

# Unlock new opportunities

Small Business Solutions



**New business  
underwriting  
guidelines**

**New York**

FOR BUSINESSES WITH 2 TO 50  
ELIGIBLE EMPLOYEES

Health/Dental benefits and Health/Dental insurance plans are offered and/or underwritten by Aetna Health Inc., 151 Farmington Avenue, Hartford, CT 06156, and/or Aetna Life Insurance Company. Life and Disability insurance plans are offered and/or underwritten by Aetna Life Insurance Company.

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We want you to know<sup>®</sup>



# Underwriting guidelines

This material is intended for brokers and agents and is for informational purposes only. It is not intended to be all inclusive. Other policies and guidelines may apply.

<b>ALL PRODUCTS</b>	
<b>Census Data</b>	<ul style="list-style-type: none"> <li>■ Census data must be provided on all eligible (and COBRA/State Continuation eligible) employees and must include name, age/date of birth, date of hire, gender, dependent status and residence zip code.</li> <li>■ Retirees are not eligible.</li> </ul>
<b>Case Submissions</b>	Groups with 2 to 50 eligible employees must have all completed paperwork into Aetna Underwriting 5 business days prior to the requested effective date. If not received by this date, the effective date will be moved to the next available effective date.
<b>Common Ownership</b>	<ul style="list-style-type: none"> <li>■ Single employer groups with multiple TINs may be considered as one group.</li> <li>■ One owner must control at least 51% of each separate business.</li> <li>■ A copy of current 1120 (Schedule K-1 Form) must be provided.</li> <li>■ A copy of most recent Quarterly Wage and Tax Statement or Payroll records must be provided.</li> <li>■ The two or more groups may have multiple Standard Industrial Classification Codes (SIC); however, rates will be based on the SIC code for the group with the majority of employees (not applicable on Medical).</li> </ul>
<b>Dependent Eligibility</b>	<ul style="list-style-type: none"> <li>■ Eligible dependents include an employee's spouse and unmarried children up to the limiting age of the plan (ages 19-23 if full-time student).</li> <li>■ Domestic Partners are considered eligible dependents when enrolled in any medical or dental plan from Aetna's 2007 and 2008 portfolio.</li> <li>■ Individuals cannot be covered as an employee and dependent under the same plan; children eligible for coverage through both parents cannot be covered by both under the same plan.</li> <li>■ If an employee and dependent work for the same company, please refer to employee eligibility.</li> <li>■ Dependents must enroll in same benefit options as the employee. For Dental, employees may select coverage for eligible dependents under the Dental plan even if they select single coverage under the Medical plan.</li> <li>■ Dependents are not eligible for AD&amp;D Ultra® or Disability.</li> </ul>
<b>Effective Date</b>	<ul style="list-style-type: none"> <li>■ The effective date will be the 1st or the 15th of the month.</li> <li>■ The effective date requested by the employer may be up to 60 days in advance.</li> </ul>
<b>Employee Eligibility</b>	<ul style="list-style-type: none"> <li>■ Eligible employees are those employees who are permanent and work on a full-time basis with a normal workweek of at least 20 hours, and who have met any authorized waiting period requirements.</li> <li>■ If an employee and dependent work for the same company and elect to enroll as employee and dependent, applicable documentation to determine dependent's actual employee eligibility status must be provided as any other employee of the group (i.e., NYS-45, Partnerships documentation, etc.).</li> <li>■ Coverage must be extended to all employees meeting the above conditions, unless they belong to a union class excluded as the result of a collective bargaining arrangement.</li> <li>■ Employees who do not meet the definition of a permanent full-time employee will not be eligible (e.g., leased, part-time, temporary, seasonal or substitute employees).</li> <li>■ NY Small Group reform excludes union employees who are covered by a collective bargaining agreement.</li> <li>■ 1099 contractors are not eligible. Stockholders, partners, Board Members or other outside consultants who are not active, permanent full-time employees are not eligible.</li> <li>■ For Life &amp; Disability, employees who are both disabled and away from work on the date their insurance would otherwise become effective will become insured on the date they return to active full-time work for one full day.</li> <li>■ An employee can waive Medical coverage and still enroll for Life/AD&amp;D and Disability.</li> <li>■ An employee is eligible to enroll in a NYC Community Plan<sup>SM</sup> only if he or she resides or works and accesses health care in the five boroughs of New York City — Manhattan, Bronx, Queens, Staten Island and Brooklyn.</li> </ul> <p><b>Retirees</b></p> <ul style="list-style-type: none"> <li>■ Retiree coverage is not available.</li> </ul> <p><b>COBRA continuees</b></p> <ul style="list-style-type: none"> <li>■ COBRA/State Continuation eligible enrollees are required to be included on the census (not eligible for Life or STD).</li> <li>■ COBRA/State Continuation qualifying event, length, start and end date must be provided.</li> </ul>
<b>Employer Eligibility</b>	<ul style="list-style-type: none"> <li>■ Medical plans can be offered to groups of 2 to 50 eligible employees.</li> <li>■ Organizations must not be formed solely for the purpose of obtaining health coverage.</li> <li>■ Associations, Taft-Hartley groups, Professional Employers Organizations (PEO)/employee leasing firms must be written individually and are not eligible to be combined for purposes of obtaining health coverage. A copy of the certificate of fictitious name should be provided.</li> <li>■ Dental and Disability have ineligible industries which are listed separately below. The Dental ineligible industry list does not apply when Dental is sold in combination with Medical.</li> </ul>

<p><b>Employer Eligibility (cont.)</b></p>	<ul style="list-style-type: none"> <li>■ Submission of the most recent NYS-45 which must contain the names, salaries, etc., of all employees of the employer group. <ul style="list-style-type: none"> <li>&gt; Employees who have terminated or work part-time should be noted accordingly on the NYS-45 (less than 20 hours per week).</li> <li>&gt; Employees not listed on the NYS-45 should have a W4 and payroll stub indicating withholdings.</li> <li>&gt; If employee is sole proprietor, partner or corporate officer, the Proof of Eligibility form must be completed and submitted with the following:</li> </ul> </li> </ul> <p><b>If Sole Proprietor not on NYS-45 submit:</b></p> <ul style="list-style-type: none"> <li>■ Assumed Name Certificate (Fictitious Business Name or DBA) AND</li> <li>■ Certificate of Organization (for LLC or LLP)</li> </ul> <p><b>One of the following:</b></p> <ul style="list-style-type: none"> <li>■ IRS Form 1040C or 1040F (profit or loss)</li> <li>■ IRS Form 1040 SE</li> <li>■ IRS Form 1040 ES</li> </ul> <p><b>If Partner not on NYS-45 submit:</b></p> <ul style="list-style-type: none"> <li>■ Partnership Agreement OR</li> <li>■ Assumed Name Certificate (Fictitious Business Name or DBA)</li> <li>■ Certificate of Organization (for LLC or LLP)</li> </ul> <p><b>One of the following:</b></p> <ul style="list-style-type: none"> <li>■ IRS Form 1065 (Schedule K)</li> <li>■ IRS Form 1040 SE</li> <li>■ IRS Form 1040 ES</li> </ul> <p><b>If Corporate Officer not on NYS-45 submit:</b></p> <ul style="list-style-type: none"> <li>■ Assumed Name Certificate (Fictitious Business Name or DBA) AND</li> <li>■ Articles of Incorporation</li> </ul> <p><b>One of the following:</b></p> <ul style="list-style-type: none"> <li>■ C-Corp &amp; Persons Services Corporation: IRS Form 1120, 1120A or 1120W and Schedule E where applicable</li> <li>■ Corp: IRS Forms 1120S, K1 &amp; 1040ES</li> </ul>
<p><b>Employer Financial Conditions</b></p>	<ul style="list-style-type: none"> <li>■ Current carrier bill with billing summary will be required; group must be no more than one month delinquent on payments (i.e., current month only may not yet be paid).</li> <li>■ Groups that have been terminated for non-payment by Aetna will not be eligible to reapply until 12 months after the date of termination.</li> </ul>
<p><b>Final Rates</b></p>	<p>Medical Rates are Community Rated. Life and Dental rating will be based on final enrollment.</p>
<p><b>Initial Premium Check</b></p>	<ul style="list-style-type: none"> <li>■ The initial premium check is not a binder check and does not bind Aetna to provide coverage.</li> <li>■ An initial premium check equal to one-month premium must accompany application.</li> <li>■ If the request for coverage is denied due to business ineligibility, participation and/or contributions not met, or other permissible reasons, the initial premium check will be returned to the employer.</li> <li>■ Checks must be on company check stock (personal checks not acceptable).</li> <li>■ If the initial premium check is returned for non-sufficient funds, coverage will be retroactively termed to the effective date.</li> </ul>
<p><b>Newly Formed Business</b></p>	<p>Must provide the following documentation for consideration:</p> <ul style="list-style-type: none"> <li>■ Payroll records or letter from attorney or Certified Public Accountant listing the names of all employees, number of hours worked on a regular basis, indication of salary draw and</li> <li>■ Tax ID Number</li> </ul>
<p><b>Plan Change Ancillary Additions</b></p>	<ul style="list-style-type: none"> <li>■ Requests to add or change ancillary benefits must be requested by the desired effective date.</li> <li>■ <b>The future renewal date of the ancillary products will be the same as the medical plan renewal date.</b></li> </ul>
<p><b>Replacing Other Group Coverage</b></p>	<ul style="list-style-type: none"> <li>■ A copy of the current billing statement that includes the account summary showing the plan is paid to the current premium due date.</li> <li>■ <b>The employer should be told not to cancel any existing medical coverage until notification of approval.</b></li> </ul>
<p><b>Waiting Period</b></p>	<ul style="list-style-type: none"> <li>■ The employer decides whether or not to impose a probationary period.</li> <li>■ The probationary period must be consistently applied to all eligible employees.</li> <li>■ On time entrant eligibility date will be the first day of the policy month (1st or 15th of the month) following the waiting period of 0, 30, 60, 90, 120 or 180 days.</li> <li>■ Changes to probationary period allowed on anniversary only.</li> </ul>

**SPECIFIC TO PRODUCTS**

	Medical	Dental	Basic Life and Packaged Life & Disability
<b>Product Availability</b>	<ul style="list-style-type: none"> <li>■ 2 to 50 eligible employees.</li> <li>■ May be written standalone or with ancillary coverages as noted in the following columns.</li> <li>■ The NYC Community Plan<sup>SM</sup> is only available to employers who are located in the five boroughs of New York City — Manhattan, Bronx, Queens, Staten Island and Brooklyn.</li> <li>■ Any employee who does not reside or work and access health care in the five boroughs of New York City is not eligible to enroll in the NYC Community Plan, but may be eligible to enroll in one of our Managed Choice<sup>®</sup> Open Access or EPO Open Access Plans.</li> </ul>	<ul style="list-style-type: none"> <li>■ 2 eligible employees — Options 2-7 available with Medical. Options V2, V3 and V4 not available.</li> <li>■ 3 to 50 eligible employees — all plans available with or without Medical.</li> <li>■ Orthodontia coverage is available to dependent children only for groups with 10 or more eligible employees.</li> </ul>	<ul style="list-style-type: none"> <li>■ 2 to 50 eligible employees if sold with Medical.</li> <li>■ 10 to 50 eligible employees if sold with Medical or Dental on a standalone basis.</li> <li>■ Must meet the qualifications of a small business. The same employer eligibility guidelines that apply to Medical will apply to Basic Life and Packaged Life/Disability coverage.</li> <li>■ Life and Disability are bundled with Medical at the employer level, not the employee level. Therefore, a subscriber within a given group can waive Medical coverage and Basic Life or the Packaged Life/Disability.</li> </ul>
<b>Excluded Class/Carve Outs</b>	<ul style="list-style-type: none"> <li>■ Union employees, as a class, may be excluded by an employer as not being eligible for coverage.</li> <li>■ Coverage of management employees only is not permitted.</li> </ul>	Not allowed	Not applicable
<b>Option Sales</b>	It is strongly recommended that Aetna be the sole carrier for groups of 2-19 eligible employees.	<ul style="list-style-type: none"> <li>■ No other employer-sponsored dental plan can be offered.</li> </ul>	Not applicable
<b>Employer Contribution</b>	<ul style="list-style-type: none"> <li>■ <b>Contracts issued for MC/EPO Open Access products:</b> <ul style="list-style-type: none"> <li>&gt; Groups with less than 10 eligible lives, the employer must contribute 100% of the employee-only cost or 50% of the total cost of the plan.</li> <li>&gt; Groups with 10 to 50 eligible lives, the employer must contribute at least 50% of employee-only cost or 50% of the total cost of the plan.</li> </ul> </li> <li>■ <b>Contracts issued for NYC Community Plan:</b> <ul style="list-style-type: none"> <li>&gt; We strongly recommend groups with less than 10 eligible lives, the employer contribute 100% of the employee cost or 50% of the total cost of the plan.</li> <li>&gt; We strongly recommend groups with 10 to 50 eligible lives, the employer contribute at least 50% of the employee-only cost or 50% of the total cost of the plan.</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>■ For Options 2-7, employers must contribute at least 25% of the total cost of the plan or 50% of the cost of employee-only coverage. Coverage can be denied based on inadequate contributions.</li> <li>■ For Options V2-V4, employer contribution of less than 50% of the cost of employee-only coverage. Employee Pay All plans are permitted.</li> </ul>	<ul style="list-style-type: none"> <li>■ 2 to 9 eligible employees — 100% of the total cost of the basic Life plan (excluding Optional Dependent Term).</li> <li>■ 10 to 50 eligible employees — at least 50% of the total cost of the plans (excluding Optional Dependent Term).</li> </ul>

	Medical	Dental	Basic Life and Packaged Life & Disability
<b>Out-of-State Employees</b>	<ul style="list-style-type: none"> <li>■ Coverage available for employees who live outside of CT, DE, MD, NJ, NY, PA, VA and DC.</li> <li>■ In order for Aetna to accommodate an out-of-state/situs employee, 51% or more of the employees must be employed in the domiciled state.</li> <li>■ Any employee residing in a state with an Aetna Managed Choice Network will be eligible to enroll in the New York Health Benefit Plan.</li> <li>■ Any employee not residing in a state with an Aetna Managed Choice Network will be enrolled in the New York Indemnity Benefit Plan.</li> <li>■ Any employee located in CT, DE, MD, NJ, NY, PA, VA or DC, but not residing in a state with an Aetna Managed Choice Network will be enrolled in the New York Indemnity Benefit Plan.</li> <li>■ For groups with more than 50% of the group's employees working outside of NY &amp; situs, Aetna will decline to offer coverage to the group.</li> </ul>	<ul style="list-style-type: none"> <li>■ Employees who reside outside of NJ, PA, DE, MD, VA, DC, NY and CT are considered outside the situs region.</li> <li>■ Out-of-State/Situs employees will be offered one of the specific out-of-state/situs dental PPO plans. Employees who fall outside a dental PPO network area will default to a comparable Indemnity plan.</li> <li>■ Maximum out-of-state/situs employee percentage (and/or number of employees) will agree with the Medical guidelines.</li> </ul>	Not applicable
<b>Participation</b>	<p><b>NYC Community Plan:</b> Contracts issued for the NYC Community Plan do not require a minimal participation. All groups must meet minimum eligibility requirements and provide waivers for those members not enrolling in an Aetna plan.</p> <p><b>Managed Choice/EPO Open Access:</b></p> <ul style="list-style-type: none"> <li>■ 2 to 4 lives: <ul style="list-style-type: none"> <li>&gt; Participation requirement is a minimum of 2 enrolling or 50%, whichever is greater, excluding waivers.</li> <li>&gt; Waivers are defined as spousal, Medicare or VA.</li> <li>&gt; Aetna must be total replacement.</li> </ul> </li> <li>■ 5 lives or greater: <ul style="list-style-type: none"> <li>&gt; Participation requirement is a minimum of 2 enrolling or 50%, whichever is greater, excluding waivers.</li> <li>&gt; Waivers are defined as spousal, Medicare, other group coverage or VA.</li> <li>&gt; Minimum 5 enrolled in a Dual Option or Pick-A-Plan.</li> <li>&gt; Every eligible employee listed on the state wage and tax form will need one of the following: enrollment form, waiver form.</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>■ Options 2-7 for Groups of 2 to 3 Eligible Employees: <ul style="list-style-type: none"> <li>&gt; 100% participation is required, excluding those with other qualifying existing dental coverage.</li> <li>&gt; Employees may select coverage for eligible dependents under the dental plan even if they selected single coverage on the medical plan or vice-versa. <b>Example:</b> 3 eligibles; 1 covered under spouse dental plan (3 minus 1 = 2 x 100% = 2 must enroll in Aetna dental plan)</li> </ul> </li> <li>■ Options 2-7 for Groups of 4 to 50 Eligible Employees: <ul style="list-style-type: none"> <li>&gt; Non-contributory plans — 100% participation is required. All employees excluding those with other qualifying existing dental coverage must enroll.</li> <li>&gt; Contributory plans — 75% participation is required, excluding those with other qualifying existing dental coverage. A minimum of 50% of total eligible employees must enroll in the dental plan. Employees may select coverage for eligible dependents under the dental plan even if they selected single coverage on the medical plan or vice-versa. <b>Example 1:</b> 6 eligibles; 2 covered under spouse dental plan (6 minus 2 = 4 x 75% = 3 must enroll in Aetna dental plan). <b>Example 2:</b> 5 eligibles; 2 covered under spouse dental plan (5 minus 2 = 3 x 75% = 2.25; 3 must enroll in Aetna dental plan because 2 would not meet the 75% test or the 50% minimum test).</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>■ Employees may elect Life or Disability insurance even if they do not elect Medical coverage and the group must meet the required participation percentage. If not, then Basic Life or Packaged Life/Disability will be declined for the group.</li> <li>■ 2 to 9 Eligible Employees: <ul style="list-style-type: none"> <li>&gt; 100% participation is required <b>Example:</b> 9 employees, 3 waiving Medical. All 9 must enroll for Life.</li> </ul> </li> <li>■ 10 to 50 Eligible Employees: <ul style="list-style-type: none"> <li>&gt; 75% must participate when the plan is at least partially contributory.</li> <li>&gt; 100% participation is required for all non-contributory plans.</li> </ul> </li> </ul>

	Medical	Dental	Basic Life and Packaged Life & Disability																																																														
<b>Participation (cont.)</b>		<ul style="list-style-type: none"> <li>Options V2-V4 for Groups of 3 to 50 Eligible Employees:               <ul style="list-style-type: none"> <li>&gt; 50% participation, excluding those with other qualifying existing dental coverage or a minimum of 3 enrollees (5 enrollees for orthodontia coverage), whichever is greater is required. Employees may select coverage for eligible dependents under the dental plan even if they select single coverage on the medical plan or vice-versa.</li> </ul> </li> <li><b>Example 1:</b> 6 eligible; 2 covered under spouse dental plan, 6 minus 2 = 4 x 50% = 2. 2 is below the 3 enrollee minimums so 3 must enroll in Aetna dental plan V2 – V4 to meet minimum requirement.</li> <li><b>Example 2:</b> 20 eligible; 2 covered under spouse dental plan, 20 – 2 = 18 x 50% = 9 must enroll in the Aetna dental plan V2-V4.</li> </ul>																																																															
<b>Late Applicants</b>	<p>An employee or dependent who enrolls for coverage more than 31 days from the date first eligible is considered a late enrollee. Applicants without a qualifying life event (i.e., marriage, divorce, newborn child, adoption, loss of spousal coverage, etc.) are subject to the Late Entrant guidelines as follows:</p>																																																																
	<ul style="list-style-type: none"> <li>Late applicants will be deferred to the next plan anniversary date of the group and may reapply for coverage 30 days prior to the anniversary date.</li> <li>Newborns will not be considered a late entrant when enrollment is received during the first year after birth.</li> </ul>	<ul style="list-style-type: none"> <li>An employee or dependent may enroll at any time; however, coverage is limited to Preventive &amp; Diagnostic Services for the first 12 months. No coverage for most Basic and Major Services for first 12 months (24 months for Orthodontics).</li> <li>Late Entrant provision does not apply to enrollees less than age 5.</li> </ul>	<ul style="list-style-type: none"> <li>Late applicants will be deferred to the next plan anniversary date of the group and may reapply for coverage 30 days prior to the anniversary date.</li> <li>The applicant will be required to complete an individual health statement/questionnaire and provide Evidence of Insurability (EOI).</li> </ul>																																																														
<b>Industries</b>	<ul style="list-style-type: none"> <li>All industries eligible.</li> <li>The employer should provide the SIC code (four digit number or 6 digit code) filed with the state on the business tax return and/or Workers' Compensation form.</li> </ul>	<ul style="list-style-type: none"> <li>Ineligible industry list applies only when Dental is sold standalone or packaged only with Group Insurance.</li> <li>This list does not apply when Dental is sold in combination with Medical.</li> </ul> <table border="1"> <thead> <tr> <th>SIC Range</th> <th>SIC Description</th> </tr> </thead> <tbody> <tr><td>7933</td><td>Bowling Centers</td></tr> <tr><td>8611</td><td>Business Associations</td></tr> <tr><td>7911</td><td>Dance Studios, Schools</td></tr> <tr><td>7361-7363</td><td>Employment Agencies</td></tr> <tr><td>7999</td><td>Misc Amusement and Recreation</td></tr> <tr><td>8699</td><td>Misc Membership Organizations</td></tr> <tr><td>8999</td><td>Misc Services</td></tr> <tr><td>7991</td><td>Physical Fitness Facilities</td></tr> <tr><td>8811</td><td>Private Households</td></tr> <tr><td>7941-7948</td><td>Professional Sports Clubs &amp; Producers, Race Tracks</td></tr> <tr><td>8621-8651</td><td>Professional Membership Organizations, Labor Unions, Civic Social &amp; Fraternal Organizations, Political Organizations</td></tr> <tr><td>7992-7997</td><td>Public Golf Courses, Amusements, Membership Sports &amp; Recreation Clubs</td></tr> <tr><td>8661</td><td>Religious Organizations</td></tr> <tr><td>7922-7929</td><td>Theatrical Producers, Bands, Orchestras, Actors</td></tr> </tbody> </table>	SIC Range	SIC Description	7933	Bowling Centers	8611	Business Associations	7911	Dance Studios, Schools	7361-7363	Employment Agencies	7999	Misc Amusement and Recreation	8699	Misc Membership Organizations	8999	Misc Services	7991	Physical Fitness Facilities	8811	Private Households	7941-7948	Professional Sports Clubs & Producers, Race Tracks	8621-8651	Professional Membership Organizations, Labor Unions, Civic Social & Fraternal Organizations, Political Organizations	7992-7997	Public Golf Courses, Amusements, Membership Sports & Recreation Clubs	8661	Religious Organizations	7922-7929	Theatrical Producers, Bands, Orchestras, Actors	<ul style="list-style-type: none"> <li>Basic Life only — all industries are eligible.</li> <li>Packaged Life/Disability — the following industries are not eligible for the Packaged Life and Disability plan:</li> </ul> <table border="1"> <thead> <tr> <th>SIC Range</th> <th>SIC Description</th> </tr> </thead> <tbody> <tr><td>1000-1499</td><td>Mining</td></tr> <tr><td>7381 Service</td><td>Detective Services</td></tr> <tr><td>2892-2899</td><td>Explosives, Bombs &amp; Pyrotechnics</td></tr> <tr><td>7500-7599</td><td>Automotive Repairs/ Services</td></tr> <tr><td>3291-3292</td><td>Asbestos Products</td></tr> <tr><td>7800-7999</td><td>Motion Picture/ Amusement</td></tr> <tr><td>3310-3329</td><td>Primary Metal Industries &amp; Recreation</td></tr> <tr><td>3480-3489</td><td>Fire Arms &amp; Ammunition</td></tr> <tr><td>8010-8043</td><td>Doctors Offices/Clinics</td></tr> <tr><td>5921</td><td>Liquor Stores</td></tr> <tr><td>8600-8699</td><td>Membership Associations</td></tr> <tr><td>6211</td><td>Security Brokers</td></tr> <tr><td>8800-8899</td><td>Service-Private Households</td></tr> <tr><td>6531</td><td>Real Estate – Agents</td></tr> <tr><td>9999</td><td>Non-classified Establishments</td></tr> </tbody> </table>	SIC Range	SIC Description	1000-1499	Mining	7381 Service	Detective Services	2892-2899	Explosives, Bombs & Pyrotechnics	7500-7599	Automotive Repairs/ Services	3291-3292	Asbestos Products	7800-7999	Motion Picture/ Amusement	3310-3329	Primary Metal Industries & Recreation	3480-3489	Fire Arms & Ammunition	8010-8043	Doctors Offices/Clinics	5921	Liquor Stores	8600-8699	Membership Associations	6211	Security Brokers	8800-8899	Service-Private Households	6531	Real Estate – Agents	9999	Non-classified Establishments
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## PRODUCT SPECIFICATIONS

MEDICAL ONLY													
<b>Dual/Triple Option</b>	<p><b>Dual Option</b> — Groups with a minimum of 5 enrolled in any Aetna Product with 50% participation after valid waivers for any combinations of our currently marketed Managed Choice Open Access, EPO Open Access, or NYC Community plans. The corresponding prescription drug benefit may be variable for each medical option elected.</p> <p><b>Triple Option</b> — Groups with a minimum of 20 employees enrolling in Aetna Health Plan as the Total Replacement Carrier are eligible for Triple Option. Three plans in any combination may be offered. Those groups with less than 20 employees enrolling will be limited to the Dual Option selection above.</p>												
DENTAL ONLY													
<b>Product Packaging</b>	<ul style="list-style-type: none"> <li>■ Options 3, 7, V2, V3 and V4 cannot be sold with any other option. It must be the only plan sold.</li> <li>■ Option 2 (DMO) can be either sold as the only dental option or can be packaged with Options 4-6.</li> <li>■ Options 4, 5 and 6 (PPO plans) can be sold standalone or packaged with DMO as a Dual Option.</li> </ul>												
<b>Open Enrollment</b>	<ul style="list-style-type: none"> <li>■ Open enrollments are prohibited for Options 2-6.</li> <li>■ An employee or dependent can enroll at any time, but is subject to the Dental Late Entrant provision if enrollment occurs other than within 31 days of first becoming eligible, unless a qualifying life event has occurred or the enrollee is less than age 5.</li> </ul>												
<b>Coverage Waiting Period</b>	<ul style="list-style-type: none"> <li>■ On PPO and Indemnity plans for coverage of Major and Orthodontic Services, must be an enrolled member of plan for 1 year before eligible.</li> <li>■ There is no Coverage Waiting Period on the DMO.</li> </ul>												
<b>Waiting Period Waiver</b>	<p>Waiting Period is waived separately for Major or Orthodontic Services for employees who were covered by the group's immediately preceding dental plan. To waive Waiting Period for Orthodontic Services, the group's immediately preceding plan must have included Orthodontic coverage. To waive Waiting Period for Major Services, the group's immediately preceding plan must have included Major coverage.</p> <p><b>Example:</b> Prior Major coverage but no Ortho coverage. New plan has both Major and Ortho coverage. The waiting period is waived for Major Services but not for Orthodontic Services.</p>												
<b>Reinstatement</b>	<p>For the Voluntary plan options: If there is a lapse in coverage, members may not re-enroll in the plan for a period of two years from the date of termination. If they are eligible for coverage at that time, they may re-enroll, subject to all provisions of the plan, including, but not limited to, the Coverage Waiting Period.</p>												
LIFE AND DISABILITY ONLY													
<b>Job Classification</b>	<ul style="list-style-type: none"> <li>■ Varying levels of coverage based on job classifications are available for groups with 10 or more lives. Up (Position) Schedules to 3 separate classes are allowed.</li> <li>■ Items such as probationary periods must be applied consistently within a class of employee.</li> <li>■ The benefit for the class with the richest benefit must not be greater than five (5) times the benefit of the class with the lowest benefit. For example, a schedule may be structured as follows:</li> </ul> <table border="1"> <thead> <tr> <th>Position/Job Class</th> <th>Basic Term Life Amount</th> <th>Packaged Life/Disability</th> </tr> </thead> <tbody> <tr> <td>Executive</td> <td>\$100,000</td> <td>High Option</td> </tr> <tr> <td>Managers/Supervisors</td> <td>\$50,000</td> <td>Medium Option</td> </tr> <tr> <td>All Other Employees</td> <td>\$25,000</td> <td>Low Option</td> </tr> </tbody> </table>	Position/Job Class	Basic Term Life Amount	Packaged Life/Disability	Executive	\$100,000	High Option	Managers/Supervisors	\$50,000	Medium Option	All Other Employees	\$25,000	Low Option
Position/Job Class	Basic Term Life Amount	Packaged Life/Disability											
Executive	\$100,000	High Option											
Managers/Supervisors	\$50,000	Medium Option											
All Other Employees	\$25,000	Low Option											
<b>Continuity of Coverage (no loss/no gain)</b>	<ul style="list-style-type: none"> <li>■ The employee will not lose coverage due to a change in carriers. This protects employees who are not actively at work during a change in insurance carriers.</li> <li>■ If an employee is not actively at work, Aetna will waive the actively-at-work requirement and provide coverage, except no benefits are payable if the prior plan is liable.</li> </ul>												

This material is for information only and is neither an offer nor invitation to contract. An application must be completed to obtain coverage. Rates and benefits vary by location. Health/dental benefits plans, health/dental insurance plans, life and disability insurance plans contain exclusions and limitations. Providers are independent contractors and are not agents of Aetna. Provider participation may change without notice. Aetna does not provide care or guarantee access to health services. If you are in a plan that requires the selection of a primary care physician and your primary care physician is a part of an integrated delivery system or physician group, your primary care physician will generally refer you to specialists and hospitals that are affiliated with the delivery system or physician group. Not all health/disability services are covered. See plan documents for a complete description of benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by location and are subject to change.

Investment services are independently offered through JPMorgan Institutional Investors, Inc., a subsidiary of JPMorgan Chase Bank.

Aetna receives rebates from drug manufacturers that may be taken into account in determining Aetna's Preferred Drug List. Rebates do not reduce the amount a member pays the pharmacy for covered prescriptions. Information subject to change. For more information about Aetna plans, refer to [www.aetna.com](http://www.aetna.com).



# Underwriting Guidelines For Groups with 2 to 50 Eligible Employees New York (Effective as of 1/1/04)

## Carve Outs/Excluded Class

- Union employees, as a class, may be excluded by an employer, as not being eligible for coverage.
- Coverage of management employees only is not permitted.

## Census Data

- Census data must be provided on all eligible (and COBRA/State Continuation eligible) employees and must include name, age/date of birth, and date of hire, gender, dependent status, and residence zip code.
- Retirees are not eligible.

## COBRA/State Continuation Eligible

- COBRA/State Continuation eligible should be included on the census.
- COBRA/State Continuation qualifying event date is required at time of enrollment.
- Employers with 20 or more employees full & part-time are required to offer COBRA Coverage.
- Employers with less than 20 employees full & part-time are required to offer State Continuation.

## Cut Off Dates

- Groups with 2 to 50 eligible must have all **completed** paperwork into Aetna Underwriting 1 business day prior to the requested effective date. If not received by this date, the effective date will be moved to the next available effective date.

## Dependent Eligibility

- Eligible dependents include an employee's spouse and unmarried children up to the limiting age of the plan (ages 19-23 – if fulltime student).
- Domestic Partners are not considered eligible dependents.
- Individuals cannot be covered as an employee and dependent under the same plan, children eligible for coverage through both parents cannot be covered by both under the same plan.
- Dependents must enroll in same benefit options as the employee.

## Dual Product Option

Minimum of 10 enrolled in any Aetna Product with 75% participation after spousal or Medicare waivers for all combinations of products.

- HMO/QPOS –
  - HMO Option 4 alongside any QPOS Option
  - HMO Option 2 or 3 alongside QPOS 1, 2, 3 or 4
- MC/HMO - Minimum of 10 enrolled with 75% participation excluding waivers (spousal or Medicare).
- MC/MC - Minimum of 10 enrolled and 75% participation excluding waivers. (spousal or Medicare)
- Aetna HMO / Another Carrier - Must offer HMO
- Aetna MC / Another Carrier - Minimum of 60% participation in Aetna excluding waivers (spousal or Medicare)

## Effective Date

- The effective date will be the 1<sup>st</sup> or the 15<sup>th</sup> of the month.
- The effective date requested by the employer may be up to 60 days in advance.

## Employer Contributions

- Contracts issued for HMO/QPOS products:
  - We strongly recommend for groups with less than 10 eligible lives, that the employer contribute 100% of the employee only cost or 50% of the total cost of the plan.

**This document is meant to be informative, and is not intended to be inclusive. Other policies and guidelines may apply.**

**Note: State and Federal Legislation/Regulations, including Small Group Reform and HIPAA, take precedence over any and all Underwriting Rules. Exceptions to Underwriting Rules require approval of Head Regional Underwriter except where Chief Underwriter approval is indicated.**

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**Underwriting Guidelines**  
**For Groups with 2 to 50 Eligible Employees**  
**New York** (Effective as of 1/1/04)

- We strongly recommend for groups with 10 to 50 eligible lives, that the employer contribute at least 50% of employee only cost or 50% of the total cost of the plan.
- Coverage can be denied if the employer contributes less than 10% of an employee’s annual premium
- Contracts issued on our ALIC (Managed Choice Products/PPO) license:
  - For Groups with < 10 eligible lives – Employer must contribute 100% of employee only cost or 50% of total cost of the plan
  - For Groups with > 10 eligible lives – Employer must contribute 75% of employee only cost or 50% of total cost of the plan

**Employee Eligibility**

- Eligible employees are those employees who are permanent and work on a full-time basis with a normal workweek of at least 20 hours, and who have met any authorized waiting period requirements.
- If an employee and dependent work for the same company, and elect to enroll as employee and dependent, applicable documentation to determine dependent’s actual employee eligibility status must be provided as any other employee of the group (i.e. NYS45, Partnerships documentation, etc.).
- Coverage must be extended to all employees meeting the above conditions, unless they belong to a union class excluded as the result of a collective bargaining arrangement.
- Employees who do not meet the definition of a permanent full-time employee will not be eligible, (e.g. Leased, part-time, temporary, seasonal or substitute employees)
- NY Small Group reform excludes union employees who are covered by a collective bargaining agreement.

**Employer Eligibility**

- Medical plans can be offered to sole proprietorships with two or more employees, partnerships or corporations.
- Organizations must not be formed solely for the purpose of obtaining health coverage.
- Associations, Taft Hartley groups, Professional Employers Organizations (PEO)/employee leasing firms must be written individually and are not eligible to be combined for purposes of obtaining health coverage. A copy of the certificate of fictitious name should be provided.
- Submission of the most recent NYS-45 and Employer Verification Form, which must contain the names, salaries, etc. of all employees of the employer group.
  - If there are employees who have the same last name, provide a W-2 for each employee.
  - Employees who have terminated or work part-time should be noted accordingly on the NYS45.
  - Employees not listed on the NYS45 should have a W4 and payroll stub indicating with-holdings
  - If employee is sole proprietor, partner or corporate office, the Proof of Eligibility form must be completed and submitted with the following:

If Sole Proprietor not on NYS-45 submit:	If Partner not on NYS-45, submit:	If Corporate Office not on NYS-45, submit:
<ul style="list-style-type: none"> <li>● State Business License reflecting SIC</li> <li>● Assumed Name Certificate (Fictitious Business Name or DBA) AND</li> <li>● Certificate of Organization (for LLC or LLP)</li> </ul>	<ul style="list-style-type: none"> <li>● Partnership Agreement OR</li> <li>● Assumed Name Certificate (Fictitious Business Name or DBA)</li> <li>● State Business License reflecting SIC AND</li> <li>● Certificate of Organization (for LLC or LLP)</li> </ul>	<ul style="list-style-type: none"> <li>● State Business License reflecting SIC</li> <li>● Assumed Name Certificate (Fictitious Business Name or DBA) AND</li> <li>● Articles of Incorporation</li> </ul>
One of the following <ul style="list-style-type: none"> <li>● IRS Form 1040C or 1040F</li> <li>● IRS Form 1040 ES</li> </ul>	One of the following: <ul style="list-style-type: none"> <li>● IRS Form 1065 (Schedule K)</li> <li>● IRS Form 1040 ES</li> </ul>	One of the following: <ul style="list-style-type: none"> <li>● C-Corp &amp; Personal Services Corporation: IRS Form 1120&amp; 1120W</li> <li>● Corp: IRS Forms 1120S, K1 &amp; 1040ES</li> </ul>

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**Employer Financial Conditions:**

- Current carrier bill with billing summary will be required; group must be no more than one month delinquent on payments (i.e. current month only may not yet be paid).
- Groups that have been terminated for non-payment by Aetna will not be eligible to reapply until 12 months after the date of termination.

**Final Rates**

- Rating will be based on final enrollment.

**Initial Premium Check**

- The initial premium check is not a binder check and does not bind Aetna to provide coverage.
- An initial premium check equal to one-month premium must accompany application.
- If the request for coverage is denied due to business ineligibility, participation and/or contributions not met, or other permissible reasons, a refund check will be returned to the employer.
- Checks must be on company check stock, (personal checks not acceptable).

**Late Applicants**

- Late applicants will be postponed to the next open enrollment period.

**Newly Formed Business**

Must provide the following documentation for consideration:

- Payroll records or letter from attorney or Certified Public Accountant listing the names of all employees, number of hours worked on a regular basis, indication of salary draw; and
- Tax I.D Number

**Option Sales**

- It is strongly recommended that Aetna be the sole carrier for groups with 2 –19 eligible employees on HMO based benefits.

**Participation**

- HMO/QPOS:
  - Contracts issued under our HMO License do not require a minimal participation.
  - All groups must meet minimum eligibility requirements and provide waivers for those members not enrolling in the Aetna plan.
- Managed Choice:
  - Contracts issued on our ALIC (Managed Choice Products/PPO) license must have a minimum participation of 60% excluding spousal waivers.
- All contracts - Every eligible employee listed on the state wage and tax form, we will need one of the following:
  - An enrollment form or
  - A waiver form.

**Probationary Period**

- The employer decides whether or not to impose a probationary period.
- The probationary period must be consistently applied to all eligible employees.
- On time entrant eligibility date will be the first day of the policy month (1<sup>st</sup> or 15<sup>th</sup> of the month) following the waiting period of 0, 30, 60, 90, 120 or 180 days.
- Changes to probationary period allowed on anniversary only.

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## Underwriting Guidelines For Groups with 2 to 50 Eligible Employees New York (Effective as of 1/1/04)

### Producers

- Only appropriately licensed Agents/Producers appointed by Aetna may market, present, sell and be paid commission on the sale of Aetna Products.
- In order to receive commissions on a sale, all Producers must be licensed and appointed with Aetna **prior** to the sale.
- All quotes are subject to change based upon additional information that becomes available in the quoting process and during the case submission/installation, including any change in census.

### Replacing other Group Coverage

- A copy of the current billing statement that includes the account summary showing the plan is paid to the current premium due date.
- The employer should be told not to cancel any existing medical coverage until they have been notified of approval.

### Retiree Eligible

- Retiree coverage is not available.

### Out of State Employees

- Any active employee, who lives in a state other than where the company is domiciled, is considered an out of state employee.
- In order for Aetna to accommodate an out of state employee we must cover the active employees in the domiciled state.
- For groups requesting an HMO Product with 50% or less employees that work or reside outside the region, Aetna will quote an out-of-state plan for those employees. (i.e. employees must reside in NY, NJ, CT, PA, MA, ME)
- For groups requesting HMO Products with more than 50% of the group's employees outside the region, Aetna may decline to offer coverage to those out-of-state employees.

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# Submission details & guidelines

## New York

Avoid potential delays in getting your client enrolled.

Make sure your new case submissions are complete!

### Employer Information Employer application

- Employer signature must be an owner or corporate officer
- Number of eligible and enrolled employees
- Premium percentage paid by employer
- Indicate selected products in Section II — Specifications for Coverage
- Complete grid for any employee/dependent health continuations (e.g., COBRA continuation)
- Applications will not be accepted more than 60 days from date signed

### NYS-45 or other applicable tax documents

- Out-of-state employees require proof of employment if not identified on NYS-45
- If owner, partner or corporate officer not listed on NYS-45, submit the Small Group Proof of Eligibility Form signed by employees and with requested documents
- If newly hired employees are not identified on the NYS-45, submit payroll report indicating compensation and taxes withheld

### Initial premium check made payable to Aetna, Inc.

- Company check required

### Copy of current/prior medical carrier's latest bill

- Include employee roster and premium summary page

### Employee Information Employee applications filled out by each employee

- Any alterations must be initialed and dated by employee
- Individual Waiver Section completely filled out for each employee waiving coverage

### Dental submissions\*

- Employer Master Application
- Employee Enrollment Form
- First month premium check required (on company check stock) — Medical, Dental and Group Insurance may be submitted on one check
- Copy of illustrative Dental rates and census

### Group Insurance submissions\*

- Employer Master Application
- Employee Enrollment Form
- First month premium check required (on company check stock)
- Group Insurance and Dental may be submitted on one check
- Copy of illustrative Life rates and census if Term Life selected
- Individual Health Statement required if selecting Life amount in excess of Guaranteed Issue amount
- Completed Joinder Agreement

\*If submitting standalone Dental or Life submission, tax documents and copy of prior carrier's bill are also required.

**Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies (Aetna).**

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# New Business Case Submission Checklist

(Groups of 50 or fewer eligible employees)

Broker Name \_\_\_\_\_ Agency Name \_\_\_\_\_

For questions on this submission, please contact \_\_\_\_\_

Phone ( ) \_\_\_\_\_ Fax ( ) \_\_\_\_\_

Email Address \_\_\_\_\_

Prospect/Client Name \_\_\_\_\_

Prospect Email Address \_\_\_\_\_

## New York

For assistance with your new case submissions, contact your Aetna Sales Manager or call us at 1-888-277-1053.

Send all information to:

Aetna Small Group  
New Case Submissions  
P.O. Box 9610  
Cranbury, NJ 08512

Overnight Mail  
Aetna Small Group  
One Farr View  
Cranbury, NJ 08512

### Step 1

#### Complete/Review Employer Application

- HMO/PPO/MC/Dental/Life Application
- Joinder Agreement filled out for Life or out-of-state products
- NYS-45 or other applicable tax documents (Proof of Eligibility Form, if owner/officer/partner not on tax form)
- Initial premium check made payable to Aetna, Inc.
- Copy of current/prior medical carrier's latest bill with employee roster and premium summary page

### Step 2

#### Complete/Review Employee Enrollment/Change Form

- Employee (EE) Enrollment Form for each employee (HMO/PPO/Dental/Life)
- Complete the Individual Waiver Section of the EE app for each employee waiving coverage

### Step 3

#### Complete/Review Broker Information

- Illustrative signed rates and copy of census (Employee Listing Report) from Aetna rating tool
- Agent/broker must be licensed in New York and appointed by Aetna

Effective dates may be the first or fifteenth of the month only. All required paperwork must be received by Aetna at least **five** business days prior to the requested effective date.

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

Signature \_\_\_\_\_

We want you to know™



# OTHER ITEMS REQUIRED WITH SUBMISSION OF POLICY

**WR30** or NYS45 (New York always requires NYS45 for every carrier)

**ATTACH A COPY OF YOUR WR30 (WAGE & PAYROLL) FOR THE LASTEST QUARTER OR APPROPRIATE TAX DOCUMENTATION**

- ✓ *OXFORD REQUIRES NO WR30*
- ✓ *AETNA REQUIRES WR30 FOR LESS THAN 5 ENROLLING, BUT IT IS A 6 EE ELIGIBLE GROUP*
- ✓ *ALL OTHER CARRIERS REQUIRE WR30 2-5 ELIGIBLE. IN OTHER WORDS IF THE GROUP HAS 6 ELIGIBLE EMPLOYEES, BUT ONLY 3 ENROLLING, WR30 IS NOT NECESSARY UNLESS UNDERWRITING COMES BACK AND MAKES A REQUEST TO SEE IT.*

## **CARRIER BILL**

**A COPY OF YOUR LAST BILLING STATEMENT SHOWING ALL THE EMPLOYEES ENROLLED FROM YOUR PREVIOUS CARRIER**

## **PREMIUM CHECK**

**ALL NEW CASES MUST SUBMIT A CHECK MADE OUT TO THE CARRIER WITH THE ESTIMATED MONTHLY PREMIUM AMOUNT FROM THE QUOTE. THIS MUST BE A COMPANY BUSINESS CHECK**

## **QUOTE**

**ATTACH A COPY OF THE QUOTED ESTIMATED PREMIUM. PLEASE CIRCLE THIS PLAN DESIGN AND AMOUNT AND HAVE THE CLIENT SIGN THEIR NAME ANYWHERE WITHIN THE PLAN DESCRIPTION OR BY THE RATES. THIS IS AN ACKNOWLEDGEMENT OF PLAN DESIGN/RATES QUOTED.**

## **TERMINATION OF PRIOR CARRIER**

**DON'T FORGET TO SEND A LETTER OFF TO THE PRIOR CARRIER, CANCELLING THE COVERAGE. PLEASE DO NOT DO SO UNTIL YOU RECEIVE APPROVAL ON THE COVERAGE THAT YOU ARE APPLYING FOR. PLEASE NOTE THAT ALL CARRIERS REQUIRE YOU TO CANCEL PRIOR OR 30 DAYS BEFORE YOUR EFFECTIVE DATE OF YOUR RENEWAL. OTHERWISE, THEY HAVE THE RIGHT TO BILL YOU. SO, YOU MAY WANT TO PUSH OUT YOUR NEW COVERAGE EFFECTIVE DATE. PLEASE CONSULT YOUR BROKER TO CHECK ON TIMEFRAMES.**



## New Case Premium Submission Form

### Individual Completing Form

**Name:** \_\_\_\_\_ **Date Prepared:** \_\_\_\_\_

**Phone #:** \_\_\_\_\_

Customer Name: \_\_\_\_\_

D/B/A Name: \_\_\_\_\_

Address: \_\_\_\_\_

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

Eligible Lives \_\_\_\_\_

Check Number \_\_\_\_\_

Check Amount \_\_\_\_\_

Triad Number \_\_\_\_\_



# Proof of Eligibility Form

For Small Employer (2-50) 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
Company Name	
Address	City / State / Zip code

Please check one of the following:

**In order to satisfy the Small Employer Requirements for Proof of Eligibility, *the following most recent documents are required:***

(Anyone eligible must appear on the below documents)

<b>Sole Proprietor</b>		<b>Submit all applicable:</b>	<b>Must Submit one of the following:</b>
<input type="checkbox"/>	<ul style="list-style-type: none"> <li>➤ Sole Proprietor</li> <li>➤ Franchise</li> <li>➤ Limited Liability Company operating as a sole proprietor or single member LLC</li> </ul>	<ul style="list-style-type: none"> <li>➤ Filed Assumed Name Certificate (Fictitious Name or DBA)</li> <li>➤ Filed Certificate of Organization (only required for LLC)</li> <li>➤ Filed Business License</li> </ul>	<ul style="list-style-type: none"> <li>➤ IRS Form 1040 C or 1040 F</li> <li>➤ IRS Form 1040 SE</li> <li>➤ IRS Form 1040 ES (estimated tax)</li> </ul>
<b>Partner</b>		<b>Submit all applicable:</b>	<b>Must Submit one of the following:</b>
<input type="checkbox"/>	<ul style="list-style-type: none"> <li>➤ Partnership</li> <li>➤ Limited Liability Partnership (member)</li> </ul>	<ul style="list-style-type: none"> <li>➤ Partnership Agreement (Filed)</li> <li>➤ Filed Assumed Name Certificate (Fictitious Name or DBA) if applicable</li> <li>➤ Filed Certificate of Organization (only required for LLC or LLP)</li> <li>➤ Filed Business License</li> </ul>	<ul style="list-style-type: none"> <li>➤ IRS Form 1065 schedule K-1</li> <li>➤ IRS Form 1040 SE</li> <li>➤ IRS Form 1040 ES (estimated tax)</li> </ul>
<b>Corporate Officer</b>		<b>Submit all applicable:</b>	<b>Must Submit one of the following:</b>
<input type="checkbox"/>	<ul style="list-style-type: none"> <li>➤ Limited Liability Company operating as a corporation</li> <li>➤ C-Corporation</li> <li>➤ Personal Service Corporation</li> <li>➤ S-Corporation</li> </ul>	<ul style="list-style-type: none"> <li>➤ Filed Assumed Name Certificate (Fictitious Name or DBA)</li> <li>➤ Articles of Incorporation <b>or</b> Statement by Domestic Stock (complete, including name of officers, shareholders and directors)</li> <li>➤ Filed Certification of Qualification (if incorporated in a different state)</li> </ul>	<ul style="list-style-type: none"> <li>➤ IRS Forms 1120, 1120 A or 1120 W (C-Corp &amp; Personal Service Corp)</li> <li>➤ IRS Form 1120 S schedule K-1 or 1040 ES (estimated tax) (S-Corp)</li> <li>➤ IRS Form 8832 (Entity Classification; for LLC's treated as a Corporation)</li> </ul>

I attest that while I am not listed on the state quarterly wage and tax statement for this company, all of the following are true:

1. I am a sole proprietor, partner or corporation officer of the company indicated above; and
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 ; and
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; and
4. I have satisfied the designated waiting period before health insurance coverage is to become effective.

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.

Signature:	Date:
------------	-------



# New York Small Group Business Employer Application

**Aetna Life Insurance Co.**  
151 Farmington Avenue  
Hartford, CT 06156

**Aetna Health Inc.**  
1425 Union Meeting Road  
Blue Bell, PA 19422

**Aetna Health Insurance Co. of New York**  
333 Earle Ovington Blvd. - Suite 104  
Uniondale, NY 11553

### FOR GROUP COVERAGE (2-50 ELIGIBLE EMPLOYEES)

Life, Accidental Death & Dismemberment, Aetna EPO plans, Aetna Indemnity, and Aetna Managed Choice Plan PPO are provided by Aetna Life Insurance Company. Aetna Primary Care Plan HMO, Aetna QPOS, and Aetna NYC Community Plan<sup>SM</sup> are provided by Aetna Health Inc. and Aetna Health Insurance Company of New York. DMO and PPO dental plans are provided by Aetna Life Insurance Company.

Company Name (Legal Name)		DBA/Doing Business As (if applicable)	
Street Address (P.O. Box not acceptable)		City	State ZIP
Billing Address (If different than above)		City	State ZIP
Company Contact Person - Title		Phone Number ( )	Fax Number ( )
E-Mail Address		Federal Tax ID Number	Date Business Established (Mo/Yr):
Employer Classification <input type="checkbox"/> Corporation <input type="checkbox"/> Non-Profit <input type="checkbox"/> Partnership <input type="checkbox"/> Sole Proprietor <input type="checkbox"/> Other: _____ SIC Code: _____		Nature of Business: _____	

### Medical Coverage Selection

<b>Managed Choice Open Access:</b> <input type="checkbox"/> 21a-07 <input type="checkbox"/> 21b-07 <input type="checkbox"/> 21c-07 <input type="checkbox"/> 22a-07 <input type="checkbox"/> 22b-07 <input type="checkbox"/> 22c-07 <input type="checkbox"/> 24-08 <input type="checkbox"/> 24b-07 <input type="checkbox"/> 24c-07 <input type="checkbox"/> 26a-07 <input type="checkbox"/> 26b-07 <input type="checkbox"/> 26c-07 <input type="checkbox"/> 27-07 <input type="checkbox"/> 29a-07 <input type="checkbox"/> 29b-07 <input type="checkbox"/> 29c-07 <input type="checkbox"/> 33a-07 <input type="checkbox"/> 33b-07 <input type="checkbox"/> 33c-07	<b>EPO Open Access:</b> <input type="checkbox"/> 1b-08 <input type="checkbox"/> 1c-08 <input type="checkbox"/> 2a-07 <input type="checkbox"/> 2b-07 <input type="checkbox"/> 2c-07 <input type="checkbox"/> 3-08 <input type="checkbox"/> 3b-07 <input type="checkbox"/> 3c-07 <input type="checkbox"/> 4-08 <input type="checkbox"/> 4b-07 <input type="checkbox"/> 4c-07
<b>Managed Choice Open Access (HSA Compatible):</b> <input type="checkbox"/> 30-07 <input type="checkbox"/> 31-07 <input type="checkbox"/> 34-07 <input type="checkbox"/> 35-08	<b>NYC Community Plan<sup>SM</sup>:</b> <input type="checkbox"/> 1D-07 <input type="checkbox"/> 2-07 <input type="checkbox"/> 3D-07 <input type="checkbox"/> 4-07 <b>Indemnity:</b> <input type="checkbox"/> 20-07

If you have selected an HSA-compatible plan:  
 - Do you plan on making contributions to your employees' HSA accounts?  Yes  No  
 - Do you plan to offer your employees payroll deductions to fund their HSA accounts?  Yes  No

### Dental Coverage Selection

<b>Aetna Dental<sup>TM</sup> Plan</b> <b>Standard Plans:</b> <input type="checkbox"/> Option 2: DMO <input type="checkbox"/> Option 3: Freedom-of-Choice: PPO Max <input type="checkbox"/> Option 4: PPO Max <input type="checkbox"/> Option 5: Active PPO <input type="checkbox"/> Option 6: PPO 1500 <input type="checkbox"/> Option 7: Consumer Directed DentalFund <input type="checkbox"/> Option 8: Freedom-of-Choice: PPO 1500 <input type="checkbox"/> Option 9: PPO 2000 <input type="checkbox"/> Out-of-State: <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$1,500 <input type="checkbox"/> \$2,000
<b>Voluntary Plans:</b> <input type="checkbox"/> Option 2: DMO <input type="checkbox"/> Option 4: PPO Max <input type="checkbox"/> Option 3: Freedom-of-Choice <input type="checkbox"/> Out-of-State: <input type="checkbox"/> \$1,000

Orthodontic coverage for dependent children is included in Standard Plan Options 2, 3, 5, 6, 8, & 9 and Voluntary Plan Options 2 & 3 and available only to groups with 10 or more eligible employees.

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, Accidental Death & Dismemberment, and Disability Coverage Selection

Groups with 10 to 50 eligible employees may select one, two, or three options for Life, Accidental Death & Dismemberment, and Disability, with a minimum requirement of three employees in each option. 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.)

	Class 1		Class 2		Class 3	
All Groups	Life*	Life & Disability or Packaged Plan	Life*	Life & Disability or Packaged Plan	Life*	Life & Disability or Packaged Plan
	<input type="checkbox"/> \$10,000	<input type="checkbox"/> Low - \$10,000	<input type="checkbox"/> \$10,000	<input type="checkbox"/> Low - \$10,000	<input type="checkbox"/> \$10,000	<input type="checkbox"/> Low - \$10,000
<input type="checkbox"/> \$15,000	<input type="checkbox"/> Medium - \$20,000	<input type="checkbox"/> \$15,000	<input type="checkbox"/> Medium - \$20,000	<input type="checkbox"/> \$15,000	<input type="checkbox"/> Medium - \$20,000	<input type="checkbox"/> Medium - \$20,000
<input type="checkbox"/> \$20,000	<input type="checkbox"/> High - \$50,000**	<input type="checkbox"/> \$20,000	<input type="checkbox"/> High - \$50,000**	<input type="checkbox"/> \$20,000	<input type="checkbox"/> High - \$50,000**	<input type="checkbox"/> High - \$50,000**
<input type="checkbox"/> \$50,000	Plans include Dependent Term Life	<input type="checkbox"/> \$50,000	Plans include Dependent Term Life	<input type="checkbox"/> \$50,000	Plans include Dependent Term Life	<input type="checkbox"/> \$50,000
<input type="checkbox"/> \$75,000		<input type="checkbox"/> \$75,000		<input type="checkbox"/> \$75,000		
<input type="checkbox"/> \$100,000		<input type="checkbox"/> \$100,000		<input type="checkbox"/> \$100,000		
<input type="checkbox"/> \$125,000		<input type="checkbox"/> \$125,000		<input type="checkbox"/> \$125,000		<input type="checkbox"/> \$125,000
<b>Additional options for Groups with 10 – 50 eligible employees</b>						
<b>Class Description</b>						

\* **Optional Dependent Term Life** (Available only to groups with 10 to 50 eligible employees.)  Yes  No  
 \*\* Available only for groups of 10 or more lives.

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

Requested effective date (may be the first or 15th of the month only): \_\_\_\_\_

### Employer Contribution(s)

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

### Employee Eligibility

Work Location (list by state)	Number of Employees				
	Full-time (based on number of minimum hours allowed by state law)	Part-time	Retired	COBRA or State Continuees	Other (i.e., temporary, substitute, seasonal)

Total number of employees: \_\_\_\_\_

Is your group subject to COBRA? (20 or more total employees during at least 50% of the working days in the previous calendar year):

Yes  No

Total number of employees eligible for coverage (must work a minimum of 20 hours per week): \_\_\_\_\_

Total number of employees waiving Aetna health benefits but covered through their spouse's health benefit plan: \_\_\_\_\_

Total number of employees waiving Aetna health benefits coverage without coverage elsewhere: \_\_\_\_\_

Total number of employees covered under another health benefit plan offered by the employer: \_\_\_\_\_

Do you exclude Union employees under this application?  Yes  No

Eligibility date will be the first day of the policy month following the waiting period.

Waiting period for future employees:  0 days  30 days  60 days  90 days  120 days  180 days



**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, including my knowledge that replacement life insurance is  is not  (check one) a part of this transaction.

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

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.

Agent/Broker Name: \_\_\_\_\_ Aetna Agent Number/Tax ID/SSN: \_\_\_\_\_

Agency Name: \_\_\_\_\_ % of Credit: \_\_\_\_\_

Phone Number: (\_\_\_\_) \_\_\_\_\_ Fax Number: (\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_ E-Mail Address: \_\_\_\_\_

Agent/Broker Name: \_\_\_\_\_ Aetna Agent Number/Tax ID/SSN: \_\_\_\_\_

Agency Name: \_\_\_\_\_ % of Credit: \_\_\_\_\_

Phone Number: (\_\_\_\_) \_\_\_\_\_ Fax Number: (\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_ E-Mail Address: \_\_\_\_\_

General Agent Name: \_\_\_\_\_ Aetna Agent Number/ID Number: \_\_\_\_\_

Phone Number: (\_\_\_\_) \_\_\_\_\_ Fax Number: (\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_ E-Mail Address: \_\_\_\_\_

**For Aetna Use Only**

Group Number \_\_\_\_\_ Control Number \_\_\_\_\_ SCD \_\_\_\_\_ Effective Date \_\_\_\_\_

Is Agent/Agency licensed and appointed?  Yes  No Appointment Expiration Date \_\_\_\_\_



# Small Group Business Customer Information Form

## Customer Information:

Employer Legal Name: \_\_\_\_\_ Contract State: \_\_\_\_\_

Employer Legal Address: \_\_\_\_\_  
\_\_\_\_\_

Billing Contact: Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_  
Address: (If different than above) \_\_\_\_\_  
\_\_\_\_\_

Effective Date: \_\_\_\_\_

Employer Classification: Corporation \_\_\_ Non-Profit Corporation \_\_\_ Partnership \_\_\_ Sole Proprietor \_\_\_ Government Entity \_\_\_

Estimated Number of total eligible lives: \_\_\_ Actual Number of Lives Applying for Coverage: \_\_\_

Prior Coverage: \_\_\_ No \_\_\_ Yes\*

\*Prior Carrier Info: Name of prior carrier: \_\_\_\_\_

Claim office phone number: \_\_\_\_\_

Date prior coverage terminated: \_\_\_\_\_

Types of Benefits: \_\_\_ Medical \_\_\_ Dental \_\_\_ Term Life \_\_\_ Disability

Prior Carrier Deductibles: Medical: Individual \$ \_\_\_\_\_ Family: \$ \_\_\_\_\_  
Dental: Individual \$ \_\_\_\_\_ Family: \$ \_\_\_\_\_

### Probationary Period:

Eligibility date will be the first day of the policy month following the waiting period.

Waiting period for future employees: \_\_\_ 0 days \_\_\_ 30 days \_\_\_ 60 days  
\_\_\_ 90 days \_\_\_ 120 days \_\_\_ 180 days

Eligibility: \_\_\_ Paper \_\_\_ EZenroll 4.0 **note: rates are subject to change based upon receipt of final enrollment.**

### Additional Information:

Domestic Partners covered? (ME only) \_\_\_ No \_\_\_ Yes

1099 employees? (CT & NJ only) \_\_\_ No \_\_\_ Yes

Is retiree coverage to be included? (ME only) \_\_\_ No \_\_\_ Yes

## General Information:

Broker Name: \_\_\_\_\_ Phone No: \_\_\_\_\_ Fax: \_\_\_\_\_  
Address: \_\_\_\_\_ Email Address: \_\_\_\_\_  
\_\_\_\_\_

General Agent Name: \_\_\_\_\_ Phone No: \_\_\_\_\_ Fax: \_\_\_\_\_  
Address: \_\_\_\_\_ Email Address: \_\_\_\_\_  
\_\_\_\_\_

Booklet-Certificates to be mailed to: \_\_\_ Employer \_\_\_ Broker/General Agent

Administration Kits to be mailed to: \_\_\_ Employer \_\_\_ Broker/General Agent

Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



# Employer Verification Form

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Account Number:** \_\_\_\_\_  
**HMO:** \_\_\_\_\_  
**PPO:** \_\_\_\_\_  
**Renewal:** \_\_\_\_\_

## PART I - EMPLOYEE CENSUS SURVEY

**Employee Breakdown by State** - Please provide a count, by state, for each category below for all employees eligible for coverage:

State	Full-Time Count	Part-Time Count	Retiree Count	Continuation Count	Other Count	Total
Total Eligible Employees						

**Employee Medical Coverage Summary** - Please provide a count for each category below for all employees eligible for coverage:

Medical Benefits Plan (Aetna)	Medical Benefits Plan (Other Carrier)	Spouse/Partner's Medical Benefits Plan	Other Employer's Medical Benefits Plan	Waiving Medical Benefits Coverage

## PART II - EMPLOYER SURVEY

- Please indicate the average number of eligible employees within the previous 12-month period.\* \_\_\_\_\_
- Have you employed 20 or more full or part-time employees for 20 or more weeks during the current or preceding calendar year?  
 Yes  No
- Have you employed 100 or more full or part-time employees on 50% or more of the business days in the preceding calendar year?  
 Yes  No
- Please indicate your rate of contribution toward your employee's health benefits:  
 Single:  0%  25%  50%  75%  Other: \_\_\_\_\_%  
 Dependent:  0%  25%  50%  75%  Other: \_\_\_\_\_%
- Do you, as an employer, cover your employees under Worker's Compensation? (If responding yes, please provide documentation as proof of coverage in conjunction with your response.)  
 Yes  No

## PART III - SIGNATURE

I hereby attest to the accuracy and truthfulness of the above information. I understand that if the information I have provided is not accurate and complete, my company's health benefits coverage may be rescinded or terminated or my company may be charged a different premium for this coverage. I understand that if my company does not meet Aetna's participation and employer contribution requirements, Aetna may choose not to offer a renewal of coverage, and that Aetna will monitor ongoing adherence to participation and employer contribution requirements prior to subsequent renewals, subject to the requirements of state small group reform laws and the federal HIPAA law. Any person who knowingly and with intent to 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 thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Signature of Owner/Officer or Authorized Representative of the Company:	Telephone Number:
Print Name:	Date Signed:

\* Please Note: Plan sponsors in the state Georgia, please indicate total eligible employees for the previous 3-month period.



# New York Small Group Business (2 – 50 Eligible Employees) Employee Enrollment/Change Form

**Aetna Life Insurance Company**  
151 Farmington Avenue  
Hartford, CT 06156

**Aetna Health Inc.**  
1425 Union Meeting Road  
Blue Bell, PA 19422

**Aetna Health Insurance Company of New York**  
333 Earle Ovington Blvd., Suite 104  
Uniondale, NY 11553

Life, Accidental Death & Dismemberment, Aetna EPO plans, Aetna Indemnity, and Aetna Managed Choice Plan PPO are provided by Aetna Life Insurance Company. Aetna Primary Care Plan HMO, Aetna QPOS, and Aetna NYC Community Plan<sup>SM</sup> are provided by Aetna Health Inc. and Aetna Health Insurance Company of New York. DMO and PPO dental plans are provided by Aetna Life Insurance Company.

Member Aetna ID Number (if available)

Employer Name		<b>INSTRUCTIONS:</b> 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. <b>If waiving coverage, please complete Sections B and D.</b>			
Effective Date	<input type="checkbox"/> New Hire <input type="checkbox"/> Rehire/Reinstatement	<input type="checkbox"/> Change of Coverage <input type="checkbox"/> Add Spouse/Domestic Partner/Dependent Child <input type="checkbox"/> Name Change <input type="checkbox"/> Other _____	<input type="checkbox"/> Employee Termination <input type="checkbox"/> Remove Spouse/Domestic Partner/Dependent Child <input type="checkbox"/> Cancel Coverage	COBRA/State Continuation for: <input type="checkbox"/> Employee <input type="checkbox"/> Dependent Length of Continuation: <input type="checkbox"/> 18 <input type="checkbox"/> 36 <input type="checkbox"/> Other _____ Original Qualifying Event Date _____	
Date of Hire	<input type="checkbox"/> New Group Enrollment <input type="checkbox"/> Late Enrollment <input type="checkbox"/> Other _____				

**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.
<b>1. Medical - Check one.</b> <b>Managed Choice Open Access:</b> <input type="checkbox"/> 21a-07 <input type="checkbox"/> 21b-07 <input type="checkbox"/> 21c-07 <input type="checkbox"/> 22a-07 <input type="checkbox"/> 22b-07 <input type="checkbox"/> 22c-07 <input type="checkbox"/> 24-08 <input type="checkbox"/> 24b-07 <input type="checkbox"/> 24c-07 <input type="checkbox"/> 26a-07 <input type="checkbox"/> 26b-07 <input type="checkbox"/> 26c-07 <input type="checkbox"/> 27-07 <input type="checkbox"/> 29a-07 <input type="checkbox"/> 29b-07 <input type="checkbox"/> 29c-07 <input type="checkbox"/> 33a-07 <input type="checkbox"/> 33b-07 <input type="checkbox"/> 33c-07 <b>Managed Choice Open Access (HSA Compatible):</b> <input type="checkbox"/> 30-07 <input type="checkbox"/> 31-07 <input type="checkbox"/> 34-07 <input type="checkbox"/> 35-08 <b>EPO Open Access:</b> <input type="checkbox"/> 1b-08 <input type="checkbox"/> 1c-08 <input type="checkbox"/> 2a-07 <input type="checkbox"/> 2b-07 <input type="checkbox"/> 2c-07 <input type="checkbox"/> 3-08 <input type="checkbox"/> 3b-07 <input type="checkbox"/> 3c-07 <input type="checkbox"/> 4-08 <input type="checkbox"/> 4b-07 <input type="checkbox"/> 4c-07 <b>NYC Community Plan<sup>SM</sup></b> <input type="checkbox"/> 1D -07 <input type="checkbox"/> 2-07 <input type="checkbox"/> 3D-07 <input type="checkbox"/> 4-07 <b>Indemnity:</b> <input type="checkbox"/> 20-07					<b>2. Dental - Check one.</b> <b>Standard Plans:</b> <input type="checkbox"/> Option 2: DMO <input type="checkbox"/> Option 3: Freedom of Choice: <input type="checkbox"/> DMO <i>or</i> <input type="checkbox"/> PPO <input type="checkbox"/> Option 4: PPO Max <input type="checkbox"/> Option 5: Active PPO <input type="checkbox"/> Option 6: Passive PPO <input type="checkbox"/> Option 7: Consumer Directed <input type="checkbox"/> Option 8: Freedom of Choice: <input type="checkbox"/> DMO <i>or</i> <input type="checkbox"/> PPO <input type="checkbox"/> Option 9: PPO 2000 <input type="checkbox"/> Out-of-State PPO Plan <b>Voluntary Plans:</b> <input type="checkbox"/> Option 2: DMO <input type="checkbox"/> Option 3: Freedom of Choice: <input type="checkbox"/> DMO <i>or</i> <input type="checkbox"/> PPO <input type="checkbox"/> Option 4: PPO Max <input type="checkbox"/> Out-of-State PPO Plan					<b>3. Life and Disability</b> <input type="checkbox"/> Basic Life/AD&D Ultra <sup>TM</sup> <input type="checkbox"/> Optional Dependent Life <input type="checkbox"/> Life & Disability Packaged Plan Beneficiary Designation - Full Name (First, Middle, Last) _____ Beneficiary Social Security Number _____ Relationship to Employee _____		
Reason _____												
<b>Before today, were you covered under this employer's dental plan?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No												

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

Social Security Number	Last Name, First Name, M.I.		Job Title	Home Telephone	Primary Language Spoken (Optional)
Home Address	Apt. No.	City, State		ZIP Code	
Work Address	City, State		ZIP Code	Work Telephone	
No. of Hours Worked Per Week	Check One <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time		Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Single	No. of Dependents Including Spouse/Domestic Partner	

**C. Individuals Covered -** List individuals for whom you are enrolling or adding/changing/removing coverage. Insert additional sheets if necessary. Height and weight information needed for Life Insurance applicants only.

Name (Last, First, M.I.)	Sex M/F	Social Security Number	Birthdate (MM/DD/YYYY)	Coverage Election	Other Health Coverage	Other Dental Coverage	Prior Dental Coverage	Student Age 19 or Older	Out of Area	Primary Office ID Number (if applicable)	Current Patient	Dental Office ID Number (if applicable)	Current Patient
Employee 1.				<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Life/Dis	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes N/A	Yes N/A		Yes <input type="checkbox"/>		Yes <input type="checkbox"/>
Spouse/Domestic Partner 2.				<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Life	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	N/A	N/A		<input type="checkbox"/>		<input type="checkbox"/>
Child 3.				<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Life	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>
Child 4.				<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Life	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>

**D. 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.

<p>1. Medical Coverage Declined for:</p> <input type="checkbox"/> Myself <input type="checkbox"/> Spouse/Domestic Partner <input type="checkbox"/> Dependents	<p>Reason for Declining Coverage (If applicable, please attach front/back of your health coverage ID card.):</p> <input type="checkbox"/> Covered by spouse/domestic partner's group coverage - Carrier Name and ID _____ <input type="checkbox"/> Enrolled in other Insurance Carrier Plans - Carrier Name and ID _____ <input type="checkbox"/> Medicare <input type="checkbox"/> Covered by TRICARE or CHAMPVA <input type="checkbox"/> Other _____ <input type="checkbox"/> Spouse/Domestic Partner covered by employer's group medical coverage <input type="checkbox"/> Spouse/Domestic Partner covered by employer's group dental coverage
<p>2. Dental Coverage Declined for:</p> <input type="checkbox"/> Myself <input type="checkbox"/> Spouse/Domestic Partner <input type="checkbox"/> Dependents	
<p>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 this plan, may not be covered for twelve months.</p>	
<p>Please sign here <b>ONLY</b> if you are declining coverage for yourself and/or dependent(s).</p>	
<p><input checked="" type="checkbox"/> Employee Signature</p>	<p>Date (Month/Day/Year)</p>

**E. Dependent Information**

<p>Does any dependent listed in Section C live at another address?    <input type="checkbox"/> Yes    <input type="checkbox"/> No</p> <p>If Yes, who and what address?</p>	<p>If any dependent's last name differs from yours, explain the circumstances.</p>
--	--

**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 the start date of coverage

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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 the start date of coverage

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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 for other than Life Insurance)

Does anyone enrolling on this enrollment form have prior coverage?

Yes     No    If you answered "Yes", provide applicant names, start and end dates of prior coverage.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**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 to the full pre-existing conditions limitation with no credit for prior coverage. You may request a Certificate of Creditable Coverage from your prior carrier.

Proof of coverage must accompany this enrollment form for pre-existing condition credit or waiver of dental waiting period.

**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 Primary Care Plan HMO, Aetna QPOS, and Aetna NYC Community Plan<sup>SM</sup>: Aetna Health Inc. and Aetna Health Insurance Company of New York
  - Aetna Managed Choice Plan PPO: Aetna Life Insurance Company
  - Life, Accidental Death & Dismemberment, DMO, Dental PPO and all other health coverages: Aetna Life Insurance Company

continued on next page