



# California Small Group Business Employer Application

FOR GROUP COVERAGE (1 - 100 EMPLOYEES)

## PENDING REGULATORY APPROVAL

**TO COMPLY WITH CALIFORNIA LAW, WHEREVER THE TERM "SPOUSE" APPEARS  
IT SHALL BE CONSTRUED TO INCLUDE DOMESTIC PARTNER.**

"Aetna" is a brand name used for products and services provided by one or more of the Aetna group of subsidiary companies. Life and Accidental Death & Personal Loss (AD&PL), Aetna Vision<sup>SM</sup> Preferred plans, Aetna Indemnity plans, Aetna EPO plans, Aetna PPO plans and Aetna MC plans are underwritten by Aetna Life Insurance Company. Aetna HMO plans are underwritten by Aetna Health of California Inc. Dental plans are provided by Aetna Dental of California Inc. and Aetna Life Insurance Company. For Vision coverage, certain claims administration services are provided by First American Administrators, Inc. and certain network administration services are provided through EyeMed Vision Care LLC ("EyeMed").

### 1. Employer information

Company name (legal name)		Doing business as (if applicable)	
Street address (PO box not acceptable)		City	State      ZIP code
Billing address (if different than above)		City	State      ZIP code
Phone number      (      )		Fax number      (      )	
Company contact – name and title		Company contact email	
Billing contact name (if different from company contact) <i>Online statements are available. Activate access to your eBusiness account at <a href="http://www.aetna.com/employersregister">www.aetna.com/employersregister</a> when you get your approval letter.</i>		Billing contact email	
Nature of business	SIC code	Federal tax ID number	Date business established (Month/Year):
Employer classification: <input type="checkbox"/> Corporation <input type="checkbox"/> Nonprofit <input type="checkbox"/> Partnership <input type="checkbox"/> Sole proprietor <input type="checkbox"/> LLC <input type="checkbox"/> LLP <input type="checkbox"/> Other: _____			

### 2. Effective date of group plan      The actual effective date will be assigned by the Aetna underwriting department.

Requested effective date (may be the first or fifteenth of the month only): _____
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**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.**

**3. Medical coverage selection – Pick 5 (employer can pick a maximum of 5 plans for current and future hires)**

Comprehensive infertility coverage is included in all plans. Do you wish to decline this coverage? Yes <input type="checkbox"/> No <input type="checkbox"/>				
Plan choices by network				
HMO	Platinum	Gold	Silver	Bronze
HMO Full HMO Network		<input type="checkbox"/> \$25/55 0 Ded		
HMO Deductible Network	<input type="checkbox"/> \$15/30 0 Ded	<input type="checkbox"/> \$25/55 0 Ded <input type="checkbox"/> \$20/50 250 Ded	<input type="checkbox"/> \$35/75 0 Ded <input type="checkbox"/> \$45/75 2000 Ded	<input type="checkbox"/> \$70/115 5500 Ded
HMO Aetna Value Network (AV)	<input type="checkbox"/> \$15/30 0 Ded	<input type="checkbox"/> \$25/55 0 Ded <input type="checkbox"/> \$20/50 250 Ded	<input type="checkbox"/> \$35/75 0 Ded <input type="checkbox"/> \$45/75 2000 Ded	<input type="checkbox"/> \$70/115 5500 Ded
HMO Basic Network	<input type="checkbox"/> \$15/30 0 Ded	<input type="checkbox"/> \$25/55 0 Ded <input type="checkbox"/> \$20/50 250 Ded	<input type="checkbox"/> \$35/75 0 Ded <input type="checkbox"/> \$45/75 2000 Ded	<input type="checkbox"/> \$70/115 5500 Ded <input type="checkbox"/> \$75/105 6300 Ded
Open Access Managed Choice (MC)	Platinum	Gold	Silver	Bronze
MC Full Network		<input type="checkbox"/> 0 80/50 <input type="checkbox"/> 750 80/50	<input type="checkbox"/> 1250 60/50 <input type="checkbox"/> 2000 Copay	<input type="checkbox"/> 6800 50/50 <input type="checkbox"/> 4800 60/50 HSA <input type="checkbox"/> 6550 100/50 HSA
MC Savings Plus Network	<input type="checkbox"/> 0 90/50	<input type="checkbox"/> 0 80/50 <input type="checkbox"/> 750 80/50	<input type="checkbox"/> 1250 60/50 <input type="checkbox"/> 2000 Copay	<input type="checkbox"/> 6800 50/50 <input type="checkbox"/> 4800 60/50 HSA <input type="checkbox"/> 6550 100/50 HSA
PPO	Platinum	Gold	Silver	Bronze
PPO Full Network		<input type="checkbox"/> 750 80/50		
Aetna Whole Health Networks	Platinum	Gold	Silver	Bronze
MemorialCare ACO EPO Plans		<input type="checkbox"/> 750 80%	<input type="checkbox"/> 2000 60%	<input type="checkbox"/> 6800 50%
MemorialCare ACO MC Plans			<input type="checkbox"/> 1250 60/50	<input type="checkbox"/> 4800 60/50 HSA
PrimeCare HMO plans		<input type="checkbox"/> \$20/50 250 Ded	<input type="checkbox"/> \$35/75 0 Ded	<input type="checkbox"/> \$70/115 5500 Ded
PrimeCare EPO Plans		<input type="checkbox"/> 750 80%	<input type="checkbox"/> 2000 60%	<input type="checkbox"/> 6800 50%
PrimeCare MC Plans			<input type="checkbox"/> 1250 60/50	<input type="checkbox"/> 4800 60/50 HSA
Providence Health & Services ACO EPO Plans		<input type="checkbox"/> 750 80%	<input type="checkbox"/> 2000 60%	<input type="checkbox"/> 6800 50%
Providence Health & Services ACO MC Plans			<input type="checkbox"/> 1250 60/50	<input type="checkbox"/> 4800 60/50 HSA

**4. Dental coverage selection (Pediatric dental is included with all medical plans.)** Available as standalone or in addition to other Aetna coverage. (Not available to groups of one.)

**Aetna Dental® Plan**  
 **Non-voluntary dental plan(s):** Option \_\_\_\_\_  **Voluntary dental plan(s):** Option \_\_\_\_\_  
*Pediatric dental and medically necessary orthodontia coverage for insureds under age 19 is included in all medical plans.*

**5. Vision coverage selection – Available as standalone or in addition to other Aetna coverage.** (Not available to groups of one.)

Aetna Vision<sup>SM</sup> Preferred – Plan option name \_\_\_\_\_

**6. Life and accidental death and personal loss (AD&PL) coverage selection**

- Groups with 2 to 9 eligible employees are limited to one class.
- Groups with 10 to 100 eligible employees may select one, two, or three classes.

<b>Life and AD&amp;PL for groups with 2 to 9 eligible employees</b>	<input type="checkbox"/> 10,000	<input type="checkbox"/> 15,000	<input type="checkbox"/> 20,000	<input type="checkbox"/> 50,000
<b>Life and AD&amp;PL for groups with 10 to 100 eligible employees</b>	<input type="checkbox"/> 10,000 <input type="checkbox"/> 75,000	<input type="checkbox"/> 15,000 <input type="checkbox"/> 100,000	<input type="checkbox"/> 20,000 <input type="checkbox"/> 125,000	<input type="checkbox"/> 50,000
<b>Optional dependent term life for groups with 10 to 100 eligible employees</b> <input type="checkbox"/> Yes <input type="checkbox"/> No				
<b>Class description</b>	<b>Class 1:</b>	<b>Class 2:</b>	<b>Class 3:</b>	

**7. Business eligibility**

Is your company a subsidiary of another company, an affiliate of another company, or under common control with another company?  
 The Health Insurance Portability and Accountability Act of 1996 (HIPAA) states that all persons treated as a single employer under subsection (b), (c), (m), or (o) of section 414 of the Internal Revenue Code of 1986 shall be treated as one employer.  Yes  No

Does your company file state or federal taxes with another company or other companies on a combined or consolidated basis?  Yes  No

Are there any associated companies to be included that are commonly owned?  Yes  No

Are multiple companies or multiple addresses to be included under this plan?  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 names of ALL groups including the company the groups are being written under	Tax identification number	Owner's name(s)	Percentage of ownership	Number of employees	Is group to be included?
					<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
					<input type="checkbox"/> Yes <input type="checkbox"/> No

If you have answered **no** to "Is the group to be included" above, explain why.

Is your company a branch of another company?  Yes  No

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 \_\_\_\_\_

Continued on next page

**7. Business eligibility (Continued)**

Do you use the services of a payroll company?		<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>If yes</b>	- Provide the name of the payroll company:	
	- Is group health coverage available to you as a client of the payroll company?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you a professional employer organization (PEO)?		<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>If yes</b>	- Is this an Aetna PEO?      Aetna group number: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
	- Do you offer health coverage to your clients under your PEO plan?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	- Are any of your clients enrolling under this health plan?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	- Are you only covering the administrative staff of the PEO?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you currently a client of a professional employer organization (PEO)?		<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>If yes</b>	- Provide the name of the PEO:	
	- Is group health coverage available to you as a client of the PEO?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>If no</b>	- Provide a letter from the PEO indicating health coverage is not available.	

**8. Participation**

How many hours a week must your employees work to be eligible for coverage?		
Number of employees eligible for coverage (employees working the minimum hours to be eligible for coverage)		
Number of employees enrolling		Number of employees waiving Aetna coverage (valid and invalid waivers)
Number of full-time employees excluding union employees		Number of employees working outside California List all states outside of California _____
Number of part-time employees		Number of employees not actively at work
Number of 1099 employees		Number of COBRA / CalCOBRA continuees
Number of union employees		Number of employees in waiting period and not eligible

**9. Full time equivalents for the prior calendar year**

The "full-time equivalent" (FTE) employee counting method in 26 U.S.C. 4980H(c)(2) must be utilized to determine group size for medical coverage. This method is the same calculation used to determine employer liability under the "Shared Responsibility for Employers" provisions of the ACA and Internal Revenue Code.

A. FTEs from full-time employees. Number of full-time employees working on average 30 hours or more a week (or 130 hours a month) for more than 120 days a year (even if they are not eligible or enrolling for health coverage).	
B. FTEs from part-time employees, i.e., who worked on average less than 30 hours a week, but more than 120 days a year. (Add up the total number of hours worked in a week by part-time employees and divide by 30. Example: 10 employees working 20 hours a week: $200 \div 30 = 6.66 = 6$ (rounding down to the nearest whole number)	
C. Total number of FTEs = A + B.	

**10. COBRA / Cal-COBRA / TEFRA / DEFRA**

Is your group subject to: <input type="checkbox"/> COBRA <input type="checkbox"/> Cal-COBRA?				
How many full-time and part-time employees did you employ 50 percent of the business days in the prior calendar year? <i>Include: full time, part time, seasonal, temporary, union, owners, partners, officers</i> <i>Exclude: self-employed persons, independent contractors (1099), directors</i> 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.				
Eligible: How many present or former employees / dependents are eligible to elect COBRA or Cal-COBRA? These present or former employees / dependents must be listed below. Attach a separate sheet, if necessary.				
Enrolled: How many present or former employees / dependents are enrolled in COBRA or Cal-COBRA? These present or former employees / dependents must be listed below. Attach a separate sheet, if necessary.				
Name of applicant	Qualifying event (e.g., termination of employment, divorce, etc.)	Have they elected COBRA / Cal-COBRA?	Date of qualifying event	Date coverage COBRA / Cal-COBRA terminates
		<input type="checkbox"/> Yes <input type="checkbox"/> No		
		<input type="checkbox"/> Yes <input type="checkbox"/> No		
		<input type="checkbox"/> Yes <input type="checkbox"/> 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 the current 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 the current or prior year, your group is Medicare primary.  
 If you employed 20 or more employees for 20 weeks in the current or prior year, your group is Aetna primary.

**12. Total average number of employees** – To calculate average number of employees, determine the number of employees for each month, add each month’s number to get an annual total, and then divide by 12. Round up or down to the nearest whole number – example: 24.6 = 25. Do not spell out the number – example: write 3, not three.

What is the average number of employees you employed for the entire previous calendar year regardless of whether or not they were eligible for coverage? An employee is defined as any person for whom the company issues a W-2, including full time, part time, and seasonal workers, and regardless of insurance eligibility.

The determination of how to count employees of related corporate entities when calculating group size for medical loss ratio (MLR) purposes is based on whether the entities are considered a single employer under Section 414 of the Internal Revenue Code (subsection (b), (c), (m), or (o)) – and is not based on the multiple tax identification status of the related entities.

**13. Benefit waiting period (BWP)**

The eligibility date for enrollment of a new employee will be the first or fifteenth of the month following the number of days designated by the group.  
**Benefit waiting period may not exceed 90 days between the date of hire and the date the coverage takes effect.**

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 the group has a fifteenth day of the month bill cycle, the new hire will be effective on the fifteenth day of the month after the waiting period chosen.

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)?  Yes  No

Benefit waiting period for future employees: First day of policy month following:  0 days - A date of hire effective date is not allowed.  
 30 days  60 days  
 exactly 90 days following date of hire

**14. Employer contribution(s) – Check one:**  Percentage or  Dollar amount

Coverage	Medical	Dental	Life	AD&PL
Employer's contribution for employee				
Employer's contribution for dependent				NA

**15. Prior carrier information**

Is this plan total replacement for any existing group plans?	Carrier name	Phone number	Start date	End date
<b>Current medical carrier</b> <input type="checkbox"/> Yes <input type="checkbox"/> No				
<b>Current life / AD&amp;PL carrier</b> <input type="checkbox"/> Yes <input type="checkbox"/> No				
<b>Current dental carrier</b> <input type="checkbox"/> Yes <input type="checkbox"/> No				

My current group dental plan has the following (check all that apply):  
 Discount dental  Preventive only  Preventive and basic  Major services  Orthodontia – ortho max \$ \_\_\_\_\_

Be sure and submit a copy of the most recent dental benefit summary to receive credit for major and ortho coverage.

Has your business ever been insured with Aetna? If **yes** provide group number: \_\_\_\_\_  Yes  No

**16. 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, permanent full-time employee (working 30 hours a week or more), or a permanent part-time employee (working 20-29 hours a week, if coverage is offered).

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 plan coverage 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 plan coverage and the applicable plan documents.

Applicant has selected, in accordance with applicable law, the plan to be offered to Applicant’s employees and Applicant has solely determined any/all 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.

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## 16. Signature section (Continued)

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.

**Attention California residents:** 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. 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 60 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.

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 but only to the extent permitted by law.

Geographic area, age and family size affect coverage or premiums and will be open for Aetna to inspect while the plan coverage 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, dental or vision care services and, therefore, cannot guarantee any results or outcome.

I hereby apply for the coverage(s) indicated above. I affirm that all information provided in this application is accurate and complete to the best of my knowledge or 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. I understand that Aetna may choose not to accept this application but only to the extent permitted by law.

Applicant understands 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.

**JOINDER AGREEMENT – REQUEST FOR PARTICIPATION** (For life and accidental death and personal loss): 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 U.S. Bank National Association, 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 listed 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.

### **EMPLOYER ACKNOWLEDGMENT – EMPLOYER WAITING PERIOD**

Starting with plan years on or after January 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.

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**16. Signature section (Continued)**

**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 will furnish Aetna with accurate and timely updated enrollment and eligibility information. 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. Insured plans must either (1) use Aetna-supplied forms in paper format or electronic format or (2) agree to incorporate the following four points into your enrollment materials.
  - a. Names(s) of the Aetna company offering the insurance coverage
  - b. State-specific fraud warning statement
  - c. A statement that the terms of the insurance documents will govern the member's rights and responsibilities
  - d. An acknowledgment that participating providers are not agents or employees of Aetna and that network composition can change.
5. You are 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, 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 premium 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:** The undersigned employer 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.

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

**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 (<https://www.aetna.com/sbcsearch/home>) 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 timely delivery. 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>.

**CALIFORNIA HMO APPLICANTS — NOTICE OF BINDING ARBITRATION — ANY DISPUTE ARISING FROM OR RELATED TO THE GROUP AGREEMENT WILL BE DETERMINED BY SUBMISSION TO BINDING ARBITRATION, AND NOT BY A LAWSUIT OR RESORT TO COURT PROCESS EXCEPT AS CALIFORNIA LAW PROVIDES FOR JUDICIAL REVIEW OF ARBITRATION PROCEEDINGS. THE AGREEMENT TO ARBITRATE INCLUDES, BUT IS NOT LIMITED TO, DISPUTES INVOLVING ALLEGED PROFESSIONAL LIABILITY OR MEDICAL MALPRACTICE, THAT IS, WHETHER ANY MEDICAL SERVICES COVERED BY THE GROUP AGREEMENT WERE UNNECESSARY OR WERE UNAUTHORIZED OR WERE IMPROPERLY, NEGLIGENTLY OR INCOMPETENTLY RENDERED.**

**THIS AGREEMENT ALSO LIMITS CERTAIN REMEDIES AND MAY LIMIT THE AWARD OF PUNITIVE DAMAGES. SEE SECTIONS "BINDING ARBITRATION" AND "LIMITATIONS ON REMEDIES" OF THE EVIDENCE OF COVERAGE FOR FURTHER INFORMATION.**

**THE UNDERSIGNED REPRESENTATIVE OF THE EMPLOYER UNDERSTANDS THAT THE EMPLOYER AND ANY GROUPS ELIGIBLE THROUGH THE EMPLOYER, IF DIFFERENT FROM THE EMPLOYER, AND ANY MEMBERS WHO ENROLL UNDER THIS HEALTH PLAN ARE GIVING UP THEIR CONSTITUTIONAL RIGHT TO HAVE ANY SUCH DISPUTE DECIDED IN A COURT OF LAW BEFORE A JURY, AND INSTEAD ARE ACCEPTING THE USE OF BINDING ARBITRATION. THIS MEANS THAT THE EMPLOYER, GROUPS, MEMBERS AND OTHER INTERESTED PARTIES WILL NOT BE ABLE TO TRY THEIR CASE IN COURT. THE UNDERSIGNED REPRESENTATIVE OF THE EMPLOYER FURTHER UNDERSTANDS AND ACCEPTS THAT THE EMPLOYER, GROUPS AND MEMBERS ARE GIVING UP CERTAIN REMEDIES AND THERE MAY BE CERTAIN LIMITATIONS TO THE RECOVERY OF PUNITIVE DAMAGES.**

Signed at city, state	Applicant (company name)
Authorized applicant signature	Official title
Print name of authorized applicant	Date

**Agent or broker certification and attestation**

I hereby certify that, to the best of my knowledge, the information on this application is complete and accurate and that I have explained to the applicant, in easy-to-understand language, the risk to the applicant of providing inaccurate information and the applicant understood the explanation. I hereby represent that I am licensed and appointed to sell Aetna group 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 being 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**

I, \_\_\_\_\_ (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: \_\_\_\_\_

<b>Agent or broker name:</b>		Agency name:	
Social Security number/TIN:		National producer number (NPN):	
% of credit:	Phone:	Fax:	
Address:	City:	State:	ZIP:
<b>Signature:</b>	Date:	Email:	
Broker admin assistant name:		Broker admin assistant email:	
<b>Agent or broker name:</b>		Agency name:	
Social Security number/TIN:		National producer number (NPN):	
% of credit:	Phone:	Fax:	
Address:	City:	State:	ZIP:
<b>Signature:</b>	Date:	Email:	
Broker admin assistant name:		Broker admin assistant email:	
General agent name:		TIN:	
Email:		Selling agent:	
Phone:		Fax:	
Address:	City:	State:	ZIP:
GA admin assistant name:		GA admin assistant email:	