

Effective Date Actual effective date will be assigned by Aetna.

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

Employer Contribution(s)

	Employer's Minimum Contribution for Employee Coverage	Employer's Minimum Contribution for Dependent Coverage
	% Contribution	% Contribution
Medical	_____ %	_____ %
Dental	_____ %	_____ %
Basic Employee Term Life (including AD&D)	_____ %	
Optional Dependent Term Life		_____ %
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	COBRA or State Continues	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

Total number of independent contractors compensated via a 1099-Misc tax form applying for coverage: _____
(Requires Underwriting approval and additional documentation.)

Total number of employees eligible for coverage (must usually work at least 30 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 Union employees excluded for eligibility purposes? Yes No

If yes, how many union employees are to be excluded? _____

Eligibility date will be the 1st of the policy month following the waiting period.

Waiting period for all employees: 0 months 1 month 2 months 3 months

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

Prior Carrier Deductible _____

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 Carrier Deductible _____

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

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 occupational in nature and, consequently, it 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).

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.

Texas Notice of Election or Rejection of Optional Medical Benefits

If medical coverage **has not been** selected or a Value Plan (Consumer Choice of Benefits Health Insurance Plan) **has been** selected, this section does not apply.

Texas law requires that the following optional benefits be offered to applicants having employees who are located in Texas. If elected, coverage will be provided to all employees covered under a Texas contract except as otherwise noted. Additional medical premium will be required for each option selected.

1. In Vitro Fertilization Coverage

Coverage includes expenses incurred by the subscriber or the subscriber's covered spouse for outpatient in vitro fertilization procedures subject to the provisions of the Texas Insurance Code.

- Applicant accepts the optional In Vitro Fertilization benefit.
 Applicant rejects the optional In Vitro Fertilization benefit.

2. Additional Speech and Hearing Impairment Coverage

The optional coverage would include benefits for the necessary care and treatment of loss or impairment of speech or hearing. Such coverage will not be less favorable than coverage under the plan for physical illness generally, subject to the same durational limits, dollar limits, deductibles and coinsurance factors that may apply.

- Applicant accepts the optional Speech and Hearing Impairment benefit.
 Applicant rejects the optional Speech and Hearing Impairment benefit.

In rejecting coverage, I understand that it will not be provided at a future date unless I request it at policy renewal.

Signature _____ Title _____ Date _____

3. Additional Coverage for Serious Mental Illness

Additional coverage offered for the treatment of "serious mental illness." A "serious mental illness" is defined as:

- Schizophrenia;
 - Paranoid and other psychotic disorders;
 - Bipolar disorders (hypomanic, manic, depressive and mixed);
 - Major depressive disorders (single episode or recurrent);
 - Schizo-affective disorders (bipolar or depressive);
 - Pervasive developmental disorders;
 - Obsessive-compulsive disorders; and
 - Depression in childhood and adolescence.
- Applicant accepts the optional Serious Mental Illness benefit.
 Applicant rejects the optional Serious Mental Illness benefit.

Texas Notice of Election or Rejection of Optional Dental Benefits

To provide flexibility to covered persons, dental coverage can be obtained through either the Dental Plan Coverage (DPC Plan), offered by Aetna Dental Inc., or the Comprehensive Dental Expense Coverage plan (Point of Service Plan), offered by Aetna Life Insurance Company. The Point of Service Plan (POS Plan) provides out-of-network coverage for covered dental expenses and includes deductible and coinsurance percentage provisions. This plan must be offered to every customer who purchases a DMO plan and has 25 or more employees. If dental coverage has not been selected or the group does not meet the criteria indicated above, this section does not apply.

If any covered services or supplies are performed or received from a Member Dental Provider or a Member Specialty Dental Provider, benefits will be considered to have been paid for such services and supplies under the DPC Plan. The covered person will be responsible for the payment of the copayment amounts specified in the Certificate of Coverage describing his/her DPC Plan.

Except for Emergency Care, if any covered services or supplies are performed or received from a Non-Member Dental Provider, benefits will be considered to have been paid for such services and supplies under the POS Plan. The covered person will be responsible for the payment of the deductible and coinsurance percentage amounts specified in the Certificate of Coverage describing his/her POS Plan.

All the terms and conditions of the plan under which the services or supplies are provided will apply.

If you live and work outside of the Service Area, you will not be eligible for the DPC Plan Coverage.

Additional dental premium will be required if the Point of Service Option is accepted.

- Applicant accepts the Point of Service Option.
 Applicant rejects the Point of Service Option.

Signature _____ Title _____ Date _____

Signature Section

APPLICABLE TO ALL COVERAGES

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 (except for health-related factors and subject to applicable HIPAA requirements for health coverage), 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.

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Signature Section (Continued)

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.

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.

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.

Any person who, with intent to defraud or knowing that he/she is facilitating a fraud, submits an application or a statement of claim containing false or deceptive statement commits insurance fraud, which is a crime subject to civil and criminal penalties.

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.

APPLICABLE TO LIFE INSURANCE COVERAGE ONLY

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.

APPLICABLE TO HEALTH AND DENTAL COVERAGE ONLY

Participating physicians, hospitals and other health care providers are independent contractors and are neither agents nor employees of Aetna. 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 subject to Texas small employer laws.

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 discretionary authority pursuant to all applicable state and Federal laws, 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
_____	_____
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. 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: _____
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: _____

For Aetna Use Only Group Number _____ Control Number _____ SCD _____ Effective Date _____