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 CPOS Plans are underwritten by Aetna Health Inc. Out-of-Network Aetna QPOS and CPOS Plans are underwritten by Aetna 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 ☐ Corporation ☐ Non-Profit ☐ Partnership ☐ Sole Proprietor ☐ Other: ____________

Nature of Business: ______________________ SIC Code: __________

Medical Coverage Selection

Aetna QPOS Plan**
☐ Plan ____________

Aetna CPOS Plan**
☐ Plan ____________

Aetna OA MC Plan**
☐ Plan ____________

Aetna PPO Plan**
☐ Plan ____________

☐ **Aetna Indemnity Plan****

Medical Out-of-State (OOS) **
☐ Plan ____________

Is employer, plan sponsor, or a third party funding any of the deductible?
☐ Yes ☐ No
If Yes, how much? ____________

NOTE: OA MC 500 plan and HMO 40 Plus plan are NOT offered under the Consumer Choice of Benefits Health Insurance Plan.

Other Coverage Selection

Aetna Dental™ Plans
☐ Plan ____________

Voluntary Dental: ☐ Yes ☐ No

Orthodontia coverage is available only to groups with 10 to 50 eligible employees and for dependent children only in Standard Plan Options 1, 2, 3, 5, and 6, and Voluntary Plan Options 1, 2, 3, 4, 5, and 6.

Packaged Dental/Life/Disability
☐ Plan ____________

Dental Out-of-State (OOS)
☐ 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	☐ $10,000	☐ $15,000	☐ $20,000	☐ $50,000
All Groups - Life & Disability Packaged Plan	☐ Low	☐ Medium	☐ High	
Additional options for Groups with 10 – 50 eligible employees	☐ $75,000	☐ $100,000	☐ $125,000	
Class Description	**Class 1**	**Class 2**	**Class 3**	
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.

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

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							

What is the normal work week you require a full-time employee to work to be eligible for coverage?	_______ hrs per week
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
Total number of eligible employees based on state law (must work a minimum of 30 hours per week)	
Total number of employees enrolling	
Total number of employees waiving	
Total number of employees in waiting period	
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 year?	☐ Medicare Primary ☐ Aetna Primary
Do you use the services of a Payroll Company? If yes, provide the name of the company. ______________________________	☐ Yes ☐ No
Are you currently a client company of a Professional Employer Organization (PEO)?	☐ Yes ☐ No
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

Prior Carrier Information

	Health	Dental	Life	Disability
Is this group transferring from another group carrier?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
If Yes, provide Carrier Name				
Effective Date of Coverage				
Proposed Termination Date				
Is this total replacement?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
If prior carrier Aetna, provide Group/Control Number				
Prior Carrier Deductible				
Dental Only – Prior coverage included, check all that apply:		☐ Major Services ☐ 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.
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.

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 ________________

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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Signature Section (Continued)

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.

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.

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, with intent to defraud or knowing that he/she is facilitating a fraud, submits an application or a statement of claim containing false or deceptive statement may be committing insurance fraud, which is a crime subject to civil and criminal penalties.

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.

APPLICABLE TO LIFE INSURANCE COVERAGE ONLY

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.

APPLICABLE TO HEALTH AND DENTAL COVERAGE ONLY

Participating physicians, hospitals and other health care providers are independent contractors and are neither agents nor employees of Aetna. 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 at its sole discretion subject to Texas small employer laws.

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 discretionary authority pursuant to all applicable state and Federal laws, 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.
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: ______________________ 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: ______________

For Aetna Use Only Group Number ________ Control Number ________ SCD ________ Effective Date ________