aetna®

Employer Application

Small Group Aetna Funding Advantage

Company Name (Legal Name)	DBA/Doing Business As (if applicable)		
Street Address (PO Box not acceptable)	City	State	ZIP
Billing Address (if different than above)	City	State	ZIP
Telephone Number ( )	Fax Number ( )		

Are there additional addresses/locations for this business? ☐ Yes ☐ No If "Yes," provide all addresses and locations.

Company Contact Name	Company Contact Email Address
Billing Contact Name (if different from Company Contact)	Billing Contact Email Address
Enrollment Contact Name (if different from Company Contact)	Enrollment Contact Email Address

Nature of Business	SIC Code	Federal Tax ID Number	Date Business Established (Mo/Yr):

Employer Classification ☐ Corporation ☐ Non-Profit ☐ Partnership ☐ Sole Proprietor ☐ LLC ☐ LLP
☐ Other: _____

Effective Date of Group Plan

The requested effective date is the 1st of the month. The actual effective date will be assigned by the Aetna underwriting department if the Application is approved. _____

Medical Coverage Selection

☐ Plan Option 1 ☐ Plan Option 2 ☐ Plan Option 3 ☐ Plan Option 4

10 to 100 eligible employees: Do you, or any third party on your behalf, in any way fund or subsidize any portion of the member's cost sharing responsibilities (deductibles, coinsurance or copays) under a high deductible health? ☐ Yes ☐ No
If yes, how much? _____ %

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

Benefit Waiting Period (BWP)

The eligibility date for enrollment will be the first day of the policy month following the waiting period unless you have selected "exactly 90 days". Policy month refers to the contract effective date of the 1st. Would you like to waive the benefit waiting period for the current employees enrolling with the group as of the initial contract effective date only? ☐ Yes ☐ No

Waiting period for future employees: ☐ 0 days ☐ 30 days ☐ 60 days ☐ exactly 90 days
If "exactly 90 days" is selected, the enrollment eligibility date will begin 90 calendar days following the date of hire.
If "0" days is selected and the employee is hired on the 1st of the month, the effective date will be the date of hire.

Is a dual waiting period offered? ☐ Yes ☐ No
If Yes, provide the two classes of employees below:
Class 1 Waiting Period Class 1 Name _____ Class 2 Waiting Period Class 2 Name _____

Employer Contribution(s)

Employer Contribution for Employee		Employer Contribution for Dependent	

Employer Eligibility/Employee Status

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

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 employees waiving		Total number of employees in benefit waiting period	
Classes Excluded: ☐ None ☐ Union – Local # _____		Domestic Partners: ☐ Same Sex ☐ Opposite Sex ☐ None	

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 or is eligible to file state or federal taxes with another company(ies) on a combined or consolidated basis?	☐ Yes ☐ No
Are there any other entities associated with the group that are eligible to file a combined tax return under section 414 of the IRS?	☐ Yes ☐ No
Are there any associated companies to be included with this group 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 ID Number	Address	Owner's Name(s)	% of Ownership	Number of Employees	Is group to be included
						☐ Yes ☐ No
						☐ Yes ☐ No
						☐ 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 tax filings 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? If yes, provide the name of the payroll company.	☐ Yes ☐ No
Are you a Professional Employer Organization (PEO)?	☐ Yes ☐ No
Are you currently a client of a Professional Employer Organization (PEO)?	☐ Yes ☐ No

If yes	Provide the name of the PEO.	
	Is group coverage available to you as a client of a PEO?	☐ Yes ☐ No

Medicare Primary versus Secondary

Is your group Medicare Primary (employed less than 20 employees for 20 consecutive weeks in the current or prior year); or Aetna Primary (employed 20 or more employees for 20 consecutive weeks in the current or prior year). Include: Full-time, Part-time, Seasonal, Temporary, Union, Owners, Partners, Officers Exclude: Self-employed persons, Independent contractors (1099), Directors, Leased employees	☐ Medicare Primary ☐ Aetna Primary
How many full-time and part-time employees have you employed for 20 or more weeks during this calendar year or prior calendar year?	
100 or More Employees – Disabled Provision: How many full-time and part-time employees did you employ on 50% or more of your business days during the prior calendar year?	

COBRA

Is your employer group required to comply with COBRA regulation?			☐ Yes ☐ No
How many full and part-time employees did you employ 50% 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.*			
How many employees have terminated in the last 90 days?			
Are any present or former employees/dependents currently on or eligible to elect COBRA? If Yes, enter information below. Attach a separate sheet if necessary.			
Name of Applicant	**Qualifying Event (e.g., termination of employment, divorce, etc.)**	**Date of Qualifying Event**	**Date COBRA Coverage Terminates**

Workers' Compensation

Does company offer Workers' Compensation?	☐ Yes ☐ No

Prior Carrier Information

If the Aetna plan is replacing an existing medical plan, submit a copy of the current bill with employee roster.

Carrier Name	**Telephone Number**	**Start Date**	**End Date**
Has your business ever been insured with Aetna? If yes, provide group number. _____			☐ Yes ☐ No
Is this plan total replacement of any existing group medical plans? Number of carriers or third party administrators within the past 5 years: _____			☐ Yes ☐ No

Signature Section

Employer Acknowledgment – Employer Waiting Period

Starting with plan years on or after 1/1/2014, the Affordable Care Act and subsequent federal regulations prohibit group health plans and health insurance issuers from requiring any otherwise eligible plan participants and beneficiaries (employees and dependents) to wait more than ninety (90) days before their health coverage is effective. The regulations define group health plan as the employer or plan administrator. The issuer is defined 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 ninety (90) day waiting period is honored. However, if neither party complies, both are subject to penalty.

The Employer Group Policyholder ("Employer") represents that it provides to Aetna effective date information regarding plan participants and beneficiaries that takes into account the eligibility conditions and waiting period requirements required under federal law, in order for such plan participants and beneficiaries to become eligible for coverage under the Employer's group health insurance coverage with Aetna. In compliance with the waiting period requirements, Aetna shall use the effective date information provided by Employer to enroll such 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 part of your participation date, the following terms and conditions apply:

1. You agree to keep copies (paper or electronic) of actual enrollment forms and 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. For electronic enrollment submissions or changes, you agree to create and maintain the records on secure information systems that can generate hard copy records of enrollments or changes entered or maintained on those information systems. Any hard copy records generated pursuant to this provision shall meet reasonable standards of availability, authenticity, non-repudiation and integrity.
3. You represent that all enrollment and eligibility information presented to Aetna is accurate and timely updated. You acknowledge that Aetna can and will rely on such enrollment and eligibility information in determining whether an individual is eligible for benefits under the plan. In the event of a discrepancy between enrollee information (including salary data) submitted and information actually presented by the enrollee on any particular claim for benefits, and the result is that Aetna must pay a higher benefit to reflect the actual information presented by the enrollee, you agree to pay promptly to Aetna applicable back premiums accruing as of the date on which the enrollee's information changed.
4. You are responsible for adhering to all applicable laws and regulations when submitting terminations to Aetna.
5. If otherwise permitted, when retro-terminations are submitted, we will regard the submission as verification that no premium/contribution was paid by the member/dependent for that period.

Billing/Payment: You agree to receive your bill online each month. Any contractual provisions related to non-payment of amounts due continue to be applicable. I/we 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: Plan sponsor agrees that each employee will agree to terms associated with the issuance and use of his/her 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. If an individual to whom a password has been issued becomes aware of a security breach (an incident in which there occurs attempted or unauthorized access, use, disclosure, modification, or destruction of information or interface with system operations), they agree to contact Aetna**.**

SUMMARY OF BENEFITS – PLEASE READ AND CHECK BELOW TO CONFIRM

☐ In accordance with my contract with Aetna to distribute information related to enrollment/coverage information, I have received the Summary of Benefits and Coverage document associated with the plan information referenced in this application. I confirm I will provide SBCs to plan participants and beneficiaries in compliance with the federal regulation and guidance related to SBCs, including the requirements for timing and delivery

Aetna Funding Advantage Self-Funded Banking Consent Form

Aetna shall be authorized to debit Customer's bank account specified below. This will be done monthly utilizing an ACH Debit to cover the total amount of Customer's monthly liabilities and/or late charges. The amount drawn will be deposited into an account at Citibank which shall be in the name of ALIC (Aetna Life Insurance Company) for Customer listed below. This is done in compliance with the Master Services Agreement ("MSA"). The Customer will instruct their bank to accept such ACH Debit transfer requests.

Customer Name: _____ **Effective Date:** _____

Customer Banking Information / Authorized to ACH Debit

Bank Name: _____

Bank Account Number: _____

ACH Routing (ABA) Number: _____

Customer Contacts

	Contact #1	**Contact #2**
Name (Printed):		
Title:		
Telephone Number:		
Email: :		

Administrative Services Only Agreement

In accordance with Section 503 of Title I of The Employee Retirement Income Security Act of 1974, as amended ("ERISA"), Aetna Life Insurance Company ("Aetna"), and subsidiaries and affiliates of Aetna to the extent specifically designated as such by Aetna, are hereby designated as the Named Fiduciary(ies) under the Aetna Funding Advantage Plan(s) ("Plan") with complete authority to review all denied claims for benefits under the Group's Contract (including but not limited to the denial of certification of the medical necessity of hospital or medical treatment). In exercising such fiduciary responsibility, Aetna and any such designated subsidiaries and affiliates shall have discretionary authority to determine whether and to what extent participants and beneficiaries are entitled to benefits, and to construe disputed or doubtful Plan terms. Aetna and any such designated subsidiaries and affiliates shall be deemed to have properly exercised such authority unless they have abused their discretion hereunder by acting arbitrarily and capriciously.

Subrogation Information Section

Is the group ERISA qualified?	☐ Yes ☐ No

Rawlings Subrogation Reporting Package
Rawlings offers self-funded plan sponsors and/or Aetna Account Managers access to their Client Reporting Website.

The quarterly reporting package includes:

- **Activity Summary** – Results of the current reporting period compared to year-to-date
- **Open File Report** – A detailed listing, by patient, of all files currently being pursued.
- **Detailed Report of Subrogation Recoveries** – This report is a detailed listing of each recovery by patient.
- **Closed File Report** – A detailed listing of all files closed without recovery.
- **Non-Cooperation Report** – This report summarizes data for members who have not responded to at least three letters of inquiry.

Quarterly subrogation reports can be viewed or printed.

These reports contain protected health information under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). By submitting this form, you are certifying that you are authorized to receive this information.

Once you have filled out the authorization form, you will receive an email from Rawlings with your login credentials and detailed instructions on how to use the website.

Please Print ALL Information:

Group Number: _____

Group Name: _____

Contact Requesting Access: _____

Email Address: _____

Recovery Fees

Is the group self-funded for Workers' Compensation?	☐ Yes ☐ No
Does customer have any other governing plan documents (i.e., master plan document or wrap document)?	☐ Yes ☐ No

If yes, Rawlings does not normally provide recovery services for workers' compensation matters involving employees of self-funded groups. Any election by the customer to use Rawlings for employee Workers' Compensation recoveries must be documented to show that the customer confirms that election and agrees to the subrogation service fee.

Please indicate whether the group is interested in this service. ***NOTE* Aetna contracts with The Rawlings Company (Rawlings), an experienced, national supplier of third-party recovery services, to perform subrogation/reimbursement services. Rawlings will provide services for Workers' Compensation Matters involving employees of self-funded groups when Aetna is the stop loss carrier and has paid claims as part of the stop loss policy.**	☐ **Yes** ☐ **No**

The Aetna Funding Advantage medical plan is self-funded, meaning the benefits are financed by the employer and/or employee contributions rather than through insurance purchased from a health insurance company. The plan is established pursuant to the Employee Retirement Income Security Act of 1974 (ERISA). The group contracts with a claims administrator, Aetna, to process pre-authorization requests and post-service claims, arrange the contracted provider networks and provide other administrative services for the Group.

Employer Authorization to Send Communications Electronically

Employer authorizes Aetna to send communications electronically to person enrolled in Employer's plan. Employer represents that its employees have access to email where they work. Aetna will send communications by paper to enrollees who so request in writing.	☐ Yes ☐ No

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. 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 any agreement between Applicant and Aetna.

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

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.

I certify that all information provided in this application is accurate and complete to the best of my knowledge and belief. I understand that Aetna intends to rely on the information provided in this application. By my signature below, I agree to be bound by the terms and conditions of the Master Services Agreement.

All data that may have a bearing on any amounts due under Master Services Agreement will be open for Aetna to inspect while the Master Services Agreement is in force.

This information, as well as other personal and privileged information, subsequently collected by the insurance institution or agent may, in certain circumstances, be disclosed to third parties without authorization. A right of access and correction exists with respect to all personal information collected. Personal information may be collected from persons other than the individual or individuals proposed for coverage.

I hereby apply for the coverage(s) indicated above. I understand that Aetna may choose not to accept this application. 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 any applicable laws. I understand that my failure to comply with any such request may also result in termination of Master Services Agreement increased fees under that agreement, or other consequences. Any person who knowingly and with intent to defraud 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 (location) City, State	Applicant (Company Name)	
Authorized Applicant Signature	Official Title	
Print Name of Authorized Applicant		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, for all products being applied for including life insurance, if applicable. 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.

TPA – Vendor Name: _____

Broker Name:			
SSN:			National Producer Number:
Agency Name:			Tax ID Number:
Address:			Pay Commissions To (check one): ☐ Broker ☐ Agency
City:			Telephone Number:
State:	ZIP:	% of Credit:	Fax Number:
Signature:			Date:
Broker Admin Assistant Name:			Broker Email Address:
Admin Email Address:			
Broker Name:			
SSN:			National Producer Number:
Agency Name:			Tax ID Number:
Address:			Pay Commissions To (check one): ☐ Broker ☐ Agency
City:			Telephone Number:
State:	ZIP:	% of Credit:	Fax Number:
Signature:			Date:
Broker Admin Assistant Name:			Broker Email Address:
Admin Email Address:			
General Agent Name:			Tax ID Number:
Selling Agent Name			Email Address:
Address:			Telephone Number:
City:	State:	ZIP:	Fax Number:
GA Admin Assistant Name:			General Agent Email Address:
Admin Email Address:			