



Georgia Small Group Business Employer Application

FOR GROUP COVERAGE (2-99 ELIGIBLE EMPLOYEES)

Life, Accidental Death & Dismemberment, Disability and Aetna PPO plans are provided by Aetna Life Insurance Company. Aetna HMO and in-network portion of POS plans are provided by Aetna Health Inc. Out-of-network portion of Aetna POS plans are provided by Aetna Health Insurance Company. Dental plans are provided by Aetna Life Insurance Company except DMO® dental coverage which is provided by Aetna Health Inc.

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: <input type="checkbox"/> Corporation <input type="checkbox"/> Non-Profit <input type="checkbox"/> Partnership <input type="checkbox"/> Sole Proprietor <input type="checkbox"/> LLC <input type="checkbox"/> LLP <input type="checkbox"/> Other: _____ <input type="checkbox"/> SIC Code: _____			

Medical Coverage Selection

Dental Coverage Selection

<p>HMO Open Access - Plan: <input type="checkbox"/> 903 <input type="checkbox"/> 905 <input type="checkbox"/> 912 <input type="checkbox"/> 913 <input type="checkbox"/> 931 <input type="checkbox"/> 944 <input type="checkbox"/> 945</p> <p>POS Open Access - Plan: <input type="checkbox"/> 901 <input type="checkbox"/> 902 <input type="checkbox"/> 903 <input type="checkbox"/> 904 <input type="checkbox"/> 912 <input type="checkbox"/> 913 <input type="checkbox"/> 914 <input type="checkbox"/> 921 <input type="checkbox"/> 922 <input type="checkbox"/> 932 <input type="checkbox"/> 933 <input type="checkbox"/> 934 <input type="checkbox"/> 941 <input type="checkbox"/> 943</p> <p>MC Open Access - Plan: <input type="checkbox"/> 902 <input type="checkbox"/> 904 <input type="checkbox"/> 905 <input type="checkbox"/> 912 <input type="checkbox"/> 913 <input type="checkbox"/> 914 <input type="checkbox"/> 922 <input type="checkbox"/> 932 <input type="checkbox"/> 933 <input type="checkbox"/> 942 <input type="checkbox"/> 943 <input type="checkbox"/> 945</p> <p>PPO - Plan: <input type="checkbox"/> 903</p> <p>Indemnity - Plan: <input type="checkbox"/> 900</p> <p>Is employer, plan sponsor or a third party funding any of the deductible? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, how much? _____</p> <p>Does this group have a flex plan under Section 125 of the Internal Revenue Service Code? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>Aetna Dental™ Plan</p> <p>Standard Plans: Option Number: _____ Plan Option Name: _____</p> <p>Voluntary Plans: Option Number: _____ Plan Option Name: _____</p> <p>Out-of-State PPO Plans: Plan Option Name: _____</p> <div style="border: 1px solid black; padding: 5px; margin-top: 10px;"> <p>Orthodontia coverage for dependent children is included in Standard Options 1, 2, 3, 5 and 6 and Voluntary Options 1, 2, and 3 and is available only to groups with 10 or more eligible employees.</p> </div>
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Life, Short Term Disability and Packaged Life & Disability Coverage Selections

Groups with 10 to 50 eligible employees may select one, two or three options for Life, Accidental Death & Dismemberment 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.) Groups of 51 – 99: Contact your Aetna Account Executive.

All Groups	<input type="checkbox"/> 10,000	<input type="checkbox"/> 15,000	<input type="checkbox"/> 20,000	<input type="checkbox"/> 50,000
Groups with 10 - 50 eligible employees	<input type="checkbox"/> 75,000	<input type="checkbox"/> 100,000	<input type="checkbox"/> 125,000	
Life & Disability Packaged Plan (Available for groups 2-50 eligible employees only)	<input type="checkbox"/> Low 1	<input type="checkbox"/> Low 2	<input type="checkbox"/> Medium 1	<input type="checkbox"/> Medium 2 <input type="checkbox"/> High
STD	<input type="checkbox"/> Option 1	<input type="checkbox"/> Option 2	<input type="checkbox"/> 100	<input type="checkbox"/> 200 <input type="checkbox"/> 300 <input type="checkbox"/> 400 <input type="checkbox"/> 500
Class Description	Class 1	Class 2	Class 3	
Optional Dependent Term Life (10 to 50 eligible employees only): <input type="checkbox"/> Yes <input type="checkbox"/> 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.

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

Requested effective date (may be the first 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 _____

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 any other company(ies) on a combined or consolidated basis?	<input type="checkbox"/> Yes <input type="checkbox"/> No
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 checked for any of the above questions, complete and submit Aetna's Associated Companies Form.	
Has your business been insured with Aetna within the past 12 months? If Yes, provide group number. _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you use the services of a Payroll Company? If Yes, provide the name of the payroll company. _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you currently a client of a PEO (Professional Employer Organization)?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Employer Eligibility/Employee Status

Work Location (list by state)	Number of Employees						Other (Temporary, substitute, seasonal, etc.)
	Full-time	Part-time	Retired	COBRA	1099	Union	
Total							
What is the normal work week you require a full-time employee to work to be eligible for coverage?							_____ hours 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.							<input type="checkbox"/> Yes <input type="checkbox"/> No
Total number of eligible employees based on state law (must work a minimum of 25 hours per work).							
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 calendar year)?							<input type="checkbox"/> Medicare Primary <input type="checkbox"/> Aetna Primary

Employer Contribution(s)

Coverage	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

Benefit Waiting Period

The 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). Yes No

Waiting period for future employees: 0 Days 30 Days 60 Days 90 Days 120 Days 180 Days 365 Days

Will you provide a dual waiting period? Yes No

If Yes, provide the two classes of employees below.
Class 1 _____ Class 2 _____

Prior Carrier Information

	Health	Dental	Life	Disability
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 and Telephone Number				
Effective Date of Coverage				
Proposed Termination Date				
If prior carrier is Aetna, provide Group/Control Number				
Dental Only – Prior coverage included, check all that apply:		<input type="checkbox"/> Major Services <input type="checkbox"/> Orthodontia		

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 Agreement and/or Group Policy). 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 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.

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 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.

continued on back

Signature Section (Continued)

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.

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.

Signed at (Location): _____
 City, State _____ Applicant (Company Name) _____

 Authorized Applicant Signature _____ Print Name of Authorized Applicant _____

 Official Title _____ 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.

Broker Name:			Social Security Number:
Agency Name:			Tax ID Number:
Address:			Pay Commissions To (check one): <input type="checkbox"/> Broker <input type="checkbox"/> Agency
City:			Telephone Number: ()
State:	ZIP:	% of Credit:	Fax Number: ()
Signature:			Date: Email Address:
Broker Name:			Social Security Number:
Agency Name:			Tax ID Number:
Address:			Pay Commissions To (check one): <input type="checkbox"/> Broker <input type="checkbox"/> Agency
City:			Telephone Number: ()
State:	ZIP:	% of Credit:	Fax Number: ()
Signature:			Date: Email Address:
General Agent Name:			Social Security Number:
Address:			Telephone Number: ()
City:			Fax Number: ()
State:	ZIP:	% of Credit:	Email Address:
Signature:			Date: