Employer Specifications for Group Insurance Access U.S.

Aetna International
Coverage underwritten by Aetna Life Insurance Company & Aetna Life & Casualty (Bermuda) Ltd. Visit us at www.aetnainternational.com.

To apply for coverage, please complete this form and submit to your local Aetna International Representative.

Internal Use Only:		
____________ /	____________ /	____________
Control	Suffix	Account

INSTRUCTIONS: Employers please complete items 1-9 below.

1. Employer's Contact Information

Employer Name ______________________

Street ______________________

City ______________ State/Country ______________ ZIP/Postal Code ______________

Contact Name ______________ Contact Title ______________

Telephone Number* ______________ Fax Number* ______________ Email Address ______________

2. Type of Business ______________________

Number of Years in Business __________ **SIC/NAICS Code** __________

3. Plan Design Options Selected
(Please select one choice from each category A-E below – Inclusion of a Medical Plan is required.)

A. Medical
- ☐ Access Elite
- ☐ Access $250
- ☐ Access $500
- ☐ Access $750
- ☐ Access $1,000
- ☐ Access $1,500
- ☐ Access $2,500
- ☐ Access HDHP $2,000
- ☐ Access HDHP $3,000
- ☐ Custom Option

B. Dental Plan
- ☐ $1,000 Without orthodontia
- ☐ $1,000 With orthodontia
- ☐ $1,500 Without orthodontia
- ☐ $1,500 With orthodontia
- ☐ None

C. Life Plan
Flat Amount **or** Earnings Related
- ☐ $10,000 ☐ 1 x salary
- ☐ $25,000
- ☐ $50,000
- ☐ None

D. AD&PL Plan
(Same as life benefits)
- ☐ Include
- ☐ None

E. LTD Plan
- ☐ Coverage as follows:
  - ☐ % Benefit
  - ☐ Maximum Monthly Benefit
  - ☐ Elimination Period
- ☐ None

4. Requested effective date of plan ______________________

5. Insurance Producer Contact Information

Insurance Producer Name ______________________

Producer's Company Name ______________________

Producer Tax ID ______________________

Address ______________ City ______________ State _____ ZIP _______

Telephone Number ______________ Fax Number ______________ Email Address ______________

*Signature ______________________ Date ______________

Insurance Producer Admin Assistant Name ______________________

Insurance Producer Admin Assistant Email address ______________________

*By signing this application, Insurance Producer acknowledges Producer Compensation to be paid to General Agent.

6. General Insurance Producer Contact Information

General Insurance Producer Name ______________ Tax ID Number ______________

Selling Insurance Producer Name ______________________

Address ______________ City ______________ State _____ ZIP _______

Telephone Number ______________ Fax Number ______________ Email Address ______________

Signature ______________________ Date ______________

Admin Assistant Name ______________ Admin Assistant Email address ______________

Aetna International pays General Agent.

7. Employer Signature ______________________ **Date** ______________

** Include area, city, and country code(s), as applicable.*

Please retain a copy for your records.

To be completed by Aetna International

8. Submitting Aetna Representative ______________________________ **Date** ______________

9. Commissions (Aetna Financial Underwriter – please select one.) **For Aetna Use Only**

☐ Standard ☐ 0% ☐ 10%

☐ Enhanced, please enter the percentage in the space provided. _____%

INSTRUCTIONS: Employers please complete items 1-3 below.

General Information

1. Carrier/Plan Information:

A. ☐ No ☐ Yes Has group been previously insured by Aetna for coverage?

If Yes, provide Control Number ____________________.

2. Member Identification (ID) Cards:

A. Name of Company to appear on ID Card: ______________________________

B1. Distribution for ID Cards:

☐ In Bulk to Policyholder – see B2 below ☐ Directly to Members*

B2. Should this method be used for the initial delivery only? ☐ No ☐ Yes

If Yes, please describe: ______________________________

*If delivered directly to members, we utilize the address given to us on the member's eligibility record (form/spreadsheet).

3. Eligibility/Participation:

A. ____________ Total number of employees employed by your company

B. ____________ Total number of eligible employees

C. ____________ Total number of eligible employees applying for coverage

D. ____________ Total number of eligible dependents

E. ____________ Total number of eligible dependents applying for coverage

Please retain a copy for your records.