



# APPLICATION FOR A SMALL GROUP HEALTH BENEFITS POLICY

**Please Print or Type**

**For Aetna Use Only**

New Policy     Change in Policy  
 Requested Effective Date \_\_\_\_\_  
**NOTE:** The Effective Date will be on or after the date Aetna approves the application.

Policy Number \_\_\_\_\_

**Section I: POLICYHOLDER INFORMATION**

1. Policyholder (Full Legal Name of Company)		2. Tax Identification Number		
3. Main Address: Street		City	State	Zip
Mailing Address: Street		City	State	Zip
Telephone Number (    )		Facsimile Number (    )		
4. Name of Correspondent			Telephone	
5. Type of Organization <input type="checkbox"/> Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Proprietorship <input type="checkbox"/> Other (explain):				
6. Nature of Business (specify)			SIC Code	
7. Number of eligible employees in your company  <b>Refer to the New Jersey Small Employer Certification for the definition of an eligible employee</b>				
8. Number of eligible employees to be insured		9. Class or classes to be excluded		
10. Insurance requested for <input type="checkbox"/> Employees Only <input type="checkbox"/> Employees and Dependents Should the plan provide coverage for domestic partners as permitted by P.L. 2003, c.246? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", should the plan provide coverage for children of a covered domestic partner? <input type="checkbox"/> Yes <input type="checkbox"/> No				
11. Is the Employer subject to the requirements of COBRA? <input type="checkbox"/> Yes <input type="checkbox"/> No				
12. Is the employer subject to the requirements of Medicare as Secondary Payor Rules for eligibility due to age? <input type="checkbox"/> Yes <input type="checkbox"/> No disability? <input type="checkbox"/> Yes <input type="checkbox"/> No				
13. Waiting period before employees become insured (may not exceed 6 months): Current Employees:                    _____ New or Rehired Employees:        _____				
14. What percentage of the premium will the employer pay?				
15. Deposit \$ _____ Premium Paid: Monthly		Premium will be due as of the effective date. The premium for the first month of coverage must be attached.		
<b>Affiliates, subsidiaries or branches (Must be included for the purposes of participation)</b>				
Legal Name and Location		No. Eligible Employees In This Company	No. Eligible Employees to Be Insured	

**Section II: SPECIFICATIONS FOR COVERAGE**

Health Benefits: Plan number (1, 2, etc.) and suffix (N or S) must be completed below.

NJ HMO: Plan Option - \_\_\_\_\_ Suffix (please circle one): N or S

NJ HMO No-Referral: Plan Option - \_\_\_\_\_ Suffix (please circle one): N or S

NJ Cost-Sharing HMO: Plan Option - \_\_\_\_\_ Suffix (please circle one): N or S

NJ POS No-Referral: Plan Option - \_\_\_\_\_ Suffix (please circle one): N or S

NJ PPO Basic Hospital Plan

NJ PPO First Dollar Plan

NJ PPO HSA Compatible:  Plan 1  Plan 2

Out-of-State/Situs PPO:  \$250 (High)  \$500 (Medium)  \$1000 (Low)

Standard Health Benefits Plans:

– NJ HMO:  \$5 Plan  \$10 Plan  \$15 Plan  \$20 Plan  \$30 Plan  With RX Rider (\$15/\$25/\$40)  Without RX Rider (50%)

– NJ Indemnity:  Plan A1  Plan A2  Plan B  Plan C  Plan D  Plan E1  Plan E2

Other Plan \_\_\_\_\_

**Section III: ALL QUESTIONS MUST BE ANSWERED**

1. Is there any Group Health Plan:

- now in force and to be continued?  Yes  No
- currently being applied for?  Yes  No

If "Yes", identify the name of the Group Health Plan, give a description of the plan(s) and the name of insurance carrier(s): \_\_\_\_\_

2. Name of present or prior group carrier \_\_\_\_\_

Effective date of prior coverage \_\_\_\_\_ Cancellation/Termination Date \_\_\_\_\_

Is the coverage applied for in this application replacing other group insurance?  Yes  No

If "Yes" give reason \_\_\_\_\_

Plan being replaced  A  B  C  D  E  HMO  HMO/POS  Dual Contract POS  Other \_\_\_\_\_

3. Has your firm been uninsured for 3 or more months prior to application?  Yes  No

4. What forms of Insurance are now or were in force?  Health Benefits  Prescription Drugs  
(Attach copies of Booklet/Certificate and most recent Billing Statement.)

5. Are extended benefits provided in case of termination of health benefits?  Yes  No

6. To the best of your knowledge, are there any current or former employees or their eligible dependents whose health insurance is being continued?  Yes  No

**Please provide the following information for each current/former employee or dependent on health continuations.**  
If additional space is needed, attach a separate sheet, signed and dated.

Name of Employee/ Dependent	Date of Birth	Type of Continuation State/Federal/ Extended Benefits	Reason for Termination Disability/Other	Continuation Dates	
				Start	End

7. To the best of your knowledge:

a. Are any employees or dependents presently incapacitated?  Yes  No

b. Are any dependent children incapable of self-support due to a physical or mental disability?  Yes  No

Additional space to explain if items 1, 2 or 3 were answered "Yes". Refer to the question number, and give details, including names, where appropriate.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

8. Does the employer participate in an arrangement with a Professional Employer Organization?  Yes  No  
(Refer to Advisory bulletin 00-SEH-02 if you need information concerning what constitutes a Professional Employer Organization.)

**Section IV: AGENT/PRODUCER INFORMATION**

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: _____

**Section V: SIGNATURE**

It is understood that, except as provided under applicable regulations, no individual shall become insured while not actively at work on a full-time basis, and only full-time employees are eligible. A full-time employee is one who regularly works at least 25 hours per week at his employer's place of business.

It is further understood that no agent has power on behalf of Aetna Health Inc. and Aetna Life Insurance Company to make or modify any request or application for insurance or to bind Aetna Health Inc. and Aetna Life Insurance Company by making any promise or representation or by giving or receiving any information.

It is further understood that no insurance will be effective unless and until the application is accepted in writing by Aetna Health Inc. and Aetna Life Insurance Company. Final rates will be based on enrollment data as of the Policy effective date. No contract of insurance is to be implied in any way on the basis of the completion and/or submission of this application.

Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

Date at \_\_\_\_\_ on \_\_\_\_\_

Print Name of Officer, Partner or Proprietor \_\_\_\_\_

Signature of Officer, Partner or Proprietor \_\_\_\_\_

Witness to Signature \_\_\_\_\_

Note: If there are any modifications to the statements and answers given in this application (i.e., crossed out, whited-out, erased information), the applicant must attest to the modifications by giving a complete signature in the margin near the modification.

