



Texas Small Group Employer Application

(for groups with 2-50 eligible employees)

| | |
|---|---------------------------|
| <input type="checkbox"/> New Policy <input type="checkbox"/> Change in Policy/Type of Change: _____ | Requested Effective Date: |
|---|---------------------------|

1. Employer Information

| | | | |
|--|--|----------------------------|--------------------|
| Employer Name or DBA (doing business as): | | Date Business Established: | Sic Code: |
| Company Contact Person: | Phone Number: | Fax Number: | Fed Tax ID Number: |
| Street Address: | City: | State: | ZIP Code: |
| Billing Address: | City: | State: | ZIP Code: |
| Email Address: | Type of Employer: <input type="checkbox"/> Corporation <input type="checkbox"/> Sole Proprietor <input type="checkbox"/> Partnership <input type="checkbox"/> Non-Profit <input type="checkbox"/> Other _____ | | |
| Has the company been insured by CIGNA or one of its affiliates in the last 24 months? <input type="checkbox"/> Yes <input type="checkbox"/> No If answered "Yes," please provide the following: Name previously insured under _____ Account Number _____ Term Date _____ | | | |
| Does the company file State or Federal taxes with another company on a consolidated basis? <input type="checkbox"/> Yes <input type="checkbox"/> No If you answered "Yes," please explain: _____ | | | |

2. Plan Options

| <input type="checkbox"/> Single Option | <input type="checkbox"/> Dual Option (2-50 Eligible) | <input type="checkbox"/> Multiple Option (2-50 Eligible) |
|---|--|--|
| Open Access Plans <input type="checkbox"/> OAP 500 <input type="checkbox"/> OAP 1000 <input type="checkbox"/> OAP 1500 <input type="checkbox"/> OAP 2000 | Health Savings Plans <input type="checkbox"/> HSP 1500 <input type="checkbox"/> HSP 2500 <input type="checkbox"/> HSP 5000 | PPO Plans <input type="checkbox"/> PPO Plan 1 <input type="checkbox"/> PPO Plan 2 A Consumer Choice of Benefits Plan |
| <input type="checkbox"/> In Vitro Fertilization Rider | | |
| <p>*You have the option to choose this Consumer Choice of Benefits Health Insurance Plan that, either in whole or in part, does not provide state-mandated health benefits normally required in accident and sickness insurance policies in Texas. This standard health benefit plan may provide a more affordable health insurance policy for you although, at the same time, it may provide you with fewer health benefits than those normally included as state-mandated health benefits in policies in Texas. If you choose this standard health benefit plan, please consult with your insurance agent to discover which state-mandated health benefits are excluded in this policy.</p> | | |

3. Employee Information

| | | | |
|---|--|---|---|
| Total No. of employees in the company: (incl. part-time, 1099s, seasonal, etc.) | Total No. of eligible employees: | Total No. of employees enrolling in coverage: | Total No. of eligible employees waiving coverage: |
| Of the employees waiving, how many have "other" group coverage? | Of the employees waiving, how many have no coverage elsewhere? | Total No. of Ineligible employees: (such as part-time, 1099s, seasonal) | |
| Do you wish to cover independent contractors (1099s)? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| Do you wish to waive the waiting period for existing employees? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| Benefit Waiting Period for New Hires will be the 1 st of the month following: <input type="checkbox"/> Date of Hire <input type="checkbox"/> 30 days <input type="checkbox"/> 60 days <input type="checkbox"/> 90 days | | | |

4. COBRA/State Continuation/Tefra/Defra/Medicare/ERISA

| | |
|---|--|
| Is your group subject to COBRA*/State Continuation? | <input type="checkbox"/> COBRA <input type="checkbox"/> State Continuation |
| For actively working employees over 65, will CIGNA be Primary or Secondary to Medicare?*** | <input type="checkbox"/> Primary <input type="checkbox"/> Secondary |
| Is your group subject to ERISA?*** <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, ERISA Code: _____ | |
| Does the group have a flex plan under Section 125 of the IRS Code? | <input type="checkbox"/> Yes <input type="checkbox"/> No |

- * Your group will be subject to COBRA if you employed 20 or more employees during at least 50% of the working days in the previous calendar year *or* State Continuation (where mandated) if you employed less than 20 employees during at least 50% of the working days in the previous calendar year.
- ** Under Tefra/Defra, **CIGNA** will be the **primary** coverage for employees and their spouses who are age 65 or older if the employer has 20 or more employees for each working day in each of the 20 or more calendar weeks in the current or preceding calendar year. **Medicare** is the **primary** coverage for such employees if the employer has less than 20 employees for each working day in each of the 20 or more calendar weeks in the current or preceding calendar year.
- *** All employer groups EXCEPT church groups and governmental entities are subject to ERISA regardless of the number of employees.

5. COBRA/State Continuees – List all current COBRA and State Continuation participants and terminated employees who have not yet elected COBRA or State Continuation:

| | | | | |
|-------|--|---------|---|--|
| Name: | <input type="checkbox"/> Currently on Continuation <input type="checkbox"/> In Continuation Election Period But Not Yet Elected | Reason: | Continuation Dates Orig. Start End | |
| Name: | <input type="checkbox"/> Currently on Continuation <input type="checkbox"/> In Continuation Election Period But Not Yet Elected | Reason: | Continuation Dates Orig. Start End | |
| Name: | <input type="checkbox"/> Currently on Continuation <input type="checkbox"/> In Continuation Election Period But Not Yet Elected | Reason: | Continuation Dates Orig. Start End | |
| Name: | <input type="checkbox"/> Currently on Continuation <input type="checkbox"/> In Continuation Election Period But Not Yet Elected | Reason: | Continuation Dates Orig. Start End | |
| Name: | <input type="checkbox"/> Currently on Continuation <input type="checkbox"/> In Continuation Election Period But Not Yet Elected | Reason: | Continuation Dates Orig. Start End | |

If more room is needed please attach a separate page to this application.

6. Employer Contribution

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|--|
| Employer contribution* to Employee Medical _____ % or \$ _____ |
| Employer contribution to Dependent Medical _____ % or \$ _____ |

*Employer must contribute at least 50% toward employee's Medical coverage.
NOTE: Contribution toward dependent coverage is not required.

7. Leave of Absence

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|---|---|
| How many months do you allow your employees to continue with Group Medical coverage while on an Employer approved Personal Leave of Absence? | <input type="checkbox"/> None <input type="checkbox"/> 1 Month <input type="checkbox"/> 2 Months <input type="checkbox"/> 3 Months <input type="checkbox"/> Other _____ |
| How many months do you allow your employees to continue with Group Medical coverage while on an Employer approved Medical Leave of Absence? | <input type="checkbox"/> None <input type="checkbox"/> 1 Month <input type="checkbox"/> 2 Months <input type="checkbox"/> 3 Months <input type="checkbox"/> Other _____ |

8. Current or Prior Coverage Information

| | | |
|---|---|---|
| Will coverage be transferring from another carrier? <input type="checkbox"/> Yes <input type="checkbox"/> No | Name of Current or Prior Carrier: | Total Replacement? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Prior Coverage* Type: <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Life | Prior or Current Carrier Effective Date: _____ | Prior or Current Carrier proposed Termination Date: _____ |

Do not cancel Existing coverage until written notification of coverage approval has been received by CIGNA.

*If insured within the last 62 days, provide a copy of prior carrier bill to insure proper credit towards any possible pre-existing waiting period.

9. Workers' Compensation Information

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|---|--|
| Does your group carry Workers' Compensation coverage? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Name of Workers' Compensation carrier: | Effective Date: _____ Renewal Date: _____ |
| Are all employees covered by Workers' Compensation coverage? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| If not all employees are covered, please indicate who is not covered and why: | |

10. Payment Method

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|---|---|
| Initial Payment: (Please select one option only) Please submit, with your application, a business check for initial payment made payable to CIGNA and attach to this completed form. | |
| Ongoing Payment Options: <input type="checkbox"/> Yes, I agree to submitting a business check monthly with payment voucher. <input type="checkbox"/> Yes, I agree to recurring automatic Easy Pay option for ongoing monthly payments.* <input type="checkbox"/> Yes, I agree to receive monthly electronic bills (eBills) and will initiate payment online for ongoing monthly payments. <i>*Eligibility changes that impact rates may vary the monthly payment drafts (ex: new hire, dependent status change, etc.).</i> | |
| Ongoing Billing Options: <input type="checkbox"/> Monthly Paper Bill (not available with eBill election above). <input type="checkbox"/> Monthly eBill, no paper will be generated. | |
| Easy Pay – (Electronic Fund Transfer – EFT) Please complete this section if you are requesting the Easy Pay option for ongoing payments. | |
| Account Number: _____ | <input type="checkbox"/> Checking Routing Number: <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> |
| Name of Bank: _____ | <input type="checkbox"/> Savings |
| Name(s) on Account: _____ | Insert picture of check with arrows identifying routing number and account number. |
| I hereby authorize CIGNA to debit my account at the financial institution identified above for my monthly CIGNA premium payment. I am accepting the terms of this Easy Pay agreement by checking the "Yes" box above and with my application enrollment form signature insert page number. Insert additional Easy Pay instructions/auth verbiage (legal). <i>Any premium adjustment made during underwriting process will automatically be charged to your account.</i> | |

11. Authorization

| | | |
|--------------------------------------|----------------------------------|--------------|
| Company Representative Signature: | Title of Company Representative: | |
| Company Representative Printed Name: | Location (City, State): | Date Signed: |

- Please keep a copy of this application for your records.
- NOTE: If there are any modifications to the statements and responses provided in this application (i.e. crossed out, white-out, erased information), the applicant must attest to the modifications by providing a complete signature in the margin near the modification.

12. Broker/Agent

| | | | |
|--|-------|---------------------------|----------------------|
| I Certify: | | | |
| <ul style="list-style-type: none"> ■ To the best of my knowledge, the information provided by my client is accurate and complete, and no information has been omitted that has bearing on this risk. ■ I have advised the client not to terminate any existing coverage until receiving written notice from CIGNA that coverage applied for by this application has been accepted. | | | |
| Producer Name: | | Producer Code: | Email Address: |
| Brokerage/Agency Name: | | | |
| Address: | | Phone: | Fax: |
| Signature: | Date: | Producer Code Payable To: | Comp. Split %: |
| Producer Name: (if applicable) | | Producer Code: | Email Address: |
| Brokerage/Agency Name: | | | |
| Address: | | Phone: | Fax: |
| Signature: | Date: | Tax ID Payable To: | Comp. Split %: |
| General Agent Name: (if applicable) | | General Agent TIN: | General Agent Phone: |
| Address: | | General Agent Fax: | Email Address: |
| Signature: | | | Date: |

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