



# Florida Statutory Plans Small Group Business Employer Application

## FOR GROUP COVERAGE (GROUPS OF FEWER THAN 51 ELIGIBLE EMPLOYEES)

Life, Accidental Death & Dismemberment, Disability, Aetna Choice PPO and Aetna Traditional Indemnity are underwritten by Aetna Life Insurance Company. Aetna Basic HMO Coinsurance Plans, Aetna Standard HMO Coinsurance Plans, Aetna Basic HMO Copay Plans and Aetna Standard HMO Copay Plans are underwritten by Aetna Health Inc. Dental plans are provided or administered by Aetna Health Inc. and 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 or Industry Type:	

### Medical Coverage Selection

### Dental Coverage Selection (Limited to one selection)

<p><b>Coinsurance HMO Plan</b></p> <p><input type="checkbox"/> Basic Plan – <input type="checkbox"/> Option 1 <input type="checkbox"/> Option 2</p> <p><input type="checkbox"/> Standard Plan – <input type="checkbox"/> Option 1 <input type="checkbox"/> Option 2</p> <p><b>Copay HMO Plan</b></p> <p><input type="checkbox"/> Basic Plan – <input type="checkbox"/> Option 1 <input type="checkbox"/> Option 2</p> <p><input type="checkbox"/> Standard Plan – <input type="checkbox"/> Option 1 <input type="checkbox"/> Option 2</p> <p><b>Aetna Choice Plan PPO</b></p> <p><input type="checkbox"/> Basic Plan – <input type="checkbox"/> Option 1 <input type="checkbox"/> Option 2 <input type="checkbox"/> Option 3 (HSA Compatible)</p> <p><input type="checkbox"/> Standard Plan – <input type="checkbox"/> Option 1 <input type="checkbox"/> Option 2</p> <p><b>Aetna Traditional Indemnity Plan</b></p> <p><input type="checkbox"/> Basic Plan – <input type="checkbox"/> Option 1 <input type="checkbox"/> Option 2</p> <p><input type="checkbox"/> Standard Plan – <input type="checkbox"/> Option 1 <input type="checkbox"/> Option 2</p>	<p><b>Aetna Dental™ Plan</b></p> <p><input type="checkbox"/> Plan Option 1</p> <p><input type="checkbox"/> Plan Option 2</p> <p><input type="checkbox"/> Freedom of Choice or <input type="checkbox"/> Dual Choice</p> <p><input type="checkbox"/> Plan Option 3</p> <p><input type="checkbox"/> Freedom of Choice or <input type="checkbox"/> Dual Choice</p> <p><input type="checkbox"/> Plan Option 4</p>
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### Life, Accidental Death & Dismemberment, & Short Term Disability Coverage Selections

Groups with 10 to 50 eligible employees may select one, two or three options for Life, Accidental Death & Dismemberment and Short Term Disability. 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.)

Premium Waiver For Totally Disabled Employees  Yes  No

All Groups	Class 1			Class 2			Class 3		
	Life	STD – Plan Option 1	STD – Plan Option 2	Life	STD – Plan Option 1	STD – Plan Option 2	Life	STD – Plan Option 1	STD – Plan Option 2
<input type="checkbox"/> \$10,000	<input type="checkbox"/> \$100	<input type="checkbox"/> \$100	<input type="checkbox"/> \$10,000	<input type="checkbox"/> \$100	<input type="checkbox"/> \$100	<input type="checkbox"/> \$10,000	<input type="checkbox"/> \$100	<input type="checkbox"/> \$100	<input type="checkbox"/> \$100
<input type="checkbox"/> \$15,000	<input type="checkbox"/> \$200	<input type="checkbox"/> \$200	<input type="checkbox"/> \$15,000	<input type="checkbox"/> \$200	<input type="checkbox"/> \$200	<input type="checkbox"/> \$15,000	<input type="checkbox"/> \$200	<input type="checkbox"/> \$200	<input type="checkbox"/> \$200
<input type="checkbox"/> \$20,000	<input type="checkbox"/> \$300	<input type="checkbox"/> \$300	<input type="checkbox"/> \$20,000	<input type="checkbox"/> \$300	<input type="checkbox"/> \$300	<input type="checkbox"/> \$20,000	<input type="checkbox"/> \$300	<input type="checkbox"/> \$300	<input type="checkbox"/> \$300
<input type="checkbox"/> \$50,000	<input type="checkbox"/> \$400	<input type="checkbox"/> \$400	<input type="checkbox"/> \$50,000	<input type="checkbox"/> \$400	<input type="checkbox"/> \$400	<input type="checkbox"/> \$50,000	<input type="checkbox"/> \$400	<input type="checkbox"/> \$400	<input type="checkbox"/> \$400
	<input type="checkbox"/> \$500	<input type="checkbox"/> \$500		<input type="checkbox"/> \$500	<input type="checkbox"/> \$500		<input type="checkbox"/> \$500	<input type="checkbox"/> \$500	<input type="checkbox"/> \$500
<b>Additional options for Groups with 10 – 50 eligible employees</b>	<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			
<b>Class Description</b>									

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

**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): \_\_\_\_\_

### Employer Contribution(s)

	Employer's Contribution for Employee Coverage	Employer's Contribution for Dependent Coverage
	% Contribution	% Contribution
Medical	_____ %	_____ %
Dental	_____ %	_____ %
Basic Employee Term Life (including AD&D)	_____ %	_____ %
Optional Dependent Term Life	_____ %	_____ %
Short Term Disability	_____ %	_____ %

### Section 125 Plan

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

### 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

Is your group  Medicare primary or  Aetna primary? (Please check one)

Under Tefra/Defra, Medicare is primary coverage for groups of less than 20 employees and Aetna would be primary coverage for group of 20 or more employees (based on the total number of employees during 50% of the working days during the previous calendar year).

Total number of employees compensated via a 1099-Misc tax form applying for coverage: \_\_\_\_\_  
(Requires Financial Underwriting approval and additional documentation.)

Total number of employees eligible for coverage (must work a minimum of 25 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: \_\_\_\_\_

Are there excluded classes of employees other than part-time and temporary employees (for example, Union employees)?  Yes  No

If Yes, describe excluded class(es): \_\_\_\_\_

Eligibility date will be the 1st or 15th day of the policy month (depending on the group effective date) following the waiting period.

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

### Prior Carrier Information

**Health:**  
Will coverage be transferring from another carrier:  Yes  No  
If yes, name of the carrier: \_\_\_\_\_ Proposed Termination Date: \_\_\_\_\_  
If prior carrier is Aetna, provide group or control #: \_\_\_\_\_ Total Replacement:  Yes  No  
Has the group been uninsured for three or more months prior to the requested effective date:  Yes  No

**Dental:**  
Will coverage be transferring from another carrier:  Yes  No  
If yes, name of the carrier: \_\_\_\_\_ Proposed Termination Date: \_\_\_\_\_  
If prior carrier is Aetna, provide group or control #: \_\_\_\_\_ Total Replacement:  Yes  No  
Prior Coverage included coverage for (check all that apply)  Major Services  Orthodontia  
Has the group been uninsured for three or more months prior to the requested effective date:  Yes  No

**Life and AD&D:**  
Will coverage be transferring from another carrier:  Yes  No  
If yes, name of the carrier: \_\_\_\_\_ Proposed Termination Date: \_\_\_\_\_  
If prior carrier is Aetna, provide group or control #: \_\_\_\_\_ Total Replacement:  Yes  No

**Prior Carrier Information** (continued)

**Short Term Disability:**

Will coverage be transferring from another carrier:  Yes  No

If yes, name of the carrier: \_\_\_\_\_

Proposed Termination Date: \_\_\_\_\_

If prior carrier is Aetna, provide group or control #: \_\_\_\_\_

Total Replacement:  Yes  No

**Workers' Compensation Information**

Aetna's coverage is not a substitute for Workers' Compensation coverage.

Name of current Workers' Compensation carrier: \_\_\_\_\_ Renewal Date: \_\_\_\_\_

Is Workers' Compensation coverage provided on all employees?  Yes  No

If not, please provide a list of all employees enrolling that are NOT covered by Workers' Compensation or similar legislation (including title).

Proof of coverage is required: Please provide a copy of the Declaration Page including effective dates.

**Medical Information**

Is any person to be covered unable to work due to illness or injury?  Yes  No

Is any person unable to perform the normal duties of another person in the same employment class of the same age and sex?  Yes  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. It is agreed that no coverage shall become effective as to any person who is not then a bona fide, full-time employee, regularly performing the duties of his or her occupation, unless otherwise specifically provided in the plan documents (which consist of the Group Policy and/or Group Agreement). All statements herein shall be deemed representations and not warranties.

The Applicant acknowledges that it has selected this plan based upon written information provided by Aetna and that no broker, agent or consultant is authorized to modify the terms of the offer or to agree to changes. All material terms of plan coverage are set forth in the plan documents. Applicant agrees to make payroll and other records directly related to employee's 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.

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.

Participating physicians, hospitals and other health care providers are independent contractors and are neither agents nor employees of Aetna.

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

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.

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 at its sole discretion.

**Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.**

Signed at (Location): \_\_\_\_\_  
City, State

\_\_\_\_\_  
Applicant (Company Name)

By: \_\_\_\_\_  
Authorized Applicant Signature

\_\_\_\_\_  
Official Title

\_\_\_\_\_  
Witness

\_\_\_\_\_  
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.

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

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

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

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Agent's Florida License Number: \_\_\_\_\_ E-Mail Address: \_\_\_\_\_

Signature: \_\_\_\_\_

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

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

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

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Agent's Florida License Number: \_\_\_\_\_ E-Mail Address: \_\_\_\_\_

Signature: \_\_\_\_\_

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

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

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Agent's Florida License Number: \_\_\_\_\_ E-Mail Address: \_\_\_\_\_

## Administration Kits

Send Administration Kits to:  Group  Agent/Broker  General Agent

## For Aetna Use Only

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