



**[AETNA HEALTH INC.]  
EMPLOYER APPLICATION FORM - NY**

<b>1. APPLICANT</b>	<b>GROUP NUMBER:</b>
Company Name: _____	
Parent Company Name: _____	
Contract Address: _____	
City: _____ State: _____ Zip Code: _____	
Federal Tax ID Number: _____	

<b>2. COVERAGE TYPE</b>	
FOR EMPLOYEES ONLY <input type="checkbox"/>	FOR EMPLOYEE AND DEPENDENT <input type="checkbox"/>
HMO Product: _____	
POS Product: _____	

<b>3. BENEFIT INFORMATION</b>
Please attach signed rate quotation(s) for each plan and service area

<b>4. CONTRACT INFORMATION</b>	
Effective Date: _____	Tier Structure
Renewal Month: _____	Tier Structure (Enter 2, 3, or 4): _____

<b>5. CONDITIONS OF ENROLLMENT - Applicant Acknowledgements and Agreements</b>
<ol style="list-style-type: none"> <li>1. Applicant acknowledges that it has selected this plan based upon written information provided by [Aetna Health Inc.] 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 Group Agreement which consists of this Application, the Group Agreement, Certificate of Coverage, Schedule of Benefits (and any endorsements or riders) and the initial rate sheets and any subsequent notification of rates issued by [Aetna Health Inc.].</li> <li>2. Applicant has selected 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.</li> <li>3. The Group Agreement 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.</li> <li>4. Applicant acknowledges that HMO participating providers, including all participating primary care physicians, are independent contractors and are neither agents nor employees of HMO.</li> <li>5. Applicant agrees to deliver to enrollees all [Aetna Health Inc.] member documents and other plan related materials upon request by [Aetna Health Inc.].</li> </ol>

## 6. IMPORTANT INFORMATION

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

## 7. EMPLOYER AUTHORIZATION

It is understood and agreed that this application is part of the enrollment process and this application is subject to [Aetna Health Inc.] corporate approval. I have signed rate quotations for the agreed upon plan offerings.

Authorized Employer Signature \_\_\_\_\_

Print Name \_\_\_\_\_

Title \_\_\_\_\_

Employer Address \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Employer Phone Number \_\_\_\_\_

Date \_\_\_\_\_