractors and are neither agents nor employees of Aetna.

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.

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.

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.

I hereby apply for the coverage(s) indicated above. I certify that all information provided in this application is accurate and complete.

I understand that this application will form a part of the Group Agreement or 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 Agreement or Group Policy. I understand that Aetna may choose not to accept this 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 material misrepresentation, fraudulent statement or omission of information regarding my health may result in 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.

JOINDER AGREEMENT - REQUEST FOR PARTICIPATION (For life, disability, accidental death and dismemberment, out-of-state medical and out-of-state dental employee benefits): The undersigned employer agrees to the establishment of an insurance trust fund ("Fund") for the purposes of implementing a Trust Agreement ("Agreement"), and to the designation of the Chase Manhattan Bank Delaware, Wilmington, DE, as "Trustee" for the Fund and Agreement. The undersigned, as a Participating Employer in the Industry Trust corresponding to the standard industry classification ("SIC") code selected above: 1) agrees to be bound by the terms of the Agreement and the policy issued to the Trustee (including any amendments); 2) requests coverage for its eligible employees under the policy (subject to applicable underwriting requirements) as of the effective date requested or as of the date of approval of the Employer for participation under the Agreement, whichever is later, and continue as long as the Employer remains actively in business; and 3) agrees to make the required contributions to the Fund; in the event of default, it will be liable to the insurer for such unpaid contributions for the coverage period, and such insurer will terminate coverage. The insurer may also terminate coverage as of the date the group fails to meet minimum underwriting requirements in effect on that date. In addition, the Participating Employer, in accordance with ERISA Title I Section 503, designates Aetna Life Insurance Company ("Aetna") as the Named Fiduciary under the Plan, with complete and discretionary authority to review all denied claims for benefits under the Plan, and to construe disputed/doubtful Plan terms. Aetna shall be deemed to have properly exercised such authority unless it has abused its discretion by acting arbitrarily and capriciously.

Signed at (Location): _____

City, State

Applicant (Company Name)

By: _____

Authorized Applicant Signature

Official Title

Witness

Date

Agent/Broker Certification

I hereby certify that I am not aware of any information not disclosed in this application by the client which may have bearing on this risk, including my knowledge that replacement life insurance is is not (check one) a part of this transaction.

I hereby 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.

Agent/Broker Name: _____ Tax ID or SSN: _____

Agency Name: _____ % of Credit: _____

Phone Number: (____) _____ Fax Number: (____) _____

Address: _____ City: _____ State: _____ Zip: _____

Signature: _____ E-Mail Address: _____

Agent/Broker Name: _____ Tax ID or SSN: _____

Agency Name: _____ % of Credit: _____

Phone Number: (____) _____ Fax Number: (____) _____

Address: _____ City: _____ State: _____ Zip: _____

Signature: _____ E-Mail Address: _____

General Agent Name: _____ ID Number: _____

Phone Number: (____) _____ Fax Number: (____) _____

Address: _____ City: _____ State: _____ Zip: _____

E-Mail Address: _____

For Aetna Use Only

Group Number _____ Control Number _____ SCD _____ Effective Date _____