



# APPLICATION FOR A SMALL GROUP HEALTH BENEFITS POLICY

Please Print or Type

For Aetna Use Only

New Policy  Change in Policy

Requested Effective Date \_\_\_\_\_

Policy Number \_\_\_\_\_

**NOTE:** The Effective Date will be on or after the date Aetna approves the application.

## Section I: POLICYHOLDER INFORMATION

1. Policyholder (Full Legal Name of Company)		2. Tax Identification Number	
3. Main Address: Street		City	State ZIP
Mailing Address: Street		City	State ZIP
Telephone Number ( )	Facsimile Number ( )	Email Address	
4. Name of Correspondent			Telephone
5. Type of Organization <input type="checkbox"/> Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Proprietorship <input type="checkbox"/> Other (explain):			
6. Nature of Business (specify)			SIC Code
7. Number of eligible employees in your company  <b>Refer to the New Jersey Small Employer Certification for the definition of an eligible employee.</b>			
8. Number of eligible employees to be insured		9. Class or classes to be excluded	
10. Insurance requested for <input type="checkbox"/> Employees Only <input type="checkbox"/> Employees and Dependents Should the plan provide coverage for domestic partners as permitted by P.L. 2003, c.246? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", should the plan provide coverage for children of a covered domestic partner? <input type="checkbox"/> Yes <input type="checkbox"/> No			
11. Is the Employer subject to the requirements of COBRA? <input type="checkbox"/> Yes <input type="checkbox"/> No			
12. Is the employer subject to the requirements of Medicare as Secondary Payor Rules for eligibility due to age? <input type="checkbox"/> Yes <input type="checkbox"/> No disability? <input type="checkbox"/> Yes <input type="checkbox"/> No			
13. Waiting period before employees become insured (may not exceed 6 months): Current Employees: _____ New or Rehired Employees: _____			
14. What percentage of the premium will the employer pay?			
15. Deposit \$ _____ Premium Paid: Monthly		Premium will be due as of the effective date. The premium for the first month of coverage must be attached.	
<b>Affiliates, subsidiaries or branches (must be included for the purposes of participation)</b>			
<b>Legal Name and Location</b>		<b>No. Eligible Employees In This Company</b>	<b>No. Eligible Employees to Be Insured</b>

**Section II: SPECIFICATIONS FOR COVERAGE**

**Health Benefits:**

<input type="checkbox"/> NJ HMO:	Plan Option - _____ RX Option - _____	<input type="checkbox"/> NJ Cost-Sharing POS No Referral:	Plan Option - _____ RX Option - _____
<input type="checkbox"/> NJ HMO No-Referral:	Plan Option - _____ RX Option - _____	<input type="checkbox"/> NJ POS HSA Compatible No Referral:	Plan Option - _____ RX Option - _____
<input type="checkbox"/> NJ Cost-Sharing HMO:	Plan Option - _____ RX Option - _____	Plan Administration:	<input type="checkbox"/> CalYr <input type="checkbox"/> PlnYr
<input type="checkbox"/> NJ Cost-Sharing HMO No Referral:	Plan Option - _____ RX Option - _____	<input type="checkbox"/> NJ PPO Basic Hospital	
<input type="checkbox"/> NJ HMO HSA Compatible No Referral:	Plan Option - _____ RX Option - _____	<input type="checkbox"/> NJ PPO First Dollar	
Plan Administration:	<input type="checkbox"/> CalYr <input type="checkbox"/> PlnYr	<input type="checkbox"/> NJ PPO HSA Compatible:	Plan Option - _____
<input type="checkbox"/> NJ POS:	Plan Option - _____ RX Option - _____	<input type="checkbox"/> Out-of-State/Situs PPO Plans:	
<input type="checkbox"/> NJ POS No-Referral:	Plan Option - _____ RX Option - _____	<input type="checkbox"/> \$250 (High) <input type="checkbox"/> \$500 (Medium) <input type="checkbox"/> \$1,000 (Low)	
<input type="checkbox"/> NJ Cost-Sharing POS:	Plan Option - _____ RX Option - _____	<input type="checkbox"/> Standard Health Benefits Plans:	
		<input type="checkbox"/> NJ HMO:	Plan Option - _____ RX Option - _____
		<input type="checkbox"/> NJ POS:	Plan Option - _____ RX Option - _____
		<input type="checkbox"/> NJ Indemnity:	Plan Option - _____
		<input type="checkbox"/> Other Plan _____	

If you have selected an HSA-compatible plan:

- Do you plan on making contributions to your employee's HSA accounts?  Yes  No
- Do you plan to offer your employees payroll deductions to fund their HSA accounts?  Yes  No

**Section III: ALL QUESTIONS MUST BE ANSWERED**

1. Is there any Group Health Plan:
  - now in force and to be continued?  Yes  No
  - currently being applied for?  Yes  No
 If "Yes", identify the name of the Group Health Plan, give a description of the plan(s) and the name of insurance carrier(s):  
 \_\_\_\_\_
2. Name of present or prior group carrier \_\_\_\_\_  
 Effective date of prior coverage \_\_\_\_\_ Cancellation/Termination Date \_\_\_\_\_  
 Is the coverage applied for in this application replacing other group insurance?  Yes  No  
 If "Yes" give reason \_\_\_\_\_  
 Plan being replaced  A  B  C  D  E  HMO  HMO/POS  Dual Contract POS  
 Other \_\_\_\_\_
3. Has your firm been uninsured for 3 or more months prior to application?  Yes  No
4. What forms of Insurance are now or were in force?  Health Benefits  Prescription Drugs  
 (Attach copies of Booklet/Certificate and most recent Billing Statement.)
5. Are extended benefits provided in case of termination of health benefits?  Yes  No
6. To the best of your knowledge, are there any current or former employees or their eligible dependents whose health insurance is being continued?  Yes  No

**Please provide the following information for each current/former employee or dependent on health continuations.**

If additional space is needed, attach a separate sheet, signed and dated.

Name of Employee/ Dependent	Date of Birth	Type of Continuation State/Federal/ Extended Benefits	Reason for Termination Disability/Other	Continuation Dates	
				Start	End

**Section III: ALL QUESTIONS MUST BE ANSWERED (continued)**

7. To the best of your knowledge:
- a. Are any employees or dependents presently incapacitated?  Yes  No
  - b. Are any dependent children incapable of self-support due to a physical or mental disability?  Yes  No

Additional space to explain if items 1, 2 or 3 were answered "Yes". Refer to the question number, and give details, including names, where appropriate.

8. Does the employer participate in an arrangement with a Professional Employer Organization?  Yes  No  
(Refer to Advisory bulletin 00-SEH-02 if you need information concerning what constitutes a Professional Employer Organization.)

**Section IV: AGENT/PRODUCER INFORMATION**

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

Agent/Broker Name: \_\_\_\_\_ Aetna Agent Number/Tax ID/SSN: \_\_\_\_\_  
Agency Name: \_\_\_\_\_ % of Credit: \_\_\_\_\_  
Phone Number: (\_\_\_\_) \_\_\_\_\_ Fax Number: (\_\_\_\_) \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_  
Signature: \_\_\_\_\_ Date: \_\_\_\_\_ E-Mail Address: \_\_\_\_\_

Agent/Broker Name: \_\_\_\_\_ Aetna Agent Number/Tax ID/SSN: \_\_\_\_\_  
Agency Name: \_\_\_\_\_ % of Credit: \_\_\_\_\_  
Phone Number: (\_\_\_\_) \_\_\_\_\_ Fax Number: (\_\_\_\_) \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_  
Signature: \_\_\_\_\_ Date: \_\_\_\_\_ E-Mail Address: \_\_\_\_\_

General Agent Name: \_\_\_\_\_ Aetna Agent Number/ID Number: \_\_\_\_\_  
Phone Number: (\_\_\_\_) \_\_\_\_\_ Fax Number: (\_\_\_\_) \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_  
Signature: \_\_\_\_\_ Date: \_\_\_\_\_ E-Mail Address: \_\_\_\_\_

**Section V: SIGNATURE**

It is understood that, except as provided under applicable regulations, no individual shall become insured while not actively at work on a full-time basis, and only full-time employees are eligible. A full-time employee is one who regularly works at least 25 hours per week at his employer's place of business.

It is further understood that no agent has power on behalf of Aetna Health Inc. and Aetna Life Insurance Company to make or modify any request or application for insurance or to bind Aetna Health Inc. and Aetna Life Insurance Company by making any promise or representation or by giving or receiving any information.

It is further understood that no insurance will be effective unless and until the application is accepted in writing by Aetna Health Inc. and Aetna Life Insurance Company. Final rates will be based on enrollment data as of the Policy effective date. No contract of insurance is to be implied in any way on the basis of the completion and/or submission of this application.

Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

Date at \_\_\_\_\_ on \_\_\_\_\_

Print Name of Officer, Partner or Proprietor \_\_\_\_\_

Signature of Officer, Partner or Proprietor \_\_\_\_\_

Witness to Signature \_\_\_\_\_

Note: If there are any modifications to the statements and answers given in this application (i.e., crossed out, whited-out, erased information), the applicant must attest to the modifications by giving a complete signature in the margin near the modification.