

# California Small Group Employer Application

FOR GROUP COVERAGE (1 - 100 EMPLOYEES)

## PENDING REGULATORY APPROVAL

"Aetna" is a brand name used for products and services provided by one or more of the Aetna group of subsidiary companies. Aetna Life Insurance Company underwrites Aetna Vision<sup>SM</sup> Preferred plans, Elect Choice EPO plans, and Managed Choice POS plans. Aetna Health of California Inc. underwrites HMO plans. Aetna Dental of California Inc. and Aetna Life Insurance Company provide Aetna Dental plans. For Vision coverage, First American Administrators, Inc. provides certain claims administration services. EyeMed Vision Care LLC ("EyeMed") provides certain network administration services.

1. Employer information

Company name (legal name)	Doing bus	Doing business as (if applicable)				
Street address (PO box not acceptable)	City	City		ZIP code		
Billing address (if different than above)	City	City State ZIF				
Phone number ( )	Fax numb	ax number ( )				
Company contact – name and title	,	Company contact email				
Billing contact name (if different from company contact)  Online statements are available. Activate access to your eBusiness acc  www.aetna.com/pspregister when you get your approval letter.	count at	Billing contact email				
Nature of business SIC co	ode	Federal tax ID numbe	Date busi (Month/Y	iness established ear):		
Employer classification: Corporation Nonprofit Partnership Sole proprietor LLC LLP  Other:						
2. Effective date of group plan The actual effective date will be as	signed by the Aetn	a underwriting departme	ent if the application	on is approved.		
Requested effective date:						

## 3. Medical coverage selection

	oic!	k 10	plans fro	m Aetna	(employer can	pick a ma	eximum of 1	10 plans f	for current a	and future hires)
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l		HMO Plans
	HMO Platinum CA \$20/40 0	AWH Southern CA HMO Platinum CA \$20/40 0
	☐ HMO Gold CA \$25/50 500	AWH Southern CA HMO Gold CA \$25/50 500
	☐ HMO Gold CA \$25/65 1250	AWH Southern CA HMO Gold CA \$25/65 1250
I	☐ HMO Gold CA \$30/60 0	☐ AWH Southern CA HMO Gold CA \$30/60 0
I	☐ HMO Gold CA \$35/65 0	☐ AWH Southern CA HMO Gold CA \$35/65 0
ĺ	☐ HMO Silver CA \$50/70 0	☐ AWH Southern CA HMO Gold CA \$35/55 250 M
I	☐ HMO Silver CA \$60/100 2500	☐ AWH Southern CA HMO Silver CA \$50/70 0
ĺ	☐ HMO Bronze CA \$75/125 8550	☐ AWH Southern CA HMO Silver CA \$55/90 2500 M
ĺ	☐ HMO Bronze CA \$60/95 6300 M	☐ AWH Southern CA HMO Silver CA \$60/100 2500
ĺ	☐ Aetna Value Network HMO Platinum CA \$20/30 0 M	AWH Southern CA HMO Bronze CA \$75/125 8550
ĺ	☐ Aetna Value Network HMO Platinum CA \$20/40 0	☐ AWH Northern CA HMO Platinum CA \$20/30 0 M
ĺ	☐ Aetna Value Network HMO Gold CA \$25/50 500	☐ AWH Northern CA HMO Platinum CA \$20/40 0
I	Aetna Value Network HMO Gold CA \$25/65 1250	AWH Northern CA HMO Gold CA \$25/50 500
	Aetna Value Network HMO Gold CA \$30/60 0	AWH Northern CA HMO Gold CA \$25/65 1250
ĺ	Aetna Value Network HMO Gold CA \$35/65 0	AWH Northern CA HMO Gold CA \$30/60 0
ĺ	☐ Aetna Value Network HMO Gold CA \$35/55 250 M	AWH Northern CA HMO Gold CA \$35/65 0
ĺ	☐ Aetna Value Network HMO Silver CA \$50/70 0	☐ AWH Northern CA HMO Gold CA \$35/55 250 M
	☐ Aetna Value Network HMO Silver CA \$55/90 2500 M	☐ AWH Northern CA HMO Silver CA \$50/70 0
ĺ	☐ Aetna Value Network HMO Silver CA \$60/100 2500	AWH Northern CA HMO Silver CA \$55/90 2500 M
	☐ Aetna Value Network HMO Bronze CA \$75/125 8550	☐ AWH Northern CA HMO Silver CA \$60/100 2500
	AWH Southern CA HMO Platinum CA \$20/30 0 M	AWH Northern CA HMO Bronze CA \$75/125 8550
l	Open Acces	ss Managed Choice Plans
l	OA Managed Choice POS Platinum CA 90/50 0 M	Savings Plus OA Managed Choice POS Platinum CA 90/50 0 M
l	OA Managed Choice POS Platinum CA 80/50 250	Savings Plus OA Managed Choice POS Platinum CA 80/50 250
l	OA Managed Choice POS Gold CA 80/50 350 M	Savings Plus OA Managed Choice POS Gold CA 80/50 350 M
l	OA Managed Choice POS Gold CA 75/50 500	Savings Plus OA Managed Choice POS Gold CA 75/50 500
l	OA Managed Choice POS Gold CA 70/50 1250	Savings Plus OA Managed Choice POS Gold CA 70/50 1250
l	OA Managed Choice POS Gold CA 80/50 1500	Savings Plus OA Managed Choice POS Gold CA 80/50 1500
l	OA Managed Choice POS Gold HDHP CA 90/50 3200 HSA	☐ Savings Plus OA Managed Choice POS Gold HDHP CA 90/50 3200 HSA
l	OA Managed Choice POS Silver CA 60/50 2100	Savings Plus OA Managed Choice POS Silver CA 60/50 2100
l	OA Managed Choice POS Silver CA Plan 65/50 2500 M	Savings Plus OA Managed Choice POS Silver CA Plan 65/50 2500 M
l	OA Managed Choice POS Silver CA 65/50 2600	Savings Plus OA Managed Choice POS Silver CA 65/50 2600
l	OA Managed Choice POS Bronze CA 55/50 5500	Savings Plus OA Managed Choice POS Bronze CA 55/50 5500
l	OA Managed Choice POS Bronze CA 50/50 8300	Savings Plus OA Managed Choice POS Bronze CA 50/50 8300
l	OA Managed Choice POS Bronze HDHP CA 100 7050 HSA M	Savings Plus OA Managed Choice POS Bronze HDHP CA 100 7050 HSA M
l	Oper	n Choice PPO Plan
l	Open Choice PPO Gold CA 80/50 1000	Open Choice PPO Bronze CA 50/50 8300
l	Open Choice PPO Silver CA 60/50 2100	Open Choice PPO Bronze CA 55/50 5500
	Are you a religious employer that meets the California qualifications a	and would like to exclude coverage for preventive contraceptives? Yes $\Box$ No $\Box$
		GIFT benefits will be added to all medical plans for the entire group at an additional
	premium.	
	Yes: Infertility Rider	
١	No: Infertility Rider	

Please note when employees are enrolling that wherever the term spouse appears it will be construed to include Domestic Partner.

Please keep a copy of this application for your records. If Aetna accepts this application, it becomes part of the issued Group Agreement and/or Group Policy.

4. Dental coverage s (Not available to gro		le as standalone or i	n addition to other Aetna co	verage.			
Aetna Dental® Plan	· · · · · · · · · · · · · · · · · · ·						
All dental plans are							
			🗌 Voluntary				
	•	~	e for insureds under age 19 i	•			
Employees in AZ, CA enroll in the DMO®.	A, GA, MA, MD, MO	, NC, NJ and TX mu	st either live or work with	in the approved DMO® s	ervice area	a to be	eligible to
			n addition to other Aetna co	verage. (Not available to g	groups of o	ne.)	
Aetna Vision <sup>SM</sup> Prefe	•	·					
Pediatric vision for ins	sureds under age 19	is included in all med	dical plans.				
6. Prior carrier infor	mation			T			
	Il replacement for a group plans?	iny	Carrier name	Phone number	Start d	late	End date
Current medical carr	rier 🗌 Yes [	☐ No					
Current dental carrie	er 🗌 Yes [	□ No					
My current group dent	•	0 (	apply): and basic	ces	thodontic r	nax \$	
Has your business ev	er been insured with	Aetna? If <b>yes</b> provid	le group number:				☐ Yes ☐ No
7. Business eligibili	tv						
	•	ountability Act of 1996	6 (HIPAA) states that all per	sons treated as a single e	mplover		
			nal Revenue Code of 1986				
I certify my business(e subsection (b), (c), (m			test for being a commonly-covenue Code of 1986.	ontrolled group as defined	d under		Yes No
			e are no other affiliated entition of the are no other affiliated entitions.		sted		
Business names of A	•	<u> </u>	<u> </u>				
including the compa		Tax identification				Num	ber of eligible
are being written un	der	number	Ov	vner's name			employees
Does your company h	ave branch offices o	or is your office a brai	nch 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
		th offices are there?	,				<u> </u>
	- Are taxes filed se	eparately or as one co	ommon filing?				parately ne common filing
	- Where is each br	ranch located? (List e	each branch business addre	ss separately.)		Numb	per of employees each location

Continued on next page

7. Business eligibili	ty (Continuea)						
Do you use the service	es of a payroll com	pany?					es 🗌 No
If yes	- Provide the nam	e of the payroll com	npany:				
Are you currently a clie	ent of a profession	al employer organiza	ation (PEO)?			☐ Ye	es 🗌 No
If yes	- Provide the name of the PEO:						
	- Is group health coverage available to you as a client of the PEO?						es 🗌 No
	- If <b>yes</b> , you are r	ot eligible for small	group coverage	9.			
Are you a professional	l employer organiza	ation (PEO)?					es 🗌 No
If yes	- Are you an exist	ting Aetna customer	that is a PEO?	Aetna group number:			es 🗌 No
	- Do you offer hea	alth coverage to you	r clients under	your PEO plan?			es 🗌 No
	- Are any of your	clients enrolling und	ler this health p	lan?			es 🗌 No
	- Are you only cov	vering the administra	ative staff of the	PEO?			es 🗌 No
8. Participation							
How many hours a we	ek must your empl	oyees work to be eli	igible for covera	age?			
•	· · · · · · · · · · · · · · · · · · ·	•	-	m hours to be eligible for o	coverage)		
Number of employees	enrolling			Number of employees w invalid waivers)	aiving Aetna coverage (va	alid and	
Number of full-time en	nployees excluding	union employees		Number of employees w List all states outside of	•		
Number of part-time e	mployees			Number of employees no	ot actively at work		
Number of 1099 emplo	oyees			Number of COBRA/Cal-0	COBRA continuees		
Number of union empl	oyees			Number of employees in	waiting period and not eli	gible	
Revenue Code.  A. FTEs from full-time	e employees. Numl	ber of full-time empl	oyees working	e "Shared Responsibility for on average 30 hours or m	ore a week (or 130 hours		
month) for more th	an 120 days a yea	r (even if they are n	ot eligible or en	rolling for health coverage	<b>)</b> .		
				30 hours a week, but more	e than 120 days a year.		
				rees and divide by 30.) (rounding down to the nea	rest whole number)		
C. Total number of F	·			(	,		
10. COBRA/Cal-COE	BRA/TEFRA/DEF	'RA					
Is your group subject t		Cal-COBRA?					
Include: full time, Exclude: self-employ Each part-time employ	part time, seasona ployed persons, ind ree counts as a fra	al, temporary, union, dependent contracto ction of an employe	owners, partne ors (1099), direct e, with the fract	ctors ion equal to the number of	·		
	esent or former em	ployees/dependents	s are eligible to	elect COBRA or Cal-COB			
•	<u> </u>			ch a separate sheet, if nee			
				in COBRA or Cal-COBRA			
termination of employment, COBRA/ Date of COBRA/Ca					coverage /Cal-COBRA		
Name of ap	phicalit	divorce,	eic.j	Cal-COBRA?	qualifying event	ter	minates
				☐ Yes ☐ No			
				☐ Yes ☐ No			
				☐ Yes ☐ No			
		•		•	•		

11. Medicare primary versus secondary	
How many full-time and part-time employees have you employed for at least 20 or more weeks during this calendar year or	
prior calendar year?	
Include: full time, part time, seasonal, temporary, union, owners, partners, officers	
Exclude: self-employed persons, independent contractors (1099), directors	
If you employed fewer than 20 employees for 20 weeks in this calendar year or prior calendar year, your group is Medicare	
primary.	
If you employed 20 or more employees for 20 weeks in this calendar year or prior calendar year, your group is Aetna primary.	

### 12. Average number of employees in prior calendar year

Enter number
here:

# 13. Eligibility waiting period

The eligibility date will be the first day of the policy month after the waiting period for 0, 30 or 60 days. An eligibility waiting period of 90 days will begin the day after 90 calendar days has been completed. Policy month refers to the contract effective date of the first or fifteenth of the month.					
If "0 days" is selected and the employee is hired on the first day of the month, the effective date will be the date of hire.  If "90 days" is selected, the enrollment eligibility date will begin the day after 90 calendar days have been completed.					
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)?					
Waiting period for future employees: First day of policy month following: 0 days 30 days 60 days  OR 90 days (eligibility date is the day after 90 days is completed)					

## 14. Employer premium contributions

Coverage	Medical	Dental	
Employer premium contribution for employee	\$ or	%	%
Employer premium contribution for dependent	\$ or	%	%

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### 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, permanent full-time employee (working an average of 30 hours a week over the course of a month), or a
  permanent part-time employee (working 20-29 hours a week), is eligible for coverage, unless otherwise specifically provided in the Group
  Agreement/Group Policy or required by federal/state law.
- 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.

- 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 **Aetna.com**.
- Participating physicians, hospitals and other health care providers are independent contractors. They are neither agents nor employees of Aetna.
- 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.
- Attention California residents: I understand Aetna will rely on the information I provide to determine:
  - Eligibility for coverage
  - Setting premium rates
  - Compliance with applicable laws
  - Other purposes

If Aetna demonstrates that I have acted fraudulently or intentionally misrepresented material facts, Aetna may rescind the policy or may increase premiums after giving me at least 30 days prior notice by certified mail. However, after 24 months following the issuance of the policy, Aetna will not rescind the policy for any reason and will not cancel the policy, limit the policy, or raise premiums due on the policy due to omission, misrepresentation or inaccuracies in the application, whether willful or not. Aetna does not base its eligibility rules on any of the following factors:

- A. Health status
- B. Medical condition, including physical and mental illnesses
- C. Claims experience
- D. Receipt of health care
- E. Medical history
- F. Genetic information
- G. Evidence of insurability, including conditions arising out of acts of domestic violence
- H. Any other health status-related factor as determined by any federal regulations, rules or guidance issued pursuant to Section 2705 of the federal Public Health Service Act

### Signature section (Continued)

• I understand that by December first of each year, Aetna will notify Aetna Medicare members of all benefit and premium changes effective as of January first of the following calendar year.

#### **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.

- 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
  - Agree to incorporate the following four points into my 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.

**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.

NOTICE: California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.

For your protection, California law requires notice of the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Traduction column for the payment of a 1000 to gainly of a crimic and may be cabject to fined and commented in cate prices.
SUMMARY OF BENEFITS AND COVERAGE (SBC) FOR GROUP HEALTH PLAN – PLEASE READ. YOU MUST CHECK BELOW TO CONFIRM:
In accordance with my contract with Aetna to distribute information related to enrollment / coverage information,
☐ I have ☐ I have not
received the Summary of Benefits and Coverage document ( <a href="https://www.aetna.com/sbcsearch/home">https://www.aetna.com/sbcsearch/home</a> ) associated with the plan information
referenced in this application. I confirm I have provided SBCs to plan participants and beneficiaries in compliance with the federal regulations and
guidance, including the requirements for timely delivery, on this date (MM/DD/YYYY). For information on the SBC regulations
and distribution requirements, please review the regulations at the HHS website: http://cciio.cms.gov/resources/other/index.html#sbcug.

Signature section (Continued)

SUMMARY OF DENTAL BENEFITS AND COVERAGE (SDBC) FOR GROUP DENTAL PLAN - PLEASE READ. YOU MUST CHECK BELOW TO

CONFIRM (only required if selecting dental):						
In accordance with my contract with Aetna to distribute information related to enro	Ilment/coverage information,					
☐ I have ☐ I have not	,					
received the Summary of Dental Benefits and Coverage document (www.aetnade	entalsdbc.com) associated with the plan in	nformation referenced in this				
application.						
I confirm I have provided SDBCs to plan participants and beneficiaries in compliar	nce with the California Department of Man	aged Health Care and				
Department of Insurance regulations and guidance, including the requirements for	timely delivery, on this date	(MM/DD/YYYY).				
Electronic Communication Opt-In						
If you elect to receive electronic notifications, you will receive this notice in an e	electronic (email) format.					
<ul> <li>☐ Yes, I elect to receive electronic notifications.</li> <li>☐ No, I elect not to receive electronic notifications.</li> </ul>						
Your choice to receive electronic notifications is voluntary.						
<ul> <li>Contact your agent or contact us at <u>www.aetna.com</u></li> </ul>						
<ul> <li>To opt in or opt out of receiving electronic communications at any time</li> </ul>						
<ul> <li>To report a change or correction in your email address</li> </ul>						
Signed at city, state	Applicant (company name)					
Authorized applicant signature	Official title					
Print name of authorized applicant		Date				

## Agent or broker certification and attestation

Phone: Address:

Signature\*:

GA admin assistant name:

\*I hereby certify that I am licensed to sell Aetna products in the state of California.

I hereby certify that I have advised the applicant 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 attestation (print name), attest to the following: 1. The information on the application is complete and accurate; and 2. I explained to the applicant, in easy-to-understand language, the risk to the applicant of providing inaccurate information and that the applicant understood the explanation. If you, as the agent or broker, willfully state as true any material fact(s) that you know to be false, you will, in addition to any applicable penalties or remedies available under current law, be subject to a civil penalty of up to ten thousand dollars (\$10,000). Agent or broker signature: Agent or broker name: TIN: National producer number (NPN): Agency name: Pay commissions to (check one): Broker ☐ Agency % of credit: Phone: Address: City: State: ZIP: Signature\*: Date: Email: Broker admin assistant name: Broker admin assistant email: \*I hereby certify that I am licensed to sell Aetna products in the state of California. Agent or broker name: Agency name: National producer number (NPN): Broker Pay commissions to (check one): Agency % of credit: Phone: ZIP: Address: City: State: Signature\*: Date: Email: Broker admin assistant email: Broker admin assistant name: \*I hereby certify that I am licensed to sell Aetna products in the state of California. TIN: General agent name: Email: Selling agent:

City:

GA admin assistant email:

State:

Date:

ZIP: