Ohio Small Group Business
Employer Application and Joinder Agreement

FOR GROUP COVERAGE (2 - 50 ELIGIBLE EMPLOYEES)

Life, Accidental Death & Dismemberment, Disability and Aetna Open Choice® PPO are underwritten by Aetna Life Insurance Company. Aetna Open Access HMO and Aetna Choice® POS (Open Access) plans are underwritten by Aetna Health Insurance Company and Aetna Health Inc. 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
Bill Address (if different than above)	City	State	ZIP
Company Contact Name and 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 ☐ LLC ☐ LLP ☐ Other: ______			
Nature of Business: ______	SIC Code: ______		

Effective Date

Requested effective date (may be the 1st or 15th of the month only): ______________. The actual effective date will be assigned by the Aetna underwriting department if the Joinder Agreement/Application is approved.

Medical Coverage Selection - Groups with 5 or more enrolled employees may offer two or three medical plans.

Aetna Choice® POS (Open Access) Plans –
Plan Option: ______________

Aetna Managed Choice® POS (Open Access) Plans –
Plan Option: ______________

Aetna Open Choice® PPO Plans –
Plan Option: ______________

Indemnity Plan –
Plan Option: ______________

Does this group qualify for the small employer exemption under Federal Mental Health Parity? ☐ Yes ☐ No

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

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

Dental Coverage Selection - Limited to one selection.

Aetna Dental™ Plans:

Standard Plans:
Option Number ______
Plan Option Name ______________

Voluntary Plans:
Option Number ______
Plan Option Name ______________

Out-of-State Plans:
Plan Option Name ______________

***Orthodontic coverage** is included in Standard Plan Options 1, 2, 5, and 7 and Voluntary Plan Options V1 and V2 for dependent children in groups with 10 or more eligible employees.*

Life, AD&D, Short Term Disability and Packaged Life & Disability Coverage Selections

Groups with 10 to 50 employees may select one, two or three options for Life, Short Term Disability and Packaged Life and Disability, with a minimum requirement of three employees in each option. 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:	☐ 10,000	☐ 15,000	☐ 20,000	☐ 50,000			
Groups with 10-50 eligibles:	☐ 75,000	☐ 100,000	☐ 125,000				
Life Disability Packaged Plan:	☐ Low	☐ Low 2	☐ Medium	☐ Medium 2	☐ High		
Short Term Disability:	☐ Option 1	☐ Option 2	☐ 100	☐ 200	☐ 300	☐ 400	☐ 500
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, as it becomes part of the issued Group Agreement and/or Group Policy.

Benefit Waiting Period (BWP)

Waive the waiting period for present employees enrolling with the group (even those who have not met the full waiting period).	☐ Yes ☐ No

Waiting period for future employees:

- ☐ 0 Days (eligible on the 1st day of employment)
- ☐ 30 Days (eligible on the 31st day)
- ☐ 60 Days (eligible on the 61st day)
- ☐ 30 Days (eligible on the 1st day of month following completion of the BWP)
- ☐ 60 Days (eligible on the 1st day of month following completion of the BWP)
- ☐ 90 Days (eligible on the 91st day)

Group Ownership Information – Optional

Check applicable boxes.
(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): ☐ African American or Black ☐ Hispanic or Latino ☐ Asian ☐ Other ______________

Business Eligibility

Is your company a subsidiary of another company, an affiliate of another company, or under common control with another company?	☐ Yes ☐ No
Does your company file state or federal taxes with another company(ies) on a combined or consolidated basis?	☐ Yes ☐ No
Are there any associated companies to be included that are commonly owned?	☐ Yes ☐ No

If Yes to any questions, complete the information below.

- 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?
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ 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?	☐ 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

Has your business been insured with Aetna within the past 12 months? If Yes, provide group number:	☐ Yes ☐ No
Do you use the services of a Payroll Company? If Yes, provide the name of the payroll company.	☐ Yes ☐ No
Are you currently a client company of a PEO (Professional Employer Organization)?	☐ Yes ☐ No
If Yes, - Provide the name of the PEO.	
- Is group coverage available to you as a client of a PEO?	☐ Yes ☐ No
- Is the group considered a Co-Employer with the PEO?	☐ Yes ☐ No
- By enrolling for coverage as a small employer I am not in violation of any contractual breach of contract with the PEO.	☐ Agree ☐ Disagree

Employer Eligibility/Employee Status

Work Location (list by state)	Full-time	Part-time	Retired	COBRA	1099	Union	Other (Temporary, substitute, seasonal, etc.)

Total number of eligible employees based on state law must work a minimum of 25 hours per week. Note: An employer may not set eligibility rules that would require an employee to work more than 25 hours a week to obtain small group coverage. As long as the employee meets the 25 hour per week standard they are considered full-time for purposes of coverage.

Total number of eligible employees		Total number of employees enrolling		Total number of employees waiving		Total number of employees in waiting period	

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
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 calendar year?	☐ Medicare Primary ☐ Aetna Primary

Employer Contribution(s)

	Medical	Dental	Voluntary Dental	Employee Life	Dependent Life	Disability	Packaged Life and Disability
Employer's Contribution for Employee					NA		
Employer's Contribution for Dependent				NA		NA	NA

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.	

Prior Carrier Information

	Health	Dental	Life	STD
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				
Did your plan have a deductible?	☐ Yes ☐ No	☐ Yes ☐ No		
Prior carrier deductibles:	☐ Individual $__________ ☐ Family $__________	☐ Individual $__________ ☐ Family $__________ ☐ Ortho Max $__________		
Dental Only – Prior coverage included, check all that apply:		☐ Major Services ☐ Orthodontia		

Ohio Cancellation Policy

Any group may cancel a signed agreement within seventy-two (72) hours after having signed the agreement to enroll under this plan. Cancellation occurs when written notice of the cancellation is given to the HMO or its agents or other representatives. A notice of cancellation mailed to the HMO shall be considered to have been filed on its postmark date.

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 (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.

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.

In accordance with current IRS regulations and the 1986 Tax Reform Act, a life insurance 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 schedule. Aetna disclaims any responsibility if the employer elects such a schedule and it is later deemed discriminatory.

The plan documents will determine the rights and responsibilities of member(s) and will govern in the event of conflicts 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.

With the exception of Aetna Rx Home Delivery®, participating physicians, hospitals and other health care providers are independent contractors and are neither agents nor employees of Aetna. Aetna Rx Home Delivery®, LLC, is a subsidiary of Aetna Inc.

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 is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

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.

continued

Signature Section (Continued)

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 understand the 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 or fraudulent statement 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. I certify that all information provided in this application is accurate and complete to the best of my knowledge and belief. 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.

JOINDER AGREEMENT - REQUEST FOR PARTICIPATION (for Life, Disability, Accidental Death and Dismemberment and out-of-state Medical and out-of-state Dental Employee Coverage): 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

______________________ ______________________

Print Name of Authorized Applicant — Date

Agent/Broker Certification

Broker Name: ______________________ SSN: ______________________

Agency Name: ______________________ TIN: ______________________

Pay commissions to: (check one) ☐ Broker ☐ Agency Phone Number: (   ) __________ Fax Number: (   ) __________

Address: ______________________ City: ______________________ State: ______ ZIP: ______

Signature: ______________________ Date: __________ E-Mail Address: ______________________ % of credit _____

Broker Name: ______________________ SSN: ______________________

Agency Name: ______________________ TIN: ______________________

Pay commissions to: (check one) ☐ Broker ☐ Agency Phone Number: (   ) __________ Fax Number: (   ) __________

Address: ______________________ City: ______________________ State: ______ ZIP: ______

Signature: ______________________ Date: __________ E-Mail Address: ______________________ % of credit _____

General Agent Name: ______________________ TIN: ______________________

Phone Number: (   ) ______________________ Fax Number: (   ) ______________________

Address: ______________________ City: ______________________ State: ______ ZIP: ______

Signature: ______________________ Date: __________ E-Mail Address: ______________________ % of credit _____

For Aetna Use Only

Group Number __________ Control Number __________ SCD __________ Effective Date __________

Is Agent/Agency licensed and appointed? ☐ Yes ☐ No Appointment Expiration Date __________