



Michigan Small Group Business Employer Application and Joinder Agreement

FOR GROUP COVERAGE (2 to 50 ELIGIBLE EMPLOYEES)

Life, Accidental Death & Dismemberment, Disability, Aetna PPO plans and Aetna Dental plans are underwritten 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
Bill 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"/> LLC <input type="checkbox"/> LLP <input type="checkbox"/> Other: _____ SIC Code: _____ Nature of Business: _____			

Effective Date

Requested effective date may be the 1st or the 15th of the month. The actual effective date will be assigned by the Aetna underwriting department if the Joinder Agreement/Application is approved.

Medical Coverage Selection

(Dual Option or Triple Option is available to groups with 5 or more enrolled employees.)

- MI PPO Split Copay** – Plan Option _____
- MI PPO Split Coinsurance** – Plan Option _____
- MI PPO HSA Compatible** – Plan Option _____
- MI PPO Consumer Directed** – Plan Option _____
- MI Indemnity** – Plan Option _____
- Other Plan** _____
- Out-of-State PPO:** 250 500 1000

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

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

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

Dental Coverage Selection

Aetna Dental™ Plan

Standard

Option Number _____
Plan Option Name _____

Voluntary

Option Number _____

Out-of-State PPO Plans

Plan Option Name _____
Plan Option Name _____

Orthodontic coverage is included in Standard Plan Options 1, 3, 5, 6 & 8 and Voluntary Plan Options 1 & 2 for dependent children to groups with 10 or more eligible employees.

Life, Accidental Death & Dismemberment & Disability Coverage Selections

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 class. 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.)

Life Options for All Group Sizes	<input type="checkbox"/> 10,000 <input type="checkbox"/> 15,000 <input type="checkbox"/> 20,000 <input type="checkbox"/> 50,000
Additional Life Options for Groups with 10 - 50 Eligible Employees	<input type="checkbox"/> 75,000 <input type="checkbox"/> 100,000 <input type="checkbox"/> 125,000
Life & Disability Packaged Plan	<input type="checkbox"/> Low Option <input type="checkbox"/> Low Option 2 <input type="checkbox"/> Medium Option <input type="checkbox"/> Medium Option 2 <input type="checkbox"/> High Option
STD	<input type="checkbox"/> Option 1 <input type="checkbox"/> Option 2 <input type="checkbox"/> 100 <input type="checkbox"/> 200 <input type="checkbox"/> 300 <input type="checkbox"/> 400 <input type="checkbox"/> 500
Class Description	Class 1 _____ Class 2 _____ Class 3 _____
Optional Dependent Term Life	(Available only to groups with 10 to 50 eligible employees.) <input type="checkbox"/> Yes <input type="checkbox"/> No

Please keep a copy of this application for your records. If the application is accepted by Aetna it becomes part of the issued Group Agreement and/or Group Policy.

Group Ownership Information – Optional

(This information is designed for the purposes of data collection and will not be used for underwriting.)

Check one or both if applicable:

- Woman Owned Business
 Minority Owned Business (indicate status): African American or Black Hispanic or Latino Asian Other _____

Business Eligibility

Affiliated Companies					<input type="checkbox"/> Yes <input type="checkbox"/> No
Is your company a subsidiary of another company, an affiliate of another company, or under common control with another company?					
Does your company file state or federal taxes with any other company(ies) on a combined or consolidated basis?					<input type="checkbox"/> Yes <input type="checkbox"/> No
Are there any associated companies to be included with this group that are commonly owned?					<input type="checkbox"/> Yes <input type="checkbox"/> No
If Yes to any questions, complete the information below.					
<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	Ownership Percentage	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
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
- Is each branch a location of one 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 Filing		
- Where is each branch located? (List each branch business address separately.)			Number of Employees at each location		
Has your business been insured with Aetna within the past 12 months?					<input type="checkbox"/> Yes <input type="checkbox"/> No
If Yes - Provide group number. _____					
Do you use the services of a Payroll Company?					<input type="checkbox"/> Yes <input type="checkbox"/> No
If Yes - Provide the name of the payroll company. _____					
Are you currently a client of a Professional Employer Organization (PEO)?					<input type="checkbox"/> Yes <input type="checkbox"/> No
If Yes - Provide the name of the PEO. _____					

Employer Eligibility/Employee Status

Work Location (list by state)	Number of Employees						Other (Temporary, substitute, seasonal, etc.)
	Full-time	Part-time	Retired	COBRA	1099	Union	
What is the normal work week you require a full-time employee to work to be eligible for coverage?							_____ hours per week
Total number of eligible employees		Total number of employees enrolling		Total number of employees waiving		Total number of employees in waiting period	
Are there excluded classes of employees other than part-time and temporary employees (for example, Union employees)? If Yes, describe class(es) and/or the union local name and number.							<input type="checkbox"/> Yes <input type="checkbox"/> No
Is your group Medicare Primary (employed less than 20 employees during at least 50% of the preceding calendar year) or Aetna Primary (employed 20 or more employees during at least 50% of the preceding calendar year)?							<input type="checkbox"/> Medicare Primary <input type="checkbox"/> Aetna Primary

Employer Contribution(s)

Coverage	Medical (No minimum required)	Dental (25% total cost or 50%)	Employee Life (2 to 9 – 100% 10 to 50 – 50%)	Dependent Life (No minimum required)	Disability (2 to 9 – 100% 10 to 50 – 50%)	Packaged Life & Disability (2 to 9 – 100% 10 to 50 – 50%)
Employer's Contribution for Employee				NA		
Employer's Contribution for Dependent			NA		NA	NA

Benefit Waiting Period

The eligibility date will be the first day of the policy month following the waiting period.	
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
Waiting period for future employees: <input type="checkbox"/> 0 Days <input type="checkbox"/> 30 Days <input type="checkbox"/> 60 Days <input type="checkbox"/> 90 Days <input type="checkbox"/> 120 Days <input type="checkbox"/> 150 Days <input type="checkbox"/> 180 Days	

Prior Carrier Information

	Health	Dental	Life	STD
Is this group transferring from another group carrier?	<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 Yes, provide Carrier Name				
Effective Date of Coverage				
Proposed Termination Date				
Is this total replacement?	<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 prior carrier is Aetna, provide Group/Control Number				
Did your plan have a deductible?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Provide prior carrier deductibles:	<input type="checkbox"/> Individual \$ _____ <input type="checkbox"/> Family \$ _____	<input type="checkbox"/> Individual \$ _____ <input type="checkbox"/> Family \$ _____ <input type="checkbox"/> Ortho Max \$ _____		
Dental Only – Prior coverage included, check all that apply:		<input type="checkbox"/> Major Services <input type="checkbox"/> Orthodontia		

Signature Section

The undersigned employer 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 (subject to applicable HIPAA requirements for Health coverage), unless otherwise specifically provided in the plan documents (which consist of the Group Policy and/or Booklet-Certificate). All statements herein shall be deemed representations and not warranties.

The undersigned employer acknowledges that it has selected this plan based upon written information provided by Aetna and that no 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. Undersigned employer agrees to make payroll and other records directly related to employee's coverage under the plan documents available to Aetna for inspection, at Aetna's expense, at employer's office, during regular business hours, upon reasonable advance request. This provision shall survive termination of the Group Policy.

Undersigned employer has selected, in accordance with applicable state law, the plan to be offered to employer's employees and employer has solely determined any/all health plan options for the employer's employees and the contribution amounts.

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

In accordance with current IRS regulations and the 1986 Tax Reform Act, a life insurance position schedule may be deemed discriminatory and result in imputed income tax to certain employees and possibly an excise tax to employers. Employers should consult with legal counsel prior to electing a position schedule. Aetna disclaims any responsibility if the employer elects such a position schedule and it is later deemed discriminatory.

The plan documents will determine the contractual provisions, including procedures, exclusions and limitations relating to the plan and will govern in the event they conflict with any benefits comparison, summary or other description of the plan.

With the exception of Aetna Rx Home Delivery, participating physicians, hospitals and other health care providers are independent contractors and are neither agents nor employees of Aetna. Undersigned employer 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. Aetna Rx Home Delivery, LLC, is a subsidiary of Aetna Inc.

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages.

Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Michigan division of insurance within the department of regulatory agencies. All data that may have a bearing on coverage or premiums will be open for Aetna to inspect while the plan documents are in force.

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 or dental care services and, therefore, cannot guarantee any results or outcome.

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

continued

