aetna®

California Small Group Business
Employer Application

FOR GROUP COVERAGE (1 - 100 EMPLOYEES)

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, Accidental Death & Personal Loss Coverage (AD&D Ultra®), Aetna Vision℠ 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) *Online statements are available. Activate access to your eBusiness account at* ***www.aetna.com/employersregister*** *when you get your approval letter.*	Billing contact email		
Nature of business / SIC code	Federal tax ID number	Date business established (Month/Year):	
Employer classification: ☐ Corporation ☐ Nonprofit ☐ Partnership ☐ Sole proprietor ☐ LLC ☐ LLP ☐ 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): _____

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

Step one: Select up to five plans ***Step two:*** Write in the five plan choices

Medical plan choices (List up to five plans.) **Please list entire plan name *and* network.**

1. _____ 2. _____
3. _____ 4. _____
5. _____

Comprehensive infertility coverage is included in all plans. Do you wish to decline this coverage? Yes ☐ No ☐

Plan choices by network

HMO plans

HMO – Full Network	HMO Aetna Value Network (AVN)	HMO Deductible Network	HMO Basic Network
	Platinum AVN HMO 15 Copay Plan		Platinum Basic HMO 15 Copay Plan
Gold HMO 20	Gold AVN HMO 20		Gold Basic HMO 20
	Gold AVN HMO 30 Copay Plan		Gold Basic HMO 30 Copay Plan
Gold HMO 45	Gold AVN HMO 45		Gold Basic HMO 45
		Gold HMO Deductible 250	Gold Basic HMO 250
		Silver HMO Deductible 1500	Silver Basic HMO 1500
		Silver HMO Deductible 2000	Silver Basic HMO 2000
		Silver HMO Ded 2000 Copay Plan	Silver Basic HMO 2000 Copay Plan
			Bronze Basic HMO 6300 Plan
		Bronze HMO Deductible 6500	Bronze Basic HMO 6500

Continued on next page

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 *(Continued)*

Open Access Managed Choice (MC)	
MC – Full Network	**MC Savings Plus Network**
	Platinum Savings Plus 0 Copay Plan
Gold MC 0 Copay Plan	Gold Savings Plus 0 Copay Plan
Gold MC 750 80/50	Gold Savings Plus 750 80/50
Silver MC 1000 70/50	Silver Savings Plus 1000 70/50
Silver MC 2000 80/50 HDHP Plan	Silver Savings Plus 2000 80/50 HDHP Plan
Silver MC 2000 60/50	Silver Savings Plus 2000 60/50
Silver MC 2000 Copay	Silver Savings Plus 2000 Copay
Bronze MC 4000 Copay	Bronze Savings Plus 4000 Copay
Bronze MC HDHP 4800 60/50 HSA Plan	Bronze Savings Plus HDHP 4800 60/50 HSA Plan
Bronze MC 6550 100/50 HSA	Bronze Savings Plus 6550 100/50 HSA
Bronze MC 6500 Copay	Bronze Savings Plus 6500 Copay

Aetna Whole Health Networks	
PrimeCare	**MemorialCare ACO**
HMO plans	**EPO plans**
Gold PrimeCare HMO 30 Copay Plan	Gold MemorialCare EPO 750 80
Gold PrimeCare HMO 45	
Silver PrimeCare HMO Ded 1500	Silver MemorialCare EPO 2000 Copay
Bronze PrimeCare HMO Ded 6500	Bronze MemorialCare EPO 4000 Copay
MC plans	**MC plans**
Gold PrimeCare MC 750 80/50	
Silver PrimeCare MC 2000 60/50	Silver MemorialCare MC 2000 60/50
Bronze PrimeCare MC 4000 Copay	Bronze MemorialCare MC 6500 Copay

Aetna Whole Health Networks *(Continued)*	
	SCCIPA ACO
	EPO plans
	Gold SCCIPA EPO 750 80
	Silver SCCIPA EPO 2000 Copay
	Bronze SCCIPA EPO 4000 Copay
	MC plans
	Silver SCCIPA MC 2000 60/50
	Bronze SCCIPA MC 6500 Copay

PPO – Full Network	**Indemnity (only available if OAMC or PPO networks are not available)**
Gold PPO 750 80/50	Silver Indemnity 1500 80

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℠ Preferred – Plan option name _____

6. Life and disability coverage selection *(Not available to groups of one. Groups of 2 to 9 eligible employees are limited to one class.)*

Life class description	**Class 1:**	**Class 2:**	**Class 3:**

Basic life (2 – 9 eligible employees)

☐ $10,000 ☐ $15,000 ☐ $20,000 ☐ $50,000

Basic life and AD&D Ultra® (10 – 50 eligible employees)

☐ $10,000 ☐ $15,000 ☐ $20,000 ☐ $25,000 ☐ $30,000 ☐ $50,000 ☐ $75,000 ☐ $100,000
☐ $125,000 ☐ $150,000 ☐ $175,000 ☐ $200,000

OR

Basic annual salary ☐ 1 x ☐ 2 x Maximum amount $ _____

(Basic annual salary will be rounded to the next higher $1000.)

Basic life and AD&D Ultra® reduction schedule (10 – 50): _____ % at age _____ then _____ % at age _____ then _____ % at age _____

Supplemental life and AD&D Ultra® (10 - 50 eligible employees)

Amounts entered must be in increments of $10,000 or $25,000.

Class 1 amount: $ _____ Maximum amount: $ _____
Class 2 amount: $ _____ Maximum amount: $ _____
Class 3 amount: $ _____ Maximum amount: $ _____
Reduction schedule: *(matches basic life benefit)*

OR

Basic annual salary ☐ 1 x ☐ 2 x ☐ 3 x ☐ 4 x ☐ 5 x Maximum amount $ _____
Reduction schedule: *(matches basic life and* AD&D Ultra®*)*

Dependent supplemental life and AD&D Ultra® (10 – 50 eligible employees)

(Employee must be insured for supplemental life to choose dependent supplemental life)

Spouse: ☐ Yes ☐ No Child: ☐ Yes ☐ No

Basic life and AD&D Ultra® (51 – 100 eligible employees)

Flat dollar amount *(may elect amounts between $10,000 - $300,000 in increments of $10,000 or $25,000)*

Class 1 amount: $ _____ Maximum amount: $ _____
Class 2 amount: $ _____ Maximum amount: $ _____
Class 3 amount: $ _____ Maximum amount: $ _____

OR *(Basic annual salary will be rounded to the next higher $1000.)*

Basic annual salary ☐ 1 x ☐ 1.5 x ☐ 2 x
Maximum amount $ _____ *(If additional classes are needed, please use a separate form.)*

Basic life and AD&D Ultra® reduction schedule (51-100): _____ % at age _____ then _____ % at age _____ then _____ % at age _____

Supplemental life and AD&D Ultra® (51 – 100 eligible employees)

Flat dollar amount *(may elect amounts between $10,000 - $500,000 in increments of $10,000 or $25,000)*

Class 1 amount: $ _____ Maximum amount: $ _____
Class 2 amount: $ _____ Maximum amount: $ _____
Class 3 amount: $ _____ Maximum amount: $ _____

OR *(Basic annual salary will be rounded to the next higher $1000.)*

Basic annual salary ☐ 1 x ☐ 2 x ☐ 3 x ☐ 4 x ☐ 5 x
Maximum amount $ _____ *(If additional classes are needed, please use a separate form.)*
Reduction schedule: *(matches basic life and AD&D Ultra®)*

Dependent supplemental life and AD&D Ultra® (51 – 100 eligible employees)

(Employee must be insured for supplemental life to choose dependent supplemental life)

Spouse: ☐ Yes ☐ No Child: ☐ Yes ☐ No

Short term disability class description	**Class 1:**	**Class 2:**	**Class 3:**

Short term disability (51 – 100 eligible employees)

Weekly benefit ☐ 50% ☐ 60% ☐ 66 2/3% Maximum amount $ _____ *(to a maximum of $2,000)*
Elimination period ☐ 1 day injury/8 day illness ☐ 15 day injury/15 day illness
☐ 8 day injury/8 day illness ☐ 30 day injury/30 day illness
Benefit duration ☐ 9 weeks ☐ 11 weeks ☐ 13 weeks ☐ 26 weeks

Long term disability class description	**Class 1:**	**Class 2:**	**Class 3:**

Long term disability (10 – 100 eligible employees)

Monthly benefit ☐ 50% ☐ 60%
Maximum benefit ☐ $2000 ☐ $3500 ☐ $5000 ☐ $6000 ☐ $8000
Elimination period ☐ 30 days ☐ 90 days ☐ 180 days
Benefit duration ☐ 2 years ☐ 5 years

7. Business eligibility

Is your company a subsidiary of another company, an affiliate of another company, or under common control with another company?	☐ 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.
If you file or are eligible to file multiple businesses under one tax ID number, all businesses must be included as one group.

Business name	Tax identification number	Owner's name(s)	Percentage of ownership	Number of employees	Is group to be included?
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No

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

Do you use the services of a payroll company? If **yes**, provide the name of the payroll company.		☐ Yes ☐ No
Are you currently a client company of a professional employer organization (PEO)?		☐ Yes ☐ No
If yes,	- Provide the name of the PEO.	
	- Is group coverage available to you as a client of a PEO?	☐ Yes ☐ No

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 ÷ 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: ☐ COBRA ☐ Cal-COBRA?	
How many full-time and part-time employees did you employ 50 percent of the business days in the prior calendar year? *Include: full time, part time, seasonal, temporary, union, owners, partners, officers* *Exclude: self-employed persons, independent contractors (1099), directors* 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.	
How many employees have terminated in the last 90 days?	
Are any present or former employees/dependents currently on or eligible to elect COBRA / Cal-COBRA? If **yes**, enter information below. Attach a separate sheet, if needed.	☐ Yes ☐ No

Name of applicant	Qualifying event (e.g., termination of employment, divorce, etc.)	Date of qualifying event	Date coverage terminates

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. **NOTE:** This information is for rating purposes and not to determine group size.

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.**	
Benefit waiting period for future employees: _____ days (Indicate the number of days within the Affordable Care Act Guidelines – may not exceed 90 days.) (Groups with a first of the month effective date will have a first of the month BWP. Groups with a fifteenth of the month effective date will have a fifteenth of the month BWP).	
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

14. Employer Contribution(s) – Check one: ☐ Percentage or ☐ Dollar Amount

Coverage	Medical	Dental	Basic Life	AD&D Ultra®	Short Term Disability	Long Term Disability
Employer's Contribution for Employee					%	%
Employer's Contribution for Dependent			NA		N/A	N/A
Employee Disability Tax Contribution *(check one)*					☐ Pre tax ☐ Post tax	☐ Pre tax ☐ Post tax

15. Prior carrier information

Is this plan total replacement of any existing group plans?	Carrier Name	Phone Number	Start Date	End Date
Current medical carrier ☐ Yes ☐ No				
Current Life/AD&D carrier ☐ Yes ☐ No				
Current STD carrier ☐ Yes ☐ No				
Current LTD carrier ☐ Yes ☐ No				
Current dental carrier ☐ Yes ☐ 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 per week or more), or a permanent part-time employee (working 20-29 hours per 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.

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) Disability;
(I) 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.

Continued on next page

16. Signature section *(Continued)*

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, disability and accidental death and personal loss coverage employee benefits for groups with 2 to 50 employees): 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.

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.

Continued on next page

16. Signature section *(Continued)*

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.

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: _____

IMPORTANT: If applicable, check box below if submitting through:

☐ Aetna Marketplace ☐ Private exchange – vendor name: _____

☐ TPA – vendor name: _____

Agent or Broker name:		Agency name:		
Social Security number/TIN:		National producer number (NPN):		
% of credit:		Phone:	Fax:	
Address:		City:	State:	ZIP:
Signature:	Date:	Email:		
Broker admin assistant name:		Broker admin assistant email:		

Agent or Broker Name:		Agency name:		
Social Security number/TIN:		National producer number (NPN):		
% of credit:		Phone:	Fax:	
Address:		City:	State:	ZIP:
Signature:	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:		