



Delaware Employer Application

FOR GROUP COVERAGE (1 - 100 Eligible Employees)

Life, Accidental Death & Personal Loss Coverage (AD&D Ultra®), Disability, Aetna VisionSM Preferred plans, Aetna PPO and Aetna Indemnity plans are underwritten by Aetna Life Insurance Company. Aetna Health Network Option plans are underwritten by Aetna Health Inc. and Aetna Health Insurance Company. Dental plans are provided or administered by 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 (“EyeMed”).

Company Name (Legal Name)		DBA/Doing Business As (if applicable)	
Street Address (PO Box not acceptable)		City	State ZIP
Billing Address (if different than above)		City	State ZIP
Phone Number ()		Fax Number ()	
Are there additional addresses/locations for this business? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes , provide all addresses and locations.			
Company Contact – Name and Title		Company Contact E-mail Address	
Billing Contact Name (if different from Company Contact) <i>Go green – online statements available. Activate access to your eBusiness account at www.aetna.com/employersregister upon receipt of your approval letter.</i>		Billing Contact E-mail Address	
Enrollment Contact Name (if different from Company Contact)		Enrollment Contact E-mail Address	
SIC Code	Nature of Business	Federal Tax ID Number	Date Business Established (Mo/Yr):
Employer Classification <input type="checkbox"/> C Corp <input type="checkbox"/> S Corp <input type="checkbox"/> Non-Profit <input type="checkbox"/> Partnership <input type="checkbox"/> Sole Proprietor <input type="checkbox"/> LLC <input type="checkbox"/> LLP <input type="checkbox"/> Other: _____			

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

Requested effective date (may be the 1st or 15th of the month only): _____

Medical Coverage Selection

To enroll, check one in each category: Metal, Network, Product Type and HSA. Then write in the plan option elected.

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

Choose 1	Metal
	<input type="checkbox"/> Platinum <input type="checkbox"/> Gold <input type="checkbox"/> Silver <input type="checkbox"/> Bronze
Choose 1	Product Type
	<input type="checkbox"/> HNOption <input type="checkbox"/> PPO <input type="checkbox"/> Indemnity
Choose 1	HSA: <input type="checkbox"/> Yes <input type="checkbox"/> No

Plan Option: _____

Dental Coverage Selection (Not available to groups of one.)

Standard Plans: Option Number _____ Plan Option Name _____
Voluntary Plans: Option Number _____ Plan Option Name _____

Vision Coverage Selection (Not available to groups of one.)

Aetna Vision Preferred Plan Option Name _____

All vision plans are available in addition to other Aetna coverage selections or standalone.

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.

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)			
<input type="checkbox"/> \$10,000 <input type="checkbox"/> \$15,000 <input type="checkbox"/> \$20,000 <input type="checkbox"/> \$50,000			
Basic Life and AD&D Ultra® (10 – 50 eligible employees)			
<input type="checkbox"/> \$10,000 <input type="checkbox"/> \$15,000 <input type="checkbox"/> \$20,000 <input type="checkbox"/> \$25,000 <input type="checkbox"/> \$30,000 <input type="checkbox"/> \$50,000 <input type="checkbox"/> \$75,000 <input type="checkbox"/> \$100,000 <input type="checkbox"/> \$125,000 <input type="checkbox"/> \$150,000 <input type="checkbox"/> \$175,000 <input type="checkbox"/> \$200,000			
OR			
Basic Annual Salary <input type="checkbox"/> 1 x <input type="checkbox"/> 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 <input type="checkbox"/> 1 x <input type="checkbox"/> 2 x <input type="checkbox"/> 3 x <input type="checkbox"/> 4 x <input type="checkbox"/> 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: <input type="checkbox"/> Yes <input type="checkbox"/> No Child: <input type="checkbox"/> Yes <input type="checkbox"/> 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 <input type="checkbox"/> 1 x <input type="checkbox"/> 1.5 x <input type="checkbox"/> 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 <input type="checkbox"/> 1 x <input type="checkbox"/> 2 x <input type="checkbox"/> 3 x <input type="checkbox"/> 4 x <input type="checkbox"/> 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: <input type="checkbox"/> Yes <input type="checkbox"/> No Child: <input type="checkbox"/> Yes <input type="checkbox"/> No			
Life & Disability Packaged Plan (2 – 50 eligible employees)			
<input type="checkbox"/> Low <input type="checkbox"/> Low 2 <input type="checkbox"/> Medium <input type="checkbox"/> Medium 2 <input type="checkbox"/> High			
Short Term Disability Class Description	Class 1:	Class 2:	Class 3:
Short Term Disability (2 – 50 eligible employees)			
<input type="checkbox"/> Option 1 EP=1/8 <input type="checkbox"/> Option 2 EP=8/8 <input type="checkbox"/> \$100 <input type="checkbox"/> \$200 <input type="checkbox"/> \$300 <input type="checkbox"/> \$400 <input type="checkbox"/> \$500			
Short Term Disability (10 – 50 eligible employees)			
Weekly Benefit <input type="checkbox"/> 50% <input type="checkbox"/> 60% Maximum Benefit <input type="checkbox"/> \$500 <input type="checkbox"/> \$750 <input type="checkbox"/> \$1000 <input type="checkbox"/> \$1500 <input type="checkbox"/> \$2000 Elimination Period <input type="checkbox"/> 1 day injury/8 day illness <input type="checkbox"/> 8 day injury/8 day illness <input type="checkbox"/> 15 day injury/15 day illness Benefit Duration <input type="checkbox"/> 13 weeks <input type="checkbox"/> 26 weeks			

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Life and Disability Coverage Selection (Continued)

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:
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Long Term Disability (10 – 50 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

Long Term Disability (51 – 100 eligible employees)

Monthly Benefit 50% 60% 66 2/3% Maximum Amount \$ _____ (to a maximum of \$10,000)
 Elimination Period 90 days 180 days
 Benefit Duration 2 years 5 years 1983 Amended Social Security Normal Retirement Age

Employer Premium Contribution(s)

Coverage	Medical	Dental	Basic Life	AD&D Ultra®	Short Term Disability	Long Term Disability	Packaged Life Disability
Employer Premium Contribution for Employee	_____% or \$ _____	%	%	%	%	%	%
Employer Premium Contribution for Dependent	_____% or \$ _____	%	%	%	N/A	N/A	%
Employee Disability Tax Contribution (check one)					<input type="checkbox"/> Pre tax <input type="checkbox"/> Post tax	<input type="checkbox"/> Pre tax <input type="checkbox"/> Post tax	<input type="checkbox"/> Pre tax <input type="checkbox"/> Post tax

Participation

How many hours per week must your employees work to be eligible for coverage? <i>Employers may cover employees who work full-time, 25 hours or more, however, to determine if Small Group Reform applies 30 hours is used to determine if the group meets the definition of a Small Employer</i>		
Number of employees eligible for coverage (working the minimum hours to be eligible for coverage)		
Number of employees enrolling		Number of employees waiving Aetna coverage
Number of full-time employees excluding union employees		Number of employees working outside Delaware List all states: _____
Number of part-time employees		Number of employees not actively at work
Number of 1099 employees		Number of COBRA continuees
Number of union employees		Number in Waiting Period and not eligible
Classes Excluded: <input type="checkbox"/> Union – Local # _____		Do you want to cover Domestic Partners? <input type="checkbox"/> Yes <input type="checkbox"/> No

Benefit Waiting Period (BWP)

Eligibility date for enrollment will be the first day of the policy month following the waiting period, except Exactly 90 Days following Date of Hire. Policy month refers to the contract effective date of the 1st or 15th.	
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)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Benefit Waiting Period for future employees: <input type="checkbox"/> First day of policy month following: <input type="checkbox"/> 0 Days A date of hire effective date is not allowed. <input type="checkbox"/> 30 Days <input type="checkbox"/> 60 Days OR <input type="checkbox"/> Exactly 90 Days following Date of Hire If "0 days" is selected and the employee is hired on the 1st day of the month, the effective date will be the date of hire. If "Exactly 90 days following Date of Hire" is selected, the enrollment eligibility date will begin 90 calendar days following the date of hire. If the group has a 15th of the month bill cycle, the new hire will be effective on the 15th of the month following the waiting period chosen, except Exactly 90 Days following Date of Hire.	
Is a dual waiting period offered? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes , provide the two classes of employees below:	
Class 1 Waiting Period: _____	Class 1 Name: _____
Class 2 Waiting Period: _____	Class 2 Name: _____

Business Eligibility

Is your company a subsidiary of another company, an affiliate of another company, or under common control with another company?	<input type="checkbox"/> Yes <input type="checkbox"/> No				
Does your company file state or federal taxes with another company(ies) on a combined or consolidated basis?	<input type="checkbox"/> Yes <input type="checkbox"/> No				
Are there any associated companies to be included that are commonly owned?	<input type="checkbox"/> Yes <input type="checkbox"/> No				
<p>If "Yes" to any of the above questions, complete the information below.</p> <ul style="list-style-type: none"> • A copy of the Quarterly Wage and Tax Statement must be provided for each group to be included for coverage. • If you file or are eligible to file multiple businesses under one tax ID number, all businesses must be included as one group. 					
Business Name	Tax Identification Number	Owner's Name(s)	Percentage of Ownership	Number of Employees	Is group to be included?
					<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No
If you have answered "No" to "Is the group to be included" above, please explain why.					
Is your company a branch of another company, or does your company have branch offices?					<input type="checkbox"/> Yes <input type="checkbox"/> No
If "Yes,"	- Is each branch office a separate legal entity?				<input type="checkbox"/> Yes <input type="checkbox"/> No
	- How many branch offices are there?				
	- Are taxes filed separately or as one common filing? <input type="checkbox"/> Separately <input type="checkbox"/> One Common				
	- Where is each branch located? (List each branch business address separately.)				Number of Employees at each location
Are you currently a client company of a Professional Employer Organization (PEO)?					<input type="checkbox"/> Yes <input type="checkbox"/> No
If "Yes,"	- Provide the name of the PEO. _____				
	- Is group coverage available to you as a client of a PEO?				<input type="checkbox"/> Yes <input type="checkbox"/> No
	- Is the group considered a Co-Employer with the PEO?				<input type="checkbox"/> Yes <input type="checkbox"/> No
	- By enrolling for coverage as a small employer I am not in violation of any contract with the PEO.				<input type="checkbox"/> Agree <input type="checkbox"/> Disagree

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.

<p>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.</p> <p>The determination of how to count employees of related corporate entities when calculating group size for 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 id status of the related entities.</p>	
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Medicare Primary versus Secondary

<p>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?</p> <p><i>Include: Full-time, Part-time, Seasonal, Temporary, Union, Owners, Partners, Officers</i> <i>Exclude: Self-employed persons, Independent contractors (1099), Directors</i></p>	
<p>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</p>	

COBRA/TEFRA/DEFRA

Is your employer group required to comply with COBRA?			<input type="checkbox"/> Yes <input type="checkbox"/> No
How many full and part-time employees did you employ 50% of the business days in the prior calendar year? <i>Include: Full-time, Part-time, Seasonal, Temporary, Union, Owners, Partners, Officers</i> <i>Exclude: Self-employed persons, Independent contractors (1099), Directors</i> Each part-time employee counts as a fraction of an employee, with the fraction equal to the number of hours that the part-time employee worked divided by the hours an employee must work to be considered full-time.			
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.			<input type="checkbox"/> Yes <input type="checkbox"/> No
Name of Applicant	Qualifying Event (e.g., termination of employment, divorce, etc.)	Date of Qualifying Event	Date COBRA or State Continuation Coverage Terminates

Prior Carrier Information

Is this plan a total replacement of any existing group plans?	Carrier Name	Phone Number	Start Date	End Date
Current Medical Carrier <input type="checkbox"/> Yes <input type="checkbox"/> No				
Current Life/AD&D Carrier <input type="checkbox"/> Yes <input type="checkbox"/> No				
Current STD Carrier <input type="checkbox"/> Yes <input type="checkbox"/> No				
Current LTD Carrier <input type="checkbox"/> Yes <input type="checkbox"/> No				
Current Dental Carrier <input type="checkbox"/> Yes <input type="checkbox"/> No				

My current group dental plan has the following (check all that apply):
 Discount Dental Preventive Only Preventive and Basic Major Services Orthodontia – Ortho Max \$ _____
 Be sure and submit a copy of the most recent dental benefit summary to verify Major, Ortho, and Preventive and Basic coverage.

Has your business ever been insured with Aetna? If "Yes," provide group number: _____ Yes No

Workers' Compensation/Disability/Leave of Absence

Do you provide Workers' Compensation coverage?			<input type="checkbox"/> Yes <input type="checkbox"/> No
Is any person currently receiving Workers' Compensation benefits?			<input type="checkbox"/> Yes <input type="checkbox"/> No
Is any person to be covered unable to work due to illness or injury?			<input type="checkbox"/> Yes <input type="checkbox"/> No
Is any person currently on leave of absence for any reason?			<input type="checkbox"/> Yes <input type="checkbox"/> No
Name	Start Date	Expected Date of Return	Details

Signature Section

The Applicant agrees that at no time shall any employee be permitted or required to contribute for non-contributory coverage; or, unless the change is approved in writing by an authorized representative of Aetna, to make contributions for contributory coverage at a rate higher than the initial contribution rate applicable for the employee's then current coverage. It is agreed that no coverage shall become effective as to any person who is not then a bona fide, full-time employee, regularly performing the duties of his or her occupation, unless otherwise specifically provided in the plan documents (which consist of the Group 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 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 state 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 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 schedule. Aetna disclaims any responsibility if the employer elects such a 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.

Any person who knowingly and with intent to deceive or defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material or which would have affected the carrier's rating, offering, issuing of coverage thereto may have violated state law. Failure to disclose all health information encompassed by the questionnaire will be deemed to be material omissions for rating purposes.

All data that may have a bearing on coverage or premiums will be open for Aetna to inspect while the plan coverage is in force.

I understand Aetna will rely on the information I provide in determining eligibility for coverage, setting premium rates, compliance with applicable laws, and other purposes, and that any material misrepresentation or fraudulent statement may result in rescission of coverage under the group policy, rescission of the group policy, termination of coverage, increase in premiums, or other consequences. Aetna reserves the right to audit and to request documentation as evidence of business activity at any time and from time to time in order to validate my compliance with eligibility and underwriting guidelines as well as validate the applicability of State and Federal laws. I understand that my failure to comply with any such request may also result in termination of coverage, increase in premiums, or other consequences.

The availability of a plan or program may vary by geographic service area. Some benefits are subject to limitations or maximums.

Aetna does not provide health, dental or vision care services and, therefore, cannot guarantee any results or outcome.

I hereby apply for the coverage(s) indicated above. I certify that all information provided in this application is accurate and complete to the best of my knowledge and 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 subject to any state requirements.

JOINDER AGREEMENT - REQUEST FOR PARTICIPATION (for Life, Disability, Accidental Death and Personal Loss Coverage):

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. In addition, the Participating Employer, in accordance with ERISA Title I Section 503, designates Aetna Life Insurance Company ("Aetna") as the Named Fiduciary under the Plan, with complete and discretionary authority to review all denied claims for benefits under the Plan, and to construe disputed/doubtful Plan terms. Aetna shall be deemed to have properly exercised such authority unless it has abused its discretion by acting arbitrarily and capriciously.

EMPLOYER ACKNOWLEDGMENT – EMPLOYER WAITING PERIOD

Starting with plan years on or after 1/1/2014, the Affordable Care Act and subsequent federal regulations prohibit group health plans and health insurance issuers from requiring any otherwise eligible plan participants and beneficiaries (employees and dependents) to wait more than ninety (90) days before their health coverage is effective. The regulations define group health plan as the employer or plan administrator. The issuer is defined as the insurance company. Since the requirement applies to both the group health plan and the issuer, each party's obligation is satisfied if the ninety (90) day waiting period is honored. However, if neither party complies, both are subject to penalty.

The Employer Group Policyholder ("Employer") represents that it provides to Aetna, effective date information regarding plan participants and beneficiaries that takes into account the eligibility conditions and waiting period requirements required under federal law, in order for such plan participants and beneficiaries to become eligible for coverage under the Employer's group health insurance coverage with Aetna. In compliance with the waiting period requirements, Aetna shall use the effective date information provided by Employer to enroll such plan participants and beneficiaries in the Employer's group health insurance coverage. In the event this information changes, the Employer shall inform Aetna immediately.

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Signature Section (Continued)

ELECTRONIC ENROLLMENT, BILLING/PAYMENT AND ACCESS AGREEMENT

Enrollment: As part of your participation date, the following terms and conditions apply:

1. You agree to keep copies (paper or electronic) of actual enrollment forms and agree to maintain a reasonably complete record of enrollment and eligibility information (via electronic, interactive voice response technology and/or hard copy format), including evidence of coverage elections, evidence of eligibility, changes to such elections and terminations. Records must be available to Aetna upon request and retained for seven years.
2. For electronic enrollment submissions or changes you agree to create and maintain the records on secure information systems that can generate hard copy records of enrollments or changes entered or maintained on those information systems. Any hard copy records generated pursuant to this provision shall meet reasonable standards of availability, authenticity, non-repudiation and integrity.
3. You represent that all enrollment and eligibility information presented to Aetna is accurate and timely updated. 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.

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>.

Signed at 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 represent that I am licensed and appointed to sell Aetna group products in the state of Delaware. 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.

IMPORTANT: Check applicable box if submitting through:

- Aetna Marketplace Private Exchange – Vendor Name: _____
 TPA – Vendor Name: _____

Broker Name:

Social Security Number:			National Producer Number:		
Agency Name:			Tax ID Number:		
Address:			Pay Commissions To (check one): <input type="checkbox"/> Broker <input type="checkbox"/> Agency		
City:			Telephone Number: ()		
State:	ZIP:	% of Credit:	Fax Number: ()		
Signature:			Date:	E-mail Address:	
Broker Admin Assistant Name:			Broker Admin Assistant E-mail Address:		

Broker Name:

Social Security Number:			National Producer Number:		
Agency Name:			Tax ID Number:		
Address:			Pay Commissions To (check one): <input type="checkbox"/> Broker <input type="checkbox"/> Agency		
City:			Telephone Number: ()		
State:	ZIP:	% of Credit:	Fax Number: ()		
Signature:			Date:	E-mail Address:	
Broker Admin Assistant Name:			Broker Admin Assistant E-mail Address:		

General Agent Name:

Selling Agent Name:			Tax ID Number:		
Address:			E-mail Address:		
City:			Telephone Number: ()		
State:	ZIP:		Fax Number: ()		
GA Admin Assistant Name:			GA Admin Assistant E-mail Address:		