Small Employer Cover Sheet & Checklist
New Business Case Information

Aetna Small Group Underwriting
4300 Centreway Place, Arlington, TX 76018
P.O. Box 91507 ● Arlington, TX 76015-0007
Phone (866) 899-4379 ● Fax (877) 362-0870

Case Name		**Date Submitted** (MM/DD/YY)	
Broker Name		**Broker Phone Number**	( )
Broker Physical Address			
City		**State**	**Zip Code**
Broker Email Address		**Broker Fax Number**	( )
Proposed Effective Date (MM/DD/YY)			

SUBMISSION DATE

All new cases with 2 to 50 employees are preferred to be received by Aetna on or before the 5th business day prior to the requested effective date. Cases will be accepted until the last day of the month prior to the effective date. If a cutoff deadline occurs on a weekend, all new cases sold need to be received on the preceding Friday. If incomplete information is provided or if the submission is not complete until after the cut-off date, the case could be assigned a later effective date.

REQUIRED FOR NEW BUSINESS

☐	**Employer Master Application**	Must be completed, signed and dated by employer
☐	**Copy of Sold Rates**	Must be signed by the employer and attached to the new case submission
☐	**Employer Disclosure**	Appropriate Disclosure Form based on plan selected for TX must be signed and dated by the employer
☐	**50/50 Benefit Description Form**	50/50 Benefit Description form signed and dated by the employer
☐	**Enrollment/Change Form/ Medical Questionnaire**	Original copy completed & signed by **each employee** enrolling for coverage & any continuees.*

*If a spouse is enrolling, a **signature** must be included on the enrollment form & medical questionnaire

☐ Employees waiving/declining coverage must complete the waiver section of the Enrollment/Change form. If coverage is being waived due to other coverage, the carrier name, telephone number and group number must be listed.

☐ Copy of most recent **Quarterly Wage and Tax Statement (QWTS)** containing the names, salaries, etc. of all employees of the employer group.

- The QWTS must be signed and dated by the owner or officer of the company unless filed electronically. If filed electronically, please provide a copy of the electronic validation.
- Employees who have terminated or work part-time must be noted accordingly on the QWTS. Terminated employees must have the date of termination listed on the QWTS.
- Newly-hired employees not listed on the QWTS must provide the first and last month's payroll stub and registry/summary for each employee.

☐ Sole Proprietor, Partners or Corporate Officers not reported on the Quarterly Wage and Tax form must submit a completed **Small Employer (2-50) Proof of Eligibility Form**. Also, as identified on the form, additional supporting documentation must be submitted.

☐ If group coverage currently exists, a **copy of the most recent prior carrier bill** must be provided. Individuals contained on the bill should match those listed on the wage and tax statement. If not, please indicate on the bill why they are not on the wage and tax.

☐ A **check** on company check stock for 100% of the first month's medical, dental, STD and life premiums payable to "Aetna Health Management, L.L.C." (Aetna's receipt of the check does not guarantee acceptance of the group)

☐ **Copy of the sold proposal** including rates and plan design(s).

☐ **Verify contribution and participation requirements** by product.

GENERAL INFORMATION

①	If applying for PPO or Indemnity medical, please list the prior carrier individual deductible		$
②	If applying for dental, does dental coverage currently exist?	☐ **YES**	☐ **NO**
③	If yes and prior plan includes Orthodontia, please provide the prior plan Ortho Max		$
④	Please note that additional documentation may be required (Common ownership, newly formed business, etc.)		

BROKER / GENERAL AGENT COMMENTS

Broker Signature		**Date (MM/DD/YY)**	
GA Signature		**Date (MM/DD/YY)**	

All paperwork is enclosed and my submission is complete. I understand incomplete paperwork could delay the effective date of coverage.

Plan Sponsor Signature		**Date (MM/DD/YY)**	

This submission does not constitute approval. Please do not cancel or change your existing health coverage until you receive formal approval from Aetna.

14.03.947.1-SW (3/06)

Proof of Eligibility Form

Small Employers with 50 or fewer eligible employees
Sole Proprietors, Partners or Corporate Officers
(To be used for eligible individuals that are not reported on a quarterly wage and tax form)

Full Name (First, MI, Last)	Phone No.
Title	Percentage of Ownership in Firm
Date of Hire	Number of hours worked per week
Company Name	

In order to satisfy the Small Employer Requirements for Proof of Eligibility, *the following most recent IRS Tax documents are required*. (Anyone eligible must appear on the below documents .)

Please check one of the following:	**Must submit one of the following identified documents :**
❑ C-Corporation	? W2
❑ S-Corporation	? IRS Form 1120 S Schedule K-1 along with Schedule E (Form1040)
❑ Partnership	? IRS Form 1065 schedule K-1; or ? IRS Form 1120S Schedule K1 along with Schedule E (Form1040)
❑ Limited Liability Company (LLC)	? May file as either C Corporation or Partnership
❑ Sole Proprietor	? IRS Schedule SE and Schedule C filed with Form 1040; or ? IRS Form 1040 Schedule F or K1

I attest that while I am not listed on the state quarterly wage and tax statement for this company, the following are true (check applicable boxes):

❑ 1. I am a sole proprietor, partner or corporation officer of the company indicated above.

❑ 2. I am actively at work at this company on a full time, permanent basis working no less than the minimum number of hours required by the applicable State Laws.

❑ 3. I draw wages, compensation, dividends or other distributions from this company on a regular basis and do not derive substantial earned income from any other employment.

❑ 4. I have satisfied the designated waiting period before health insurance coverage is to become effective.

❑ 5. I am a retiree of the above company and qualify for benefits under their guidelines.
(Retiree coverage is only available in states where mandated. Maine and New Hampshire - all groups. Florida and Illinois - municipalities only.)

I understand this information may be subject to audit and agree to provide Aetna and/or its affiliates, with any and all information and documentation necessary to validate the above statements. I also understand that any misrepresentation by me of my true circumstances may result in the termination of group health coverage from Aetna and/or its affiliates, for me, my enrolled dependents and or this company as Aetna and/or its affiliates may choose. Aetna and/or its affiliates also expressly reserve any other rights and remedies.

It is unlawful to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

Signature _____ Date _____

Aetna®

Texas Employer Application

FOR GROUP COVERAGE:
Large Employer – 51 or more employees
Small employer – 2 – 50 employees

**** You have the option to choose this Consumer Choice of Benefits Health Insurance Plan or Health Maintenance Organization health care plan that, either in whole or in part, does not provide state-mandated health benefits normally required in accident and sickness insurance policies or evidences of coverage in Texas. This standard health benefit plan may provide a more affordable health insurance policy or health plan for you although, at the same time, it may provide you with fewer health or health plan benefits than those normally included as state-mandated health benefits in Texas. If you choose this standard health benefit plan, please consult with your insurance agent to discover which state-mandated health benefits are excluded in this Policy or evidence of coverage.**

Life, Accidental Death & Dismemberment, Disability and Aetna PPO Plan, Aetna Savings Plus Plan and Aetna Indemnity Plan are underwritten by Aetna Life Insurance Company. Aetna HMO Plans and Aetna HNOnly Plans are underwritten by Aetna Health Inc. Aetna HNOption Plans are underwritten by Aetna Health Inc. and Aetna Health Insurance Company. Dental plans are provided or administered by Aetna Dental Inc. and Aetna Life Insurance Company.

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 Name and Title	Phone Number ( )	Fax Number ( )	
E-Mail Address	Federal Tax ID Number	Date Business Established (Mo/Yr):	

Employer Classification ☐ Corporation ☐ Non-Profit ☐ Partnership ☐ Sole Proprietor ☐ LLC ☐ LLP ☐ Other: _____
SIC Code: _____ Nature of Business: _____

Number of years in business: _____ Number of years with current carrier: _____ Number of carriers within the past 5 years: _____

Are multiple companies or multiple addresses to be included under this plan? If Yes, provide details. ☐ Yes ☐ No

Medical Coverage Selection

Aetna HMO Plan**
☐ Plan _____

Aetna OA MC Plan**
☐ Plan _____

Aetna PPO Plan**
☐ Plan _____

Aetna Savings Plus Plan**
☐ **Plan** _____

Aetna HNOption Plan**
☐ Plan _____

Aetna HNOnly Plan**
☐ Plan _____

☐ **Aetna Indemnity Plan****

Medical Out-of-State (OOS) **
☐ Plan _____

Does this group qualify for the exemption under Federal Mental Health Parity?
☐ Yes ☐ No

Other Coverage Selection

Aetna Dental™ Plans
☐ Plan _____

Voluntary Dental: ☐ Yes ☐ No

Orthodontia coverage is available for dependent children only to groups with 10 or more eligible employees with 5 enrolled employees.

Dental Out-of-State (OOS)
☐ Plan _____

Is employer, plan sponsor, or a third party funding any of the deductible? ☐ Yes ☐ No If Yes, how much? _____

NOTE: OA MC E500 plan, HNOption E20 plan, HNOnly E20 plan and Savings Plus 1500 80/60/50 plan are NOT offered under the Consumer Choice of Benefits Health Insurance Plan.

Life, Accidental Death & Dismemberment, & Disability Coverage Selections

Groups of 2 to 9 eligible employees are limited to one class. Groups with 10 to 50 eligible employees may select one, two, or three options for Life, Accidental Death & Dismemberment, and Disability. 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 to 100: contact your Aetna Account Executive.**

All Groups - Life		☐ 10,000	☐ 15,000	☐ 20,000	☐ 50,000
All Groups - Life & Disability Packaged Plan		☐ Low	☐ Medium	☐ High	
Additional options for Groups with 10 to 50 eligible employees		☐ 75,000	☐ 100,000	☐ 125,000	
Class Description	**Class 1:**	**Class 2:**		**Class 3:**	

Optional Dependent Term Life (Available only to groups with 10 to 50 eligible employees.) ☐ Yes ☐ 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.

Domestic Partner Option

Please indicate whether you will provide Domestic Partner coverage to your employees:

☐ Yes, include Domestic Partner coverage for my employees ☐ No, decline Domestic Partner coverage for my employees

Effective Date

Actual effective date will be assigned by Aetna.

Requested effective date (may be the 1st 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 _____

Employer Contribution(s)

Coverage	Medical	Dental	Employee Life	Dependent Life	Disability
Employer's Minimum Contribution for Employee	%	%	%	NA	%

Employee Disability Contribution

Employee's disability contribution percent – check one: ☐ Pre-Tax ☐ Post-Tax

Section 125 Plan

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

Employer Eligibility/Employee Status

Work Location (list by state) Please note if locations are a work site or "work-at-home".	Number of Employees						
	Full-time (i.e, usually at least 30 hours per week)	Part-time	Retired	COBRA	1099	Union	Other (i.e., temporary, substitute, seasonal, etc.)
TOTAL							

What is the normal work week you require a full-time employee to work to be eligible for coverage?	_____ hrs per week
Are there excluded employees other than part-time and temporary employees (for example, Union employees)? If Yes, describe the employees and/or the union local name and number.	☐ Yes ☐ No

Total number of eligible employees		Total number of employees enrolling		Total number of employees waiving		Total number of employees in waiting period	

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.	
Do you use the services of a Payroll Company? If Yes, provide the name of the company. _____	☐ Yes ☐ No
Are you currently a client company of a Professional Employer Organization (PEO)?	☐ Yes ☐ No
Eligibility date will be the 1st of the policy month following the waiting period. Waiting period for all employees: ☐ 0 months ☐ 1 month ☐ 2 months ☐ 90 days	
Is the group waiving the waiting period at initial enrollment?	☐ 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)?	☐ Medicare Primary ☐ Aetna Primary
In total, how many full-time and part-time employees (including any seasonal employees, owners or partners) have you employed on 50% or more of your business days during the prior calendar year?	
How many of the employees that you noted above are self-employed, independent contractors (or their employees and agents), leased employees, or non-employee directors?	

COBRA versus Continuation

Is your employer group required to comply with COBRA regulation?	☐ Yes ☐ No
If you answered Yes to the above question but you currently employ less than 20 full-time and part-time employees, provide in total, how many full-time and part-time employees (including any seasonal employees, owners or partners) that you have employed for 20 or more weeks during this calendar year or prior calendar year?	
Are any present or former employees/dependents currently on or eligible to elect COBRA/State Continuation? If Yes, enter information below. Attach a separate sheet, if necessary.	☐ Yes ☐ No

Name of Applicant	Qualifying Event (e.g., termination of employment, divorce, etc.)	Date of Qualifying Event	Date of COBRA or State Continuation Coverage Terminates

Prior Carrier Information

	Health	Dental	Life	Disability
Is this group transferring from another group carrier?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
If Yes, provide Carrier Name and submit a copy of the carrier statement and employee roster				
Effective Date of Coverage				
Proposed Termination Date				
Is this total replacement?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
If prior carrier Aetna, provide Group/Control Number				
Prior Carrier Deductible				
Dental Only – Prior coverage included, check all that apply:		☐ Major Services ☐ Orthodontia Ortho Max $ _____		

Medical Information

Is any person to be covered unable to work due to illness or injury?	☐ Yes ☐ No
Is any person currently receiving Workers' Compensation benefits?	☐ Yes ☐ No
Is any person currently on leave of absence? If so, provide start date and expected date of return below.	☐ Yes ☐ No
If Yes is answered to any of the above, provide name(s) of the individual(s) and details.	

Texas Notice of Election or Rejection of Optional Medical Benefits - If medical coverage **has not been** selected or a Consumer Choice of Benefits Health Insurance Plan **has been** selected, this section does not apply.

Texas law requires that the following optional benefits be offered to applicants having employees who are located in Texas. If elected, coverage will be provided to all employees covered under a Texas contract except as otherwise noted. Additional medical premium will be required for each option selected.

1. **In Vitro Fertilization Coverage**
   Coverage includes expenses incurred by the subscriber or the subscriber's covered spouse for outpatient in vitro fertilization procedures subject to the provisions of the Texas Insurance Code.
   ☐ Applicant accepts the optional In Vitro Fertilization benefit.
   ☐ Applicant rejects the optional In Vitro Fertilization benefit.
2. **Additional Speech and Hearing Impairment Coverage**
   The optional coverage would include benefits for the necessary care and treatment of loss or impairment of speech or hearing. Such coverage will not be less favorable than coverage under the plan for physical illness generally, subject to the same durational limits, dollar limits, deductibles and coinsurance factors that may apply.
3. **Additional Coverage for Serious Mental Illness**
   Additional coverage offered for the treatment of "serious mental illness." A "serious mental illness" is defined as:
   - Schizophrenia;
   - Paranoid and other psychotic disorders;
   - Bipolar disorders (hypomanic, manic, depressive and mixed);
   - Major depressive disorders (single episode or recurrent);
   - Schizo-affective disorders (bipolar or depressive);
   - Obsessive-compulsive disorders; and
   - Depression in childhood and adolescence.

   ☐ Applicant accepts the optional Serious Mental Illness benefit.
   ☐ Applicant rejects the optional Serious Mental Illness benefit.

☐ Applicant accepts the optional Speech and Hearing Impairment benefit.
☐ Applicant rejects the optional Speech and Hearing Impairment benefit.

In rejecting coverage, I understand that it will not be provided at a future date unless I request it at policy renewal.

Signature _____ Title _____ Date _____

Texas Notice of Election or Rejection of Optional Dental Benefits

To provide flexibility to covered persons, dental coverage can be obtained through either the Dental Plan Coverage (DPC Plan), offered by Aetna Dental Inc., or the Comprehensive Dental Expense Coverage plan (Point of Service Plan), offered by Aetna Life Insurance Company. The Point of Service Plan (POS Plan) provides out-of-network coverage for covered dental expenses and includes deductible and coinsurance percentage provisions. This plan must be offered to every customer who purchases a DMO plan and has 25 or more employees. If dental coverage has not been selected or the group does not meet the criteria indicated above, this section does not apply.

If any covered services or supplies are performed or received from a Member Dental Provider or a Member Specialty Dental Provider, benefits will be considered to have been paid for such services and supplies under the DPC Plan. The covered person will be responsible for the payment of the copayment amounts specified in the Certificate of Coverage describing his/her DPC Plan.

Except for Emergency Care, if any covered services or supplies are performed or received from a Non-Member Dental Provider, benefits will be considered to have been paid for such services and supplies under the POS Plan. The covered person will be responsible for the payment of the deductible and coinsurance percentage amounts specified in the Certificate of Coverage describing his/her POS Plan.

All the terms and conditions of the plan under which the services or supplies are provided will apply.

If you live and work outside of the Service Area, you will not be eligible for the DPC Plan Coverage.

Additional dental premium will be required if the Point of Service Option is accepted.

☐ Applicant accepts the Point of Service Option. ☐ Applicant rejects the Point of Service Option.

Signature _____ Title _____ Date _____

Signature Section

APPLICABLE TO ALL COVERAGES

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 full-time employee, usually working at least 30 hours per week, regularly performing the duties of his or her occupation (except for health-related factors and subject to applicable HIPAA requirements for health coverage), unless otherwise specifically provided in the plan documents (which consist of the Group Policy and/or Group Agreement). 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 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.

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.

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.

Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any intentional misrepresentation of material fact or conceals, for the purpose of misleading, information concerning any fact material thereto may commit a fraudulent insurance act, which may be a crime and may subject such person to criminal and civil penalties.

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.

APPLICABLE TO LIFE INSURANCE COVERAGE ONLY: 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.

APPLICABLE TO HEALTH AND DENTAL COVERAGE ONLY

Participating physicians, hospitals and other health care providers are independent contractors and are neither agents nor employees of Aetna. 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 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 subject to Texas small employer laws.

continued on next page

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 group size and minimum participation 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 upon the first renewal date following the first day of the next month after six consecutive months during which time the group failed to meet minimum group size or participation requirements.

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 authority pursuant to all applicable state and Federal laws, to review all denied claims for benefits under the Plan, and to construe disputed/doubtful Plan terms.

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.

I hereby certify that I am licensed to sell Aetna Small Group products in the state of Texas.

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:		SSN:			
Agency Name:		TIN:			
Pay commissions to: (check one) ☐ Broker ☐ Agency		Phone:	Fax:		
Address:		City:	State:	ZIP:	
Signature:	Date:	E-mail Address:		% of credit:	

Broker Name:		SSN:			
Agency Name:		TIN:			
Pay commissions to: (check one) ☐ Broker ☐ Agency		Phone:	Fax:		
Address:		City:	State:	ZIP:	
Signature:	Date:	E-mail Address:		% of credit:	

General Agent Name:		TIN:			
Phone:		Fax:			
Address:		City:	State:	ZIP:	
Signature:	Date:	E-mail Address:			

Form CCP Figure 1

TEXAS DEPARTMENT OF INSURANCE REQUIRED DISCLOSURE NOTICE
FOR ALL EMPLOYER GROUP INDEMNITY CONSUMER CHOICE BENEFIT PLANS ISSUED IN TEXAS

As required by 28 TAC §21.3530, I have been informed that the Consumer Choice Standard Benefit Plan that I am purchasing does not include all state mandated health insurance benefits. I understand that purchase of this plan may limit future coverage options in the event that plan participant's health changes and needed benefits are not covered under the consumer choice health benefit plan. I understand that the following benefits are provided at a reduced level from what is mandated, or are excluded completely from the plan:

Mandated Benefit Description	Benefit Reduced	Benefit Excluded
IN VITRO FERTILIZATION Article 3.51-6, Section 3A, Texas Insurance Code Unless rejected in writing by the group policyholder, benefits for in-vitro fertilization must be provided to the same extent as benefits provided for other pregnancy-related procedures subject to certain requirements.		Not offered; not covered.
MENTAL HEALTH Article 3.70-2(F), Texas Insurance Code The insurer must offer and the group policyholder shall have the right to reject benefits for mental or emotional illness.	The base medical plan (for groups 2-50) provides coverage for both serious and non-serious mental illness, limited to 14 days inpatient and 20 visits outpatient per member per year. Full benefit per mandate included in medical plans for groups over 50 lives.	
SERIOUS MENTAL ILLNESS Article 3.51-14, Texas Insurance Code Small employer carriers must offer to small employers coverage for serious mental illness that complies with the following: (a) coverage for 45 days of inpatient treatment, and 60 visits for outpatient treatment, including group and individual outpatient treatment in each calendar year; (b) the coverage may NOT include a lifetime limit on the number of days of inpatient treatment or the number of outpatient visits covered under the policy; and (c) the coverage must include the same amount limits, and deductibles and coinsurance factors for serious mental illness as for physical illness.	The base medical plan (for groups 2-50) provides coverage for both serious and non-serious mental illness, limited to 14 days inpatient and 20 visits outpatient per member per year. Full benefit per mandate included in medical plans for groups over 50 lives.	Additional benefits not offered or covered
SPEECH AND HEARING - Article 3.70-2(G), Texas Insurance Code Unless rejected by the group policyholder or an alternative level of benefits is negotiated, benefits must be provided for the necessary care and treatment of loss or impairment of speech or hearing that are not less favorable than for physical illness generally. (See also "Hearing Screening for Children" under section for Mandated Benefits).	Outpatient Speech therapy limited to 20 visits per year.	Additional benefits not covered or offered.

* Note: if additional space is needed, the carrier may add additional lines, or may continue the list on a subsequent page, but must clearly note that an additional page is attached.

Form CCP Figure 1

** Pursuant to the Federal Patient Protection and Access to Care Act (PPACA), the following are covered at 100% with no Copayments, Deductibles or dollar maximum benefits:

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventative Service Task Force (USPSTF);
- Routine Adult Physical Examinations (including immunizations, routine vision and hearing screenings);
- Routine Well Child Care (including immunizations);
- Routine Cancer Screenings (which include Screening Mammograms; Prostate Specific Antigen (PSA) Tests; Digital-Rectal Exams (DRE); Fecal Occult Blood Tests (FOBT); Sigmoidoscopies; Double Contrast Barium Enemas (DCBE) and Colonoscopies);
- Routine Eye Examinations, including refraction;
- Pediatric Preventive Dental; and
- Routine Gynecological Exams, including routine Pap smears.

I understand that I may obtain from the Department of Insurance a consumer brochure with more information on Consumer Choice Health Benefit Plans, either by visiting the TDI website at www.tdi.state.tx.us/consumer/indexc.html, or by calling 1-800-252-3439.

By signing this document I affirm that I was offered a benefit plan that contains the state mandated health insurance benefits and that I have elected to purchase this Consumer Choice Benefit Plan.

Signature of Applicant _____ Name of Applicant _____

Name of Business (if applicable) _____ Date _____

Address _____ City _____ State _____ Zip _____

Note: This form must be retained by the carrier issuing the policy and must be provided to the Commissioner of Insurance upon request. **You have the right to a copy of this written disclosure statement free of charge.** A new form must be completed upon each subsequent renewal of this policy.

Addendum to New Business Input Documents
Mandatory Requirement for Health Care Reform

Aetna is collecting employee count information to comply with the health care reform law.

We are asking you to provide the average number of people you employed in the prior calendar year. We need this information so we can accurately report your data and calculate any potential rebates to which you and your covered subscribers may be entitled under the new medical loss ratio requirements set forth in the Affordable Care Act (ACA).

The law defines the number of employees as "the average number of employees employed by the employer's company during the preceding calendar year." 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 (sample calculation below). We need the average number of total employees for your company in 2010 to support the 2011 calculations and reports and the payment of any rebates due in 2012.

How to calculate the average number of total employees*

To calculate average number of employees for the year, determine the average number of employees for each month in 2010, add them together and then divide the total by twelve. In the example below, 253 / 12 = 21. Round up or down to the nearest whole number.

Month	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Average
Full Time	15	14	14	15	14	15	16	16	15	14	14	14	
Part Time	5	6	5	5	6	6	7	7	5	5	5	5	
Seasonal	0	0	0	0	0	2	3	3	2	0	0	0	
Total	20	20	19	20	20	23	26	26	22	19	19	19	21

*Subject to change based on future regulatory guidance

Please enter your calculated average number of employees in the box below.

Average Employees in 2010 (whole numbers only; please print legibly)

By signing below I certify that:

- I am an authorized representative of the plan(s) for which this information is being provided.
- The information I have provided is true and correct.
- Aetna may rely on the responses I have provided.

First Name (Please Print): **Last Name (Please Print):** **Title:**

Company Name: **Email Address (optional):**

Signature: **Today's Date:**

Aetna reserves the right to audit all information provided. Providing false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company, may violate applicable insurance statutes.

NOTE: Before submitting this completed form to your employer, you may wish to protect the confidentiality of your health information by taping or stapling the form so that pages 2 and 3 are not visible.

Aetna®

Texas Employee Enrollment/Change Form

Large Employer: 51 or more employees
Small Employer: 2 – 50 employees

Social Security Number

Employer Name	**INSTRUCTIONS:** You, the employee, must complete this enrollment form in full or it will be returned to you resulting in a delay in processing. You are solely responsible for its accuracy and completeness. **If waiving coverage, please complete Sections B and G.**

Effective Date / **Date of Hire**	☐ New Hire ☐ Rehire/Reinstatement ☐ New Group Enrollment ☐ Late Enrollment ☐ Other _____	☐ Change of coverage ☐ Add Spouse/Domestic Partner/ Dependent Child ☐ Name Change ☐ Other _____	☐ Employee Termination ☐ Remove Spouse/ Domestic Partner/ Dependent Child ☐ Cancel Coverage	COBRA/State Continuation for: ☐ Employee ☐ Dependent Length of Continuation: ☐ 18 ☐ 36 ☐ Other _____ Original Qualifying Event Date _____ Reason _____

A. Coverage Selection – *Please print clearly, using black ink. (Shaded sections for Employer/Aetna Use Only)*

Control/Group No.	Suffix	Account	Plan No.	Class Code	Control/Group No.	Suffix	Account	Plan No.	Control/Group No.	Suffix	Account	Plan No.

1. Medical - *Check one.*

- ☐ Aetna HMO Plan – Plan _____
- ☐ Aetna OA MC Plan – Plan _____
- ☐ Aetna HNOption Plan – Plan _____
- ☐ Aetna HNOnly Plan – Plan _____
- ☐ Aetna Savings Plus Plan – Plan _____
- ☐ Aetna PPO Plan – Plan _____
- ☐ Aetna Indemnity Plan

2. Dental - *To enroll, enter plan number and name elected below.*

Standard Plan:
Plan Number: _____
Plan Name: _____
If FOC Option, check: ☐ DMO® *or* ☐ PDN

Voluntary Plans:
Plan Number: _____
Plan Name: _____
If FOC Option, check: ☐ DMO® *or* ☐ PDN

Out-of-State PDN Plans:
Plan Name: _____

Before today, were you covered under this employer's dental plan? ☐ Yes ☐ No

3. Life and Disability

- ☐ Basic Life/AD&D Ultra®
- ☐ Optional Dependent Life
- ☐ Life & Disability Packaged Plan

Beneficiary Designation - **Full Name** (First, Middle, Last)

Beneficiary Social Security Number

Relationship to Employee

B. Employee Information - *Must be completed by the employee.*

Member ID Number (If Available)	Last Name, First Name, M.I.		Job Title	Home Telephone

Home Address	Apt. No.	City, State	ZIP Code

Work Address	City, State	ZIP Code	Work Telephone

Salary $	☐ Hourly ☐ Weekly ☐ Monthly	No. of Hours Usually Worked Per Week	Check One ☐ Full-Time ☐ Part-Time ☐ 1099 ☐ Retiree ☐ Union ☐ COBRA ☐ Seasonal ☐ Temporary	Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Legally Separated	No. of Dependents Including Spouse/ Domestic Partner

Subscriber Primary Language (other than English) **Primer Idioma del suscriptor (que no sea el Ingles)** What is your primary Language? ¿Cuál es su primer idioma? _____	**Subscriber Disability** Do you have a disability which affects your ability to communicate or read? ☐ Yes ☐ No If Yes, please indicate the nature of your disability. _____

C. Individuals Covered - *List individuals for whom you are enrolling or adding/changing/removing coverage. Insert additional sheets if necessary.*

NOTE: Enter Domestic Partner ONLY if your employer has elected that coverage.

NOTE FOR MEDICAL AND DENTAL COVERAGE: While the Federal Patient Protection and Affordable Care Act mandates coverage of dependent children up to age 26, your plan may allow coverage beyond age 26. Some exceptions apply. Please refer to your plan documents or contact your benefits administrator.

(A)dd (C)hange (R)emove	Name (Last, First, M.I.)	Sex M/F	Social Security Number	Birthdate (MM/DD/YYYY)	Incapacitated	Coverage Election	Other Health Coverage	Other Dental Coverage	Child less than 25 years of age (Life/AD&D only)	Primary Office ID Number (if applicable)	Current Patient	Dental Office ID Number (if applicable)	Current Patient
	Employee 1.				Yes N/A	☐ Medical ☐ Dental ☐ Life/Dis	Yes ☐	Yes ☐	Yes N/A		Yes ☐		Yes ☐
	☐ **Spouse** ☐ **Domestic Partner** 2.				N/A	☐ Medical ☐ Dental ☐ Life	☐	☐	N/A		☐		☐
	☐ **Child** ☐ **Stepchild** ☐ **Other** 3.				☐	☐ Medical ☐ Dental ☐ Life	☐	☐	☐		☐		☐
	☐ **Child** ☐ **Stepchild** ☐ **Other** 4.				☐	☐ Medical ☐ Dental ☐ Life	☐	☐	☐		☐		☐
	☐ **Child** ☐ **Stepchild** ☐ **Other** 5.				☐	☐ Medical ☐ Dental ☐ Life	☐	☐	☐		☐		☐
	☐ **Child** ☐ **Stepchild** ☐ **Other** 6.				☐	☐ Medical ☐ Dental ☐ Life	☐	☐	☐		☐		☐

Social Security Number

D. Dependent Information

List any dependent in Section C living at another address.	Name:	Reason:	Address:
If any dependent's last name differs from yours, explain.	Name:	Reason:	

FOR DEPENDENT LIFE: If age +19 and a full-time student, provide the following:

Child Name	School Name	Expected Graduation Date	Number of Credit Hours

E. Race/Ethnicity – Optional (This information is designed for the purpose of data collection and will not be used for determining eligibility, rating or claim payment.)

Employee
1. ☐ White – 01 ☐ African American or Black – 02 ☐ Hispanic or Latino – 03 ☐ Asian – 04 ☐ Other – 05 _____

Spouse/Domestic Partner
2. ☐ White – 01 ☐ African American or Black – 02 ☐ Hispanic or Latino – 03 ☐ Asian – 04 ☐ Other – 05 _____

Child/Stepchild/Other
3. ☐ White – 01 ☐ African American or Black – 02 ☐ Hispanic or Latino – 03 ☐ Asian – 04 ☐ Other – 05 _____

Child/Stepchild/Other
4. ☐ White – 01 ☐ African American or Black – 02 ☐ Hispanic or Latino – 03 ☐ Asian – 04 ☐ Other – 05 _____

Child/Stepchild/Other
5. ☐ White – 01 ☐ African American or Black – 02 ☐ Hispanic or Latino – 03 ☐ Asian – 04 ☐ Other – 05 _____

Child/Stepchild/Other
6. ☐ White – 01 ☐ African American or Black – 02 ☐ Hispanic or Latino – 03 ☐ Asian – 04 ☐ Other – 05 _____

F. Other Insurance

If you have checked "Yes" to Other **Health** Coverage (Section C), provide name and policy number of insurance carrier, HMO, or other source, a copy of the insurance card, and start date of the coverage.

If you have checked "Yes" to Other **Dental** Coverage (Section C), provide name and policy number of insurance carrier, HMO, or other source, a copy of the insurance card, and start date of the coverage.

Is your Spouse/Domestic Partner employed? ☐ Yes ☐ No If Yes, provide name and address of spouse/domestic partner's employer.

PROOF OF PRIOR COVERAGE – IMPORTANT *(Required)*

Does anyone age 19 and over enrolling on this enrollment form have prior medical coverage? If Yes, provide the information requested in the table below.

Proof of coverage should accompany this enrollment form for pre-existing condition credit if enrolling in other than an HMO plan.

Acceptable forms of proof are:
1. Certificate of Creditable Coverage from prior carrier, or
2. Copy of ID card or most recent payroll stub showing medical coverage deduction, or
3. Copy of most recent medical premium bill from prior carrier.

Failure to provide Proof of Prior Coverage may subject you or a family member (age 19 and over) to the full pre-existing conditions limitation with no credit for prior coverage if enrolling in other than an HMO plan. You may request a Certificate of Creditable Coverage from your prior carrier. **NOTE:** If your Plan contains a pre-existing conditions provision, the pre-existing conditions exclusion and limitation will not apply to a person under 19 years of age.

Name of Covered Individual	Carrier Name	Group Number	Start Date	Termination Date	Health
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No

G. Declination/Waiver of Coverage - *To be completed if medical and/or dental coverage is declined or refused by an eligible employee and/or their eligible family members.*

1. **Medical Coverage Declined for:**
   ☐ Myself ☐ Dependents ☐ Spouse/Domestic Partner
2. **Dental Coverage Declined for:**
   ☐ Myself ☐ Dependents ☐ Spouse/Domestic Partner

Reason for Declining Coverage *(If applicable, please attach front/back of your health coverage ID card.)*:
- ☐ Spousal/Domestic Partner group coverage
- ☐ Medicare
- ☐ Medicaid
- ☐ Individual coverage
- ☐ Retiree coverage
- ☐ COBRA coverage
- ☐ TRICARE or CHAMPVA
- ☐ Another group plan provided by my employer
- ☐ Do not want
- ☐ Other _____

I acknowledge I have been given the right to apply for this coverage, however, I am electing not to enroll. By declining this group coverage I acknowledge that myself and/or my dependents may have to wait until the plan's next anniversary date to be enrolled for group coverage. Pre-existing conditions, when enrolled in other than an HMO plan, may not be covered for twelve months. **NOTE:** If your Plan contains a pre-existing conditions provision, the pre-existing conditions exclusion and limitation will not apply to a person under 19 years of age.

Please sign here ONLY if you are declining coverage for yourself or dependent(s).	***Date (Month/Day/Year)***
X Employee Signature	

H. Health Questionnaire for Groups Enrolling 2 - 100 Eligible Employees (and employees of groups enrolling for Life coverage greater than the Guaranteed Issue Level)

Health History for Employees and your Dependents. ***The following information is confidential and will not be seen by or given to your employer.***

- ALL of the questions must be answered by you or your dependents or the enrollment form will be returned.
- Incomplete enrollment forms may delay the effective date of your coverage.

List all individuals enrolling for coverage. Name	Sex	Age	Height	Weight	Smoker	Currently Taking Prescription Medication(s)
					☐ Yes ☐ No	☐ Yes ☐ No
					☐ Yes ☐ No	☐ Yes ☐ No
					☐ Yes ☐ No	☐ Yes ☐ No
					☐ Yes ☐ No	☐ Yes ☐ No
					☐ Yes ☐ No	☐ Yes ☐ No
					☐ Yes ☐ No	☐ Yes ☐ No
					☐ Yes ☐ No	☐ Yes ☐ No
					☐ Yes ☐ No	☐ Yes ☐ No

Answer all the questions.

1. Within the last 5 years has anyone applying for coverage consulted, received treatment, by a doctor, psychiatrist, psychologist, or other practitioner or been diagnosed with any of the following conditions or disorders? (Check all that apply.) ☐ Yes ☐ No

   a. ☐ Diabetes
   b. ☐ Infertility
   c. ☐ Endocrine/Metabolic
   d. ☐ Pancreas
   e. ☐ Liver/Hepatitis
   f. ☐ Immune System
   g. ☐ Blood Disorder
   h. ☐ Epilepsy/Seizure
   i. ☐ Heart
   j. ☐ Paralysis/Paresis
   k. ☐ Tumor/Cyst/Growth
   l. ☐ Systemic or Discoid Lupus
   m. ☐ Lung or Respiratory
   n. ☐ Alcohol or Drug Use
   o. ☐ Kidney/Bladder/Urinary
   p. ☐ Circulatory/Vascular
   q. ☐ Digestive/Stomach/Intestinal
   r. ☐ Central Nervous System
   s. ☐ Pituitary/Adrenal/Growth Disorder
   t. ☐ Birth Defects/Congenital Abnormalities
   u. ☐ Arthritis/Bone/Joint/Muscle/Prosthetic Device
   v. ☐ Mental/Nervous/Emotional/Eating Disorder
   w. ☐ Stroke/Brain/Neurological
   x. ☐ Transplant: ☐ Recommended ☐ Pending ☐ Complete
   y. ☐ Advised to have surgery or course of treatment not yet determined
   z. ☐ Cancer: Type: _____ Stage _____ ☐ Surgery ☐ Chemo ☐ Radiation
   aa. ☐ Using: ☐ Crutches ☐ Walker ☐ Wheelchair
   bb. ☐ Other _____

2. Has anyone applying for coverage ever been diagnosed as having or been told by a medical doctor that they have AIDS, HIV or an ARC disorder? ☐ Yes ☐ No

3. Is any female currently pregnant? If so, provide due date _____ Check applicable boxes: ☐ C section planned ☐ Multiple Births Expected (# _____) ☐ Complications: ☐ Past or ☐ Present ☐ Yes ☐ No

4. Has anyone applying for coverage incurred medical expenses in excess of $5,000 in the past 24 months? ☐ Yes ☐ No

5. Has anyone applying for coverage been prescribed medications in the past 12 months? ☐ Yes ☐ No

6. Does anyone applying for coverage have a known condition that requires on-going treatment? ☐ Yes ☐ No

7. Do you or your spouse use tobacco products? If so, check the applicable boxes: ☐ Employee: ☐ Cigarettes ☐ Pipe ☐ Cigars ☐ Chewing Tobacco ☐ Spouse: ☐ Cigarettes ☐ Pipe ☐ Cigars ☐ Chewing Tobacco ☐ Yes ☐ No

Provide details below to any boxes checked above. ***(If additional space is needed, attach a separate sheet and be sure to sign and date the sheet.)***

Question Number	Name of Individual	Condition/Diagnosis/Treatment	Date of Onset	Date Treatment Ended	Names of Prescription Medication(s)	Dosage	Still Taking Medication
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No

If you are providing additional sheets, check here ☐ ***and insert the sheets before sealing this Enrollment form.***

Conditions of Enrollment

On behalf of myself and the dependents listed on the reverse side, I agree to or with the following:

1. I acknowledge that by enrolling in the following plans, coverage is provided by the following entities (collectively referred to as "Aetna"):
   - Aetna HMO Plan and Aetna HNOnly Plan: Aetna Health Inc.
   - Aetna HNOption Plans: Aetna Health Inc. (In-Network) and Aetna Health Insurance Company, (Out-of-Network)
   - Aetna Dental DMO: Aetna Dental Inc.
   - Life, disability, dental and all other health coverages: Aetna Life Insurance Company.
2. I understand and agree that my employer's application will determine coverage and that there is no coverage unless and until both the eligible employee and employer applications have been accepted by Aetna. Even if this enrollment form is accepted, any intentional misstatement or omission of material fact may result in future claims being denied.

   For life and disability coverages: I understand that the effective date of insurance for myself or for any of my dependents is subject to my being actively at work on that date and that the effective date of insurance for any of my dependents is also subject to the dependent health condition requirements of the benefit plan. Further, I understand that any insurance subject to evidence of good health or medical information will not become effective until Aetna gives its written consent.
3. I understand and agree that this Enrollment/Change Form may be transmitted to Aetna or its agent by my employer or its agent. I authorize any physician, other healthcare professional, hospital or any other healthcare organization ("Providers"), to give to Aetna or its agent information concerning the medical history, services or treatment provided to anyone listed on this Enrollment/Change Form, including those involving mental health and substance abuse. I further authorize Aetna to use such information and to disclose such information to affiliates, Providers, payors, other insurers, third party administrators, vendors, consultants and governmental authorities with jurisdiction when necessary for my care or treatment, payment for services, the operation of my health plan, or to conduct related activities. I have discussed the terms of this authorization with my spouse/domestic partner and competent adult dependents and I have obtained their consent to those terms. This authorization will remain valid for the term of the coverage and so long thereafter as allowed by law. I understand that I am entitled to receive a copy of this authorization upon request and that a photocopy is as valid as the original.
4. The plan documents will determine the rights and responsibilities of member(s) and will govern in the event they conflict with any benefits comparison, summary or other description of the plan.
5. I understand and agree that, with the exception of Aetna Rx Home Delivery®, all participating providers and vendors are independent contractors and are neither agents nor employees of Aetna. Aetna Rx Home Delivery, LLC, is a subsidiary of Aetna Inc. The availability of any particular provider cannot be guaranteed and provider network composition is subject to change. Notice of the change shall be provided in accordance with applicable state law.
6. I understand and agree that, with certain exceptions described in the plan documents, HMO and DMO plans only provide coverage for referred benefits, and that, in order to be covered, services must be performed either by a participating primary care physician, primary care dentist or by the participating specialist, hospital, pharmacy, dentist, or other provider as authorized by a referral from a participating primary care physician.
7. I understand and agree that, as described in the plan documents, when enrolled for medical coverage in other than an HMO plan, any pre-existing conditions for my spouse/domestic partner, dependents or myself may not be covered for 12 months. **NOTE:** If your Plan contains a pre-existing conditions provision, the pre-existing conditions exclusion and limitation will not apply to a person under 19 years of age.

Misrepresentation

8. Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any intentional misrepresentation of material fact or conceals, for the purpose of misleading, information concerning any fact material thereto may commit a fraudulent insurance act, which may be a crime and may subject such person to criminal and civil penalties.

I represent that all information supplied in this form is true and complete. I have read and agree to the Conditions of Enrollment and Misrepresentation on this **Texas** Employee Enrollment/Change Form. I understand that, in the event I fail to sign this form within 31 days after the above transaction request or for any reason Aetna does not receive notice of the above transaction request within a reasonable time following the event, my and my dependents' eligibility may be affected. I am employed by the employer shown on Page 1, and I am working full time, usually 30 hours per week, for this employer at the regular place of business.

If you have questions concerning the benefits and services that are provided by or excluded under this Agreement, please contact a Member Services representative at 1-800-323-9930 before signing this form.

Employee Signature	*Employee E-mail Address (optional)*	*Date (Month/Day/Year)*
X		