# Texas Health | aetna Employer Application

**FOR GROUP COVERAGE (51 - 100 ELIGIBLE EMPLOYEES)**

## Texas Health + Aetna Health Insurance Company

**** 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 or evidences of coverage in Texas. This standard health benefit plan may provide a more affordable health insurance policy or health plan for you although, at the same time, it may provide you with fewer health or health plan benefits than those normally included as state-mandated health benefits 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 or evidence of coverage.**

Texas Health + Aetna Health Insurance Company ("Texas Health Aetna") underwrites Texas Health Aetna Open Access Managed Plus plans, Texas Health Aetna Care Plus Open Access Managed Plus plans, Texas Health Aetna Open Access Network Only Plus plans and Texas Health Aetna Care Plus Open Access Network Only Plus plans. "Texas Health Aetna" is the brand name used for products and services provided by one or more of the Texas Health Aetna group of subsidiary companies.

| | | | |
|---|---|---|---|
| Company name (Legal name) | Doing business as (if applicable) | | |
| Street address (PO box not acceptable) | City | State | ZIP code |
| Billing address (if different from above) | City | State | ZIP code |
| Phone number ( ) | Fax number ( ) | | |
| Are there additional addresses or locations for this business? ☐ Yes ☐ No If **yes**, provide all addresses and locations. | | | |

| | |
|---|---|
| Company contact – Name and title | Company contact email |
| Billing contact name (if different from company contact)<br>*Online statements available. Activate access to your eBusiness account at* ***(https://www.texashealthaetna.com/en/employers)*** *when you get your approval letter.* | Billing contact email |
| Enrollment contact name (if different from company contact) | Enrollment contact email |

| | | | |
|---|---|---|---|
| SIC code | Nature of business | Federal tax ID number | Date business established (Month/Year): |

Employer classification ☐ S Corp ☐ C Corp ☐ Nonprofit ☐ Partnership ☐ Sole proprietor ☐ LLC ☐ LLP ☐ Other: _____

**Effective date of group plan –** The actual effective date will be assigned by the Texas Health Aetna underwriting department.

Requested effective date (may be the first or fifteenth of the month only): _____

**Please keep a copy of this application for your records. If Texas Health Aetna accepts the application, it becomes part of the issued Group Agreement and / or Group Policy.**

## Medical coverage selection

☐ Texas Health Aetna Open Access Managed Plus (THA OA Managed Plus)**
Plan option _____

☐ Texas Health Aetna Open Access Managed Plus 1000 80/50 In Vitro Fertilization (IVF) (THA OA Managed Plus 1000 80/50 IVF)
Plan option _____

☐ Texas Health Aetna Care Plus Open Access Managed Plus (THA CP OA Managed Plus)**
Plan option _____

☐ Texas Health Aetna Care Plus Open Access Managed Plus 1000 80/50 IVF (THA CP OA Managed Plus 1000 80/50 IVF)
Plan option _____

☐ Texas Health Aetna Open Access Network Only Plus (THA OA Network Only Plus)**
Plan option _____

☐ Texas Health Aetna Open Access Network Only Plus 1000 80/50 IVF (THA OA Network Only Plus 1000 80/50 IVF)
Plan option _____

☐ Texas Health Aetna Care Plus Open Access Network Only Plus (THA CP OA Network Only Plus)**
Plan option _____

☐ Texas Health Aetna Care Plus Open Access Network Only Plus 1000 80/50 IVF (THA CP OA Network Only Plus 1000 80/50 IVF)
Plan option _____

Do you, or any third party on your behalf, in any way fund or subsidize any portion of the member's cost sharing responsibilities (deductibles, coinsurance or copays) under a high deductible health plan (HSA or HRA)? ☐ Yes ☐ No If **yes**, how much? _____

## Business eligibility

| | |
|---|---|
| Is your company a subsidiary of another company, an affiliate of another company, or under common control with another company?<br>The Health Insurance Portability and Accountability Act of 1996 (HIPAA) states that all persons treated as a single employer under subsection (b), (c), (m), or (o) of section 414 of the Internal Revenue Code of 1986 shall be treated as one employer. | ☐ Yes ☐ No |
| Does your company file state or federal taxes with another company or other companies on a combined or consolidated basis? | ☐ Yes ☐ No |
| Are there any associated companies to be included with this group that are commonly owned? | ☐ Yes ☐ No |
| Are multiple companies or multiple addresses to be included under this plan? | ☐ Yes ☐ No |

If you answered **yes** to any of these questions, complete the information below.
- A copy of the Quarterly Wage and Tax Statement must be provided for each group to be included for coverage.
- If you file or are eligible to file multiple businesses under one tax ID number, all businesses must be included as one group.

| Business names of ALL groups including the company the groups are being written under | Tax identification number | Owner's name | Percentage of ownership | Number of employees | Is group to be included? |
|---|---|---|---|---|---|
| | | | | | ☐ Yes ☐ No |
| | | | | | ☐ Yes ☐ No |
| | | | | | ☐ Yes ☐ No |
| | | | | | ☐ Yes ☐ No |
| | | | | | ☐ Yes ☐ No |

If you have answered **no** to "Is the group to be included" above, explain why.

| | | |
|---|---|---|
| Does your company have branch offices? Is your office a branch location? | | ☐ Yes ☐ No |
| **If yes** | - Is each branch office a separate legal entity? | ☐ Yes ☐ No |
| | - Is each branch a location of one legal entity? | ☐ Yes ☐ No |
| | - How many branch offices are there? | |
| | - Are taxes filed separately or as one common filing? | ☐ Separately<br>☐ One common filing |
| | - Where is each branch located? (List each branch business address separately.) | Number of employees at each location |
| | | |
| | | |

*Continued on next page*

## Business eligibility *(Continued)*

| | | |
|---|---|---|
| Do you use the services of a payroll company? | | ☐ Yes ☐ No |
| **If yes** | - Provide the name of the payroll company: | |
| | - Is group health coverage available to you as a client of the payroll company? | ☐ Yes ☐ No |
| Are you a professional employer organization (PEO)? | | ☐ Yes ☐ No |
| **If yes** | - Is this an Aetna PEO? Aetna group #: _____ | ☐ Yes ☐ No |
| | - Do you offer health coverage to your clients under your PEO plan? | ☐ Yes ☐ No |
| | - Are any of your clients enrolling under this health plan? | ☐ Yes ☐ No |
| | - Are you only covering the administrative staff of the PEO? | ☐ Yes ☐ No |
| Are you currently a client of a professional employer organization (PEO)? | | ☐ Yes ☐ No |
| **If yes** | - Provide the name of the PEO: | |
| | - Is group health coverage available to you as a client of the PEO?<br>- If **no**, provide a letter from the PEO indicating health coverage is not available. | ☐ Yes ☐ No |

## Participation

| | | | |
|---|---|---|---|
| How many hours a week must your employees work to be eligible for coverage? (The minimum hours must be at least 25 hours a week.) | | | |
| Number of employees eligible for coverage (employees working the minimum hours to be eligible for coverage) | | | |
| Number of employees enrolling | | Number of employees waiving Texas Health Aetna coverage | |
| Number of full-time employees excluding union employees | | Number of employees working outside Texas<br>List all states _____ | |
| Number of part-time employees | | Number of employees not actively at work | |
| Number of 1099 employees | | Number of COBRA subscribers | |
| Number of union employees | | Number of employees in waiting period and not eligible | |
| Excluded classes: ☐ Union – Local number: _____ | | | |
| Do you want to cover domestic partners as eligible dependents? ☐ Yes ☐ No If **yes**, coverage will include same and opposite sex partners. Please notify Texas Health Aetna in writing if you intend to have coverage apply differently. | | | |

## Total average number of employees

**You MUST supply this number:** To calculate average number of employees, determine the number of employees for each month, add each month's number to get an annual total, and then divide by 12. Round up or down to the nearest whole number. For example: 24.6 = 25. Do not spell out the number. For example: write 3, not three.

| | |
|---|---|
| What is the average number of employees you employed for the entire previous calendar year regardless of whether or not they were eligible for coverage? An employee is defined as any person for whom the company issues a W-2, including full time, part time, and seasonal workers, and regardless of insurance eligibility.<br>The determination of how to count employees of related corporate entities when calculating group size for medical loss ratio (MLR) purposes is based on whether the entities are considered a single employer under Section 414 of the Internal Revenue Code (subsection (b), (c), (m), or (o)) – and is not based on the multiple tax ID status of the related entities. | |

## Medicare primary versus secondary

| | |
|---|---|
| How many full-time and part-time employees have you employed for at least 20 or more weeks during the current or prior calendar year? *Include: Full time, part time, seasonal, temporary, union, owners, partners, officers*<br>*Exclude: Self-employed persons, independent contractors (1099), directors*<br>If you employed fewer than 20 employees for 20 weeks in the current or prior year, your group is Medicare primary.<br>If you employed 20 or more employees for 20 weeks in the current or prior year, your group is Texas Health Aetna primary. | |

## COBRA / TEFRA / DEFRA

| | |
|---|---|
| Is your employer group required to comply with COBRA? | ☐ Yes ☐ No |
| How many full- and part-time employees did you employ 50 percent of the business days in the prior calendar year?<br>*Include: Full time, part time, seasonal, temporary, union, owners, partners, officers*<br>*Exclude: Self-employed persons, independent contractors (1099), directors*<br>Each part-time employee counts as a fraction of an employee, with the fraction equal to the number of hours that the part-time employee worked divided by the hours an employee must work to be considered full time. | |
| Eligible: How many present or former employees / dependents are eligible to elect COBRA?<br>These present or former employees / dependents must be listed below. Attach a separate sheet, if needed. | |
| Enrolled: How many present or former employees / dependents are enrolled in COBRA?<br>These present or former employees / dependents must be listed below. Attach a separate sheet, if needed.<br>Any individuals eligible for COBRA who are still within their election period, but have not enrolled, and enroll in the future retroactive to the group effective date, will constitute a change in census, and your company's health benefits plan may be charged a different premium for this coverage. | |

| Name of applicant | Qualifying event (e.g., termination of employment, divorce, etc.) | Have they elected COBRA? | Date of qualifying event | Date COBRA coverage terminates |
|---|---|---|---|---|
| | | ☐ Yes ☐ No | | |
| | | ☐ Yes ☐ No | | |
| | | ☐ Yes ☐ No | | |

## Benefit waiting period

The eligibility date will be the first day of the policy month after the waiting period for 0, 30 or 60 days or *exactly* 90 days from date of hire. Policy month refers to the contract effective date of the first or fifteenth day of the month

If "0 days" is selected and the employee is hired on the first day of the month, the effective date will be the date of hire.

If "exactly 90 days" is selected, the enrollment eligibility date will begin 90 calendar days after the date of hire.

If the group has a fifteenth day of the month bill cycle, the new hire will be effective on the fifteenth day of the month after the waiting period chosen, except exactly 90 days after date of hire.

Do you want to waive the waiting period for present employees enrolling with the group (even those who have not met the full waiting period)? ☐ Yes ☐ No

Benefit waiting period for future employees: First day of policy month following:
☐ 0 days - A date of hire effective date is not allowed.
☐ 30 days ☐ 60 days
*OR* ☐ exactly 90 days from date of hire*

*Employees must be added to the group coverage no later than 90 days after their first day of employment.

Is a dual waiting period offered? If **yes**, provide the two classes of employees below: ☐ Yes ☐ No

Class 1 name _____ Class 1 waiting period _____

Class 2 name _____ Class 2 waiting period _____

## Employer premium contribution(s)

| | |
|---|---|
| Employer premium contribution for employee | Medical $ _____ or _____ % |
| Employer premium contribution for dependent | Medical $ _____ or _____ % |

## Prior carrier information

| Is this plan a total replacement for any existing group plans? | Carrier name | Phone number | Start date | End date |
|---|---|---|---|---|
| **Current medical carrier** ☐ Yes ☐ No | | | | |

Has your business ever been insured with Texas Health Aetna? If **yes**, provide group number: _____ ☐ Yes ☐ No

## Workers' compensation / disability / leave of absence

| | |
|---|---|
| Do you provide workers' compensation coverage? | ☐ Yes ☐ No |
| Is any person currently receiving workers' compensation benefits? | ☐ Yes ☐ No |
| Is any person to be covered unable to work due to illness or injury? | ☐ Yes ☐ No |
| Is any person currently on leave of absence? | ☐ Yes ☐ No |

| Name | Start date | Expected date of return | Details |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

**Texas notice of election or rejection of optional medical benefit** – If a Consumer Choice of Benefits Health Insurance Plan or Health Maintenance Organization health care plan **has been** selected, this section does not apply.

Texas law requires that the following optional benefit 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 if option is selected.

**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.

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 _____

## 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 Texas Health Aetna as applicable, 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 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.

The Applicant acknowledges that it has selected this plan based upon written information provided by Texas Health Aetna as applicable 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 plan coverage under the Group Agreement or Group Policy available to Texas Health Aetna as applicable for inspection, at Texas Health Aetna's expense, at Applicant's office, during regular business hours, upon reasonable advance request. This provision shall survive termination of plan coverage and the applicable plan documents.

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 plan options for the Applicant's employees and the contribution amounts.

Information on agent's compensation is available from your agent or at Texashealthaetna.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.

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

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

Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any intentional misrepresentation of material fact or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which may be a crime and may subject such person to criminal and civil penalties.

All data that may have a bearing on coverage or premiums will be open for Texas Health Aetna as applicable 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.

Texas Health Aetna as applicable does not provide health, dental or vision 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 to the best of my knowledge and belief. I understand that this application will form a part of the Group Agreement or Group Policy issued by Texas Health Aetna as applicable (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 Texas Health Aetna may choose not to accept this application subject to Texas large employer laws.

**ELECTRONIC ENROLLMENT, BILLING / PAYMENT AND ACCESS AGREEMENT**

**Enrollment:** As part of your participation date, the following terms and conditions apply:

1. You agree to keep copies (paper or electronic) of actual enrollment forms and agree to maintain a reasonably complete record of enrollment and eligibility information (via electronic, interactive voice response technology and / or hard copy format), including evidence of coverage elections, evidence of eligibility, changes to such elections and terminations. Records must be available to Texas Health Aetna upon request and retained for seven years.
2. For electronic enrollment submissions or changes you agree to create and maintain the records on secure information systems that can generate hard copy records of enrollments or changes entered or maintained on those information systems. Any hard copy records generated pursuant to this provision shall meet reasonable standards of availability, authenticity, non-repudiation and integrity.

*Continued on next page*

**Signature section *(Continued)***

3. You represent that all enrollment and eligibility information presented to Texas Health Aetna is accurate and timely updated. You acknowledge that Texas Health Aetna can and will rely on such enrollment and eligibility information in determining whether an individual is eligible for benefits under the plan. In the event of a discrepancy between enrollee information (including salary data) submitted and information actually presented by the enrollee on any particular claim for benefits, and the result is that Texas Health Aetna must pay a higher benefit to reflect the actual information presented by the enrollee, you agree to pay promptly to Texas Health Aetna applicable back premiums accruing as of the date on which the enrollee's information changed.
4. Insured plans must either (1) use Texas Health Aetna-supplied forms in paper format or electronic format or (2) agree to incorporate the following four points into your enrollment materials.
   a. Names(s) of the Texas Health Aetna company offering the insurance coverage
   b. State-specific fraud warning statement
   c. A statement that the terms of the insurance documents will govern the member's rights and responsibilities
   d. An acknowledgment that participating providers are not agents or employees of Texas Health Aetna and that network composition can change.
5. You are responsible for adhering to both state and federal laws and regulations when submitting terminations to Texas Health Aetna.
6. If otherwise permitted, when retro-terminations are submitted, we will regard the submission as verification that no premium / contribution was paid by the member / dependent for that period.

**Billing / payment:** You agree to receive your bill online each month. Any contractual provisions related to non-payment of premium continue to be applicable. I / we understand and agree to the terms set forth in this agreement. By signing below, I represent that I am authorized to sign this agreement.

**Access:** The undersigned employer agrees that each employee will agree to terms associated with the issuance and use of his / her password and system access. An individual's password may be used only by that individual to access the system and may not be shared for any reason. Each individual is personally responsible for the information entered into the system. If an individual to whom a password has been issued becomes aware of a security breach (an incident in which there occurs attempted or unauthorized access, use, disclosure, modification, or destruction of information or interface with system operations), they agree to contact Texas Health Aetna.

**EMPLOYER ACKNOWLEDGMENT – EMPLOYER WAITING PERIOD**

Starting with plan years on or after January 1, 2014, the Affordable Care Act and subsequent federal regulations prohibit group health plans and health insurance issuers from requiring any otherwise eligible plan participants and beneficiaries (employees and dependents) to wait more than ninety (90) days before their health coverage is effective. The regulations define group health plan as the employer or plan administrator. The issuer is defined as the insurance company. Since the requirement applies to both the group health plan and the issuer, each party's obligation is satisfied if the ninety (90) day waiting period is honored. However, if neither party complies, both are subject to penalty.

The Employer Group Policyholder ("Employer") represents that it provides to Texas Health Aetna, effective date information regarding plan participants and beneficiaries that takes into account the eligibility conditions and waiting period requirements required under federal law, in order for such plan participants and beneficiaries to become eligible for coverage under the Employer's group health insurance coverage with Texas Health Aetna. In compliance with the waiting period requirements, Texas Health Aetna shall use the effective date information provided by Employer to enroll such plan participants and beneficiaries in the Employer's group health insurance coverage. In the event this information changes, the Employer shall inform Texas Health Aetna immediately.

**SUMMARY OF BENEFITS AND COVERAGE (SBC) FOR GROUP HEALTH PLAN - PLEASE READ. YOU MUST CHECK BELOW TO CONFIRM:**

In accordance with my contract with Texas Health Aetna to distribute information related to enrollment / coverage information,

☐ I have ☐ I have not

received the Summary of Benefits and Coverage document (**https://www.texashealthaetna.com/en/legal-notices/summary-benefits-and-coverage.html**) associated with the plan information referenced in this application. I confirm I will provide SBCs to plan participants and beneficiaries in compliance with the federal regulation and guidance related to SBCs, including the requirements for timely delivery.

For information on the SBC regulations and distribution requirements, please review the regulations at the HHS website: **http://cciio.cms.gov/resources/other/index.html#sbcug**.

| Signed at city, state | Applicant (company name) |
|---|---|
| Authorized applicant signature | Official title |
| Print name of authorized applicant | Date |

**Agent or broker certification**

I certify that I am not aware of any information not disclosed in this application by the client that may have bearing on this risk, for all products being applied for.

I represent that I am licensed to sell Texas Health Aetna products in the state of Texas.

I certify that I have advised the client not to terminate any existing coverage until receiving written notice from Texas Health Aetna that the coverage being applied for by this application is accepted.

Appointment with Texas Health Aetna: In order to receive commissions you must be appointed with Texas Health Aetna. To become appointed with Texas Health Aetna, apply online: **https://texashealthaetna.com/en/producers/licensing-and-appointments.html.** If you are not yet appointed and your state has a limited time to become appointed, you may want to include another broker from your office.

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|---|---|---|---|---|
| **Agent or broker name:** | | | | |
| Social Security number: | | National producer number: | | |
| Agency name: | | TIN: | | |
| Pay commissions to (check one): ☐ Broker ☐ Agency | | Phone: ( ) | Fax: ( ) | |
| Address: | | City: | State: | ZIP: |
| Signature: | Date: | Email: | | % of credit: |
| Broker admin assistant name: | | Broker admin assistant email: | | |
| **Agent or broker name:** | | | | |
| Social Security number: | | National producer number: | | |
| Agency name: | | TIN: | | |
| Pay commissions to (check one): ☐ Broker ☐ Agency | | Phone: ( ) | Fax: ( ) | |
| Address: | | City: | State: | ZIP: |
| Signature: | Date: | Email: | | % of credit: |
| Broker admin assistant name: | | Broker admin assistant email: | | |
| **General agent name:** | | TIN: | | |
| Selling agent name: | | Email: | | |
| Phone: ( ) | | Fax: ( ) | | |
| Address: | | City: | State: | ZIP: |
| Signature: | | | Date: | |
| GA admin assistant name: | | GA admin assistant email: | | |