



APPLICATION FOR A SMALL EMPLOYER HEALTH BENEFITS POLICY

Please Print or Type

For Aetna Use Only

<input type="checkbox"/> New Policy <input type="checkbox"/> Change in Policy Requested Effective Date _____	Policy Number _____
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Section I: POLICYHOLDER INFORMATION

1. Policyholder (Full Legal Name of Company)		2. Tax Identification Number	
3. Main Street Address (P.O. Box not acceptable)			
City		State	Zip
Facsimile Number			
Mailing Street Address (P.O. Box not acceptable)			
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 Refer to the New Jersey Small Employer Certification for the definition of an eligible employee			
8. Number 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		11. Are you subject to the requirements of COBRA? <input type="checkbox"/> Yes <input type="checkbox"/> No	
12. Waiting period before employees become insured (may not exceed 6 months): Present Employees: _____ New or Rehired Employees: _____			
13. What percentage of the premium will the employer pay? %			
14. Deposit \$ _____ Premium Paid: <input type="checkbox"/> Monthly <input type="checkbox"/> Quarterly		Premium will be due as of the effective date. The premium for the first month of coverage must be attached.	
Affiliates, subsidiaries or branches (Must be included for the purposes of participation)			
Legal Name and Location		No. of Eligible Employees In This Company	No. of Eligible Employees to Be Insured

Section II: SPECIFICATIONS FOR COVERAGE

Medical:

- | | |
|---|--|
| <input type="checkbox"/> Aetna Primary Care™ Plan HMO | <input type="checkbox"/> Aetna Choice™ Plan POS (with No Referrals) |
| <input type="checkbox"/> Aetna Choice™ Plan POS | <input type="checkbox"/> Mandated Plan Option (HMO \$15 Copay Option) |
| <input type="checkbox"/> Aetna Primary Care™ Plan HMO (with No Referrals) | Primary Copay (Check Applicable): |
| <input type="checkbox"/> Aetna Cost-Sharing™ Plan HMO | <input type="checkbox"/> \$10 <input type="checkbox"/> \$15 <input type="checkbox"/> \$20 <input type="checkbox"/> \$30 <input type="checkbox"/> Other _____ |

Section III: ALL QUESTIONS MUST BE ANSWERED

- 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):

- 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 _____
- Has your firm been uninsured for three or more months prior to this application? Yes No
- What forms of Insurance are now or were in force? Health Benefits Prescription Drugs
 (Attach copies of Booklet/Certificate and most recent Billing Statement.)
- Are extended benefits provided in case of termination of health benefits? Yes No
- To the best of your knowledge, are there any current or former employees or 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

- To the best of your knowledge:
 - Are any employees or dependents presently incapacitated? Yes No
 - Are any dependent children incapable of self-support due to a physical or mental disability? Yes No

Use 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.

Section III: 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.™ to make or modify any request or application for insurance or to bind Aetna Health Inc. 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. Final rates will be based on enrollment data as of the Policy effective date. No contract of insurance to be is 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.

For Aetna Health Inc. Use Only	Effective Date	Billing	Coverage Code	Type	Pre-Ex	Continuous Coverage	Transcode