



Arizona Group Business

Employer Joinder Agreement and Application

FOR GROUP COVERAGE (2 – 99 ELIGIBLE EMPLOYEES)

Life, Accidental Death & Dismemberment, Disability, Aetna Indemnity, and Aetna PPO plans are underwritten by Aetna Life Insurance Company. Aetna HMO, Aetna CPOS and Aetna QPOS plans are underwritten by Aetna Health Inc., Aetna Life Insurance Company and/or Aetna Health Insurance Company. Dental plans are underwritten by Aetna Health Inc. and/or 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"/> Other:			SIC Code:

Medical Coverage Selection

(Please select all plans in which your employees have enrolled.)

- HMO 15/30/250
- HMO+ (QPOS): 15/30/250 20/40/500
- CPOS: 500 90/70 250 80/60 500 80/60 750 80/60 1000 80/60 1500 70/50 1500 100/50 2500 100/50 5000 100/50
- PPO: 500 90/70 250 80/60 500 80/60 750 80/60 1000 70/50 2000 70/50
- PPO Value Value 1500 80/50 Value Saver 10,000 100/50 Value Limited 750 50/50
- CDHP: HSA HDHP 2400 100/50 HSA HDHP 3000 80/50
- Indemnity 500 80
- Out-of-State: PPO 250 PPO 500 PPO 1000

Dental Coverage Selection

Aetna Dental™ Plan

Standard Plans:

- Option 1: DMO®
- Option 2: Freedom-of-Choice
- Option 3: PPO Max 1500
- Option 4: PPO Max 1000
- Option 5: PPO 1500 (90th)
- Option 6: DMO® Plan 41
- Option 7: DMO® Access
- Option 8: Aetna Dental Preventive CareSM PPO Max
- Option 9: PPO Max 2000
- Out-of-State PPO: 1000 1500 2000

Voluntary Plans:

- Option V1: DMO®
- Option V2: Freedom-of-Choice
- Option V3: PPO Max 1500
- Option V4: DMO® Plan 41
- Option V5: DMO® Access
- Option V6: Aetna Dental Preventive CareSM PPO Max
- Out-of-State PPO: 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? _____

Orthodontic coverage for dependent children is included **only** in Standard Plan Options 1, 2, 5 and 6 and Voluntary Plan Options 1, 2 and 4 **only** 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 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.)

All Groups	Class 1		Class 2		Class 3	
	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"/> 15,000 <input type="checkbox"/> 20,000 <input type="checkbox"/> 50,000	<input type="checkbox"/> Low <input type="checkbox"/> Low - 2 <input type="checkbox"/> Medium <input type="checkbox"/> Medium - 2 <input type="checkbox"/> High	<input type="checkbox"/> 10,000 <input type="checkbox"/> 15,000 <input type="checkbox"/> 20,000 <input type="checkbox"/> 50,000	<input type="checkbox"/> Low <input type="checkbox"/> Low - 2 <input type="checkbox"/> Medium <input type="checkbox"/> Medium - 2 <input type="checkbox"/> High	<input type="checkbox"/> 10,000 <input type="checkbox"/> 15,000 <input type="checkbox"/> 20,000 <input type="checkbox"/> 50,000	<input type="checkbox"/> Low <input type="checkbox"/> Low - 2 <input type="checkbox"/> Medium <input type="checkbox"/> Medium - 2 <input type="checkbox"/> High
Additional options for Groups with 10 – 50 eligible employees	<input type="checkbox"/> 75,000 <input type="checkbox"/> 100,000 <input type="checkbox"/> 125,000		<input type="checkbox"/> 75,000 <input type="checkbox"/> 100,000 <input type="checkbox"/> 125,000		<input type="checkbox"/> 75,000 <input type="checkbox"/> 100,000 <input type="checkbox"/> 125,000	
Class Description						

Optional Dependent Term Life (Available only to groups with 10 to 50 eligible employees.) Yes No

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

Employer Contribution(s)

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

* Requires a minimum of 50% per employee per month (employee coverage only -- does not apply to dependent coverage).

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

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

Business Eligibility

Is your company a subsidiary of another company, an affiliate of another company, or under common control with another company?					<input type="checkbox"/> Yes <input type="checkbox"/> No
Does your company file state or federal taxes with another company(ies) on a combined or consolidated basis?					<input type="checkbox"/> Yes <input type="checkbox"/> No
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(s)	Percentage of Ownership	Number of Employees	Is group to be included?
					<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No
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"/> Common Filing
- Where is each branch located? (List each branch business address separately.)					Number of Employees at each location
Has any business to be included been declined for coverage with Aetna or any other carrier in the past 12 months? If Yes, provide details.					<input type="checkbox"/> Yes <input type="checkbox"/> No
Has your business been insured with Aetna within the past 12 months? If Yes, provide group number.					<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you currently a client company of PEO?					<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you use the services of a Payroll Company? If Yes, provide the name of the payroll company.					<input type="checkbox"/> Yes <input type="checkbox"/> No

Employer Eligibility/Employee Status

Work Location (list by state)	Number of Employees						
	Full-time	Part-time	Retired	COBRA	1099	Union	Other (i.e., temporary, substitute, seasonal, etc.)
TOTAL							
Total number of eligible employees (must work a minimum of 25 hours per week).							
Of the total number of eligible employees as indicated above, how many are:							
- waiving Aetna health benefits coverage because they are covered through their spouse's health benefit plan?							
- waiving Aetna health benefits due to coverage under another health benefit plan offered by this employer?							
- waiving Aetna health benefits coverage but do not have coverage elsewhere?							
Total number of eligible employees enrolling in the Aetna health benefits plan.							
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 full-time employees who are currently in the waiting period and not eligible.							
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							
Does the group allow Domestic Partners to be eligible for coverage?							
<input type="checkbox"/> Yes <input type="checkbox"/> No							

COBRA/Tefra/Defra

Is your group subject to COBRA? (20 or more total employees during at least 50% of the working days in the previous calendar year)	<input type="checkbox"/> Yes <input type="checkbox"/> No
How many employees have terminated in the last 90 days?	
To the best of your knowledge, will any of these employee(s)/dependent(s) exercise their COBRA option?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, is the employee/dependent presently disabled?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is your group subject to Tefra/Defra? Under Tefra/Defra, Aetna is primary coverage for groups of 20 or more full-time and part-time employees (based on the total number of employees during 50% of the working days during the previous calendar year.) Medicare is primary for groups of less than 20 full-time and part-time employees.	<input type="checkbox"/> Medicare Primary <input type="checkbox"/> Aetna Primary

Benefit Waiting Period

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"/> 180 days	

Employee Eligibility Criteria

Aetna assumes an industry standard Employee Eligibility Criteria definition, which is as follows:
 An eligible employee works on a permanent basis and who is working a minimum average of 25 hours per week and is actively engaged in the conduct of the business of the employer, in the employer's regular place of business, and who has met any authorized waiting period requirements. Part-time (averaged less than 25 hours per week), seasonal, retirees, stockholders, or substitute employees are not considered eligible employees. In certain circumstances, 1099 contractors will be considered eligible employees.
 If the company's Employee Eligibility Criteria definition differs from the above definition, please provide the company's definition in the space below or as a separate attachment. Note that final rates may be impacted should Aetna underwriting deem that the company's definition places an increased risk to Aetna.

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 and Telephone Number				
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 Aetna, provide Group/Control Number				
Dental Only – Prior coverage included, check all that apply:		<input type="checkbox"/> Major Services <input type="checkbox"/> Orthodontia		

Workers' Compensation

Aetna's coverage is not occupational in nature and, consequently, it is not a substitute for Workers' Compensation coverage.	
Name of current Workers' Compensation Carrier:	Effective Date: Renewal Date:
Is Workers' Compensation coverage provided on all employees?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If No, please provide a list of all employees enrolling that are NOT covered by Workers' Compensation or similar legislation (including title).	

Medical Information

Is any person to be covered unable to work due to illness or injury?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is any person unable to perform the normal duties of another person in the same employment class of the same age and sex?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If Yes is answered to either question, attach a sheet with the names of the individual(s), dates and degree of recovery.	

Signature Section

The Applicant agrees that at no time shall any employee be permitted or required to contribute for non-contributory coverage; or, unless the change is approved in writing by an authorized representative of Aetna, to make contributions for contributory coverage at a rate higher than the initial contribution rate applicable for the employee's then current coverage. All statements herein shall be deemed representations and not warranties.

The Applicant acknowledges that it has selected this plan based upon written information provided by Aetna and that no broker, agent or consultant is authorized to modify the terms of the offer or to agree to changes. All material terms of plan coverage are set forth in the plan documents. Applicant agrees to make payroll and other records directly related to employee's coverage under the Group Agreement or Group Policy available to Aetna for inspection, at Aetna's expense, at Applicant's office, during regular business hours, upon reasonable advance request. This provision shall survive termination of the Group Agreement or Group Policy.

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

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

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. Aetna Rx Home Delivery, LLC, is a subsidiary of Aetna Inc.

Applicant agrees to deliver, or otherwise make available to enrollees, all Aetna paper or online member documents and other plan-related materials upon request by Aetna.

I understand that if it is determined that I have committed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact, my company's group health coverage may be terminated or my company may be charged a different premium for this coverage.

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

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

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

This information, as well as other personal and privileged information, subsequently collected by the insurance institution or agent may, in certain circumstances, be disclosed to third parties without authorization.

A right of access and correction exists with respect to all personal information collected.

Further disclosures required by Arizona law will be furnished to the policyholder upon request.

Personal information may be collected from persons other than the individual or individuals proposed for coverage.

I hereby apply for the coverage(s) indicated above. I certify that all information provided in this application is accurate and complete.

I understand that this application will form a part of the Group Agreement or Group Policy issued by Aetna (a sample of which may be available on request), and by my signature below I agree to be bound by the terms and conditions of that Group Agreement or Group Policy. I understand that Aetna may choose not to accept this application consistent with provision of Arizona law.

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

JOINDER AGREEMENT - REQUEST FOR PARTICIPATION (For life, disability, accidental death and dismemberment, out-of-state medical and out-of-state dental employee benefits): The undersigned employer agrees to the establishment of an insurance trust fund ("Fund") for the purposes of implementing a Trust Agreement ("Agreement"), and to the designation of the Chase Manhattan Bank Delaware, Wilmington, DE, as "Trustee" for the Fund and Agreement. The undersigned, as a Participating Employer in the Industry Trust corresponding to the standard industry classification ("SIC") code selected above: 1) agrees to be bound by the terms of the Agreement and the policy issued to the Trustee (including any amendments); 2) requests coverage for its eligible employees under the policy (subject to applicable underwriting requirements) as of the effective date requested or as of the date of approval of the Employer for participation under the Agreement, whichever is later, and continue as long as the Employer remains actively in business; and 3) agrees to make the required contributions to the Fund; in the event of default, it will be liable to the insurer for such unpaid contributions for the coverage period, and such insurer will terminate coverage. The insurer may also terminate coverage as of the date the group fails to meet minimum underwriting requirements in effect on that date. In addition, the Participating Employer, in accordance with ERISA Title I Section 503, designates Aetna Life Insurance Company ("Aetna") as the Named Fiduciary under the Plan, with complete and discretionary authority to review all denied claims for benefits under the Plan, and to construe disputed/doubtful Plan terms. Aetna shall be deemed to have properly exercised such authority unless it has abused its discretion by acting arbitrarily and capriciously.

Signed at (Location): _____
City, State

Applicant (Company Name)

By: _____
Authorized Applicant Signature

Official Title

Printed Authorized Applicant Signature

Date

Agent/Broker Certification

I hereby certify that I am not aware of any information not disclosed in this application by the client which may have bearing on this risk, including my knowledge that replacement life insurance is is not (check one) a part of this transaction.
 I hereby certify that I have advised the client not to terminate any existing coverage until receiving written notice from Aetna that the coverage being applied for by this application is accepted.

Broker Name:		SSN:	
Agency Name:		TIN:	
Pay commissions to: (check one) <input type="checkbox"/> Broker <input type="checkbox"/> Agency		Phone:	Fax:
Address:		City:	State: ZIP:
Signature:	Date:	E-mail Address:	% of credit:
Broker Name:		SSN:	
Agency Name:		TIN:	
Pay commissions to: (check one) <input type="checkbox"/> Broker <input type="checkbox"/> Agency		Phone:	Fax:
Address:		City:	State: ZIP:
Signature:	Date:	E-mail Address:	% of credit:
General Agent Name:		TIN:	
Phone:		Fax:	
Address:		City:	State: ZIP:
Signature:		E-mail Address:	% of credit:

For Aetna Use Only

Group Number _____	Control Number _____	SCD _____	Effective Date _____
Is Agent/Agency licensed and appointed? <input type="checkbox"/> Yes <input type="checkbox"/> No		Appointment Expiration Date _____	