[Aetna Voluntary Plans]
Policyholder Application

Aetna Life Insurance Company
151 Farmindton Ave, Hartford CT 06105

Policy or Group Number (for Aetna use only) _____

[Company name]: _____

Street address: _____

City: _____ State: _____ Zip code: _____

Federal Tax ID #: _____

Parent company name (if applicable): _____

The purpose of the application is to request:

a. ☐ Issuance of new coverage

b. ☐ Change in existing coverage

c. ☐ Extension of existing coverage to additional groups of [employees]

Coverage selection

Underwritten by Aetna Life Insurance Company ("Aetna")

	[Employees]	Dependents	Retirees		Type of coverage
[Contributory	☐	☐	☐	☐	Accident]
Non-Contributory	☐	☐	☐	☐	
[Contributory	☐	☐	☐	☐	Critical illness]
Non-Contributory	☐	☐	☐	☐	
[Contributory	☐	☐	☐	☐	Hospital indemnity]
Non-Contributory	☐	☐	☐	☐	
[Contributory	☐	☐	☐	☐	Dental]
Non-Contributory	☐	☐	☐	☐	
[Contributory	☐	☐	☐	☐	Vision]
Non-Contributory	☐	☐	☐	☐	
[Contributory	☐	☐	☐	☐	Fixed indemnity]
Non-Contributory	☐	☐	☐	☐	

General enrollment and eligibility

Requested effective date: _____ Actual effective date will be assigned by us if the application is accepted and a policy issued.

Applicant will utilize electronic enrollment (select one): **Yes** ☐ **No** ☐

All of the regular, [full-time], [active] [employees] of any [employer] mentioned above shall be eligible to participate as to the coverage hereby applied for, except the following (state here, by coverage, the class or classes excluded). If more space is needed, please attach an additional sheet.

Agency or firm: _____ Agent signature: _____

Agent of record: _____ Agent license #: _____

Agency or firm: _____ Agent signature: _____

Agent of record: _____ Agent license #: _____

Applicant acknowledgements and agreements

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 (subject to applicable HIPAA requirements for health coverage), unless otherwise specifically agreed to by Aetna and provided in the Group Policy. All statements herein shall be deemed representations and not warranties.

The Applicant acknowledges that it has selected the coverage specified herein 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 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 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 Policy.

Applicant has selected, in accordance with applicable state law, the coverage to be offered to Applicant's [employees] and Applicant has solely determined any/all coverage options for the Applicant's [employees] and the contribution amounts. Coverage may not be denied on the basis of information not requested in this application except as described herein.

The plan documents will determine the contractual provisions, including procedures, exclusions and limitations relating to the coverage and will govern in the event they conflict with any benefits comparison, summary or other description of the coverage.

All data that may have a bearing on coverage or premiums will be open for Aetna to inspect while the Group Policy is in force. The availability of a plan or program may vary by geographic service area.

"Aetna" is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies.

Important information

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

Signature section

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 Policy issued by Aetna and by my signature below I agree to be bound by the terms and conditions of that Group Policy. I understand that Aetna may choose not to accept this application at its sole discretion, subject to any state requirements.

Signed at (location): _____ _____

City, State | Applicant (Company Name)

By: _____ _____

Authorized applicant signature | Official title

_____ _____

Witness | Date

Your premium purchases insurance coverage from Aetna, as well as the services of any Aetna-appointed licensed independent agent or broker identified in this Application. Aetna has various programs for compensating producers (agents, brokers and consultants). If you would like information regarding compensation programs for which your producer is eligible, payments (if any) which Aetna has made to your producer, or other material relationships your producer may have with Aetna, you may contact your producer or your Aetna account representative. Information regarding Aetna's programs for compensating producers is also available at www.aetna.com. **We appreciate your business and the opportunity to serve you.**

Please keep a copy of this application for your records. If it is accepted by Aetna, it becomes part of the issued Group Policy.