



# Colorado Small Group Business Employer Joinder Agreement and Application

**FOR GROUP COVERAGE (1 to 50 ELIGIBLE EMPLOYEES)\***

Coverage is underwritten by Aetna Life Insurance Company.

Company Name (Legal Name)		DBA/Doing Business As (if applicable)	
Street Address (P.O. Box not acceptable)		City	State ZIP
Bill Address (if different than above)		City	State ZIP
Company Contact Name and Title		Phone Number ( )	Fax Number ( )
E-Mail Address		Federal Tax ID Number	Date Business Established (Mo/Yr):
Employer Classification <input type="checkbox"/> Corporation <input type="checkbox"/> Non-Profit <input type="checkbox"/> Partnership <input type="checkbox"/> Sole Proprietor <input type="checkbox"/> LLC <input type="checkbox"/> LLP <input type="checkbox"/> Other: _____		SIC Code: _____ Nature of Business: _____	

**Effective Date**

Requested effective date may be the 1st or the 15th of the month. The actual effective date will be assigned by the Aetna underwriting department if the Joinder Agreement and Application is approved.
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**Medical Coverage Selection**

**Managed Choice Open Access Plans:**

<input type="checkbox"/> 500 90/60 15/30	<input type="checkbox"/> 2000 80/60 20/40	<input type="checkbox"/> HDHP HRA 2000 100/50	<input type="checkbox"/> CO Basic Limited Mandated Indemnity Plan
<input type="checkbox"/> 750 90/50/50 15/30	<input type="checkbox"/> 2500 80/50 25/50	<input type="checkbox"/> HDHP HRA 2500 100/50	<input type="checkbox"/> CO Standard Health Mandated Indemnity Plan
<input type="checkbox"/> 1000 80/60 20/40	<input type="checkbox"/> 2500 100/60 20/40	<input type="checkbox"/> HDHP HRA 5000 100/50	<input type="checkbox"/> CO Basic Limited Mandated PPO Plan
<input type="checkbox"/> 1000 90/60 15/30	<input type="checkbox"/> 3000 100/60 25/50	<input type="checkbox"/> Value 1500 70/50	<input type="checkbox"/> CO Standard Mandated Benefit PPO Plan
<input type="checkbox"/> 1500 100/60 20/40	<input type="checkbox"/> HDHP HSA 2800 100/50	<input type="checkbox"/> Value Plus 750 50/50	
<input type="checkbox"/> 1500 90/60 20/40	<input type="checkbox"/> HDHP HSA 3500 100/50	<input type="checkbox"/> Value Limited 1000 50/50	
<input type="checkbox"/> 1500 80/50/50 20/40			

**If choosing an HSA or HRA option, please answer the following questions:**

- Is employer, plan sponsor, or a third party funding any of the deductible? .....  Yes  No  
 If "Yes," how much? \_\_\_\_\_

- Does this group have a flex plan under Section 125 of the Internal Revenue Service Code? ....  Yes  No

**Dental Coverage Selection - Aetna Dental™ Plan**

<b>Standard Plans:</b>	<input type="checkbox"/> Option 1: DMO®	<input type="checkbox"/> Option 2: Freedom-of-Choice	<input type="checkbox"/> Option 3: PPO Max 1000
	<input type="checkbox"/> Option 4: Active PPO	<input type="checkbox"/> Option 5: PPO 1500	<input type="checkbox"/> Option 6: PPO 2000
	<input type="checkbox"/> Option 7: PPO 2000 High	<input type="checkbox"/> Option 8: Aetna Dental Preventive Care <sup>SM</sup> , Indemnity	
	Out-of-State Plans: <input type="checkbox"/> PPO 1000 <input type="checkbox"/> PPO 1500 <input type="checkbox"/> PPO 2000		
<b>Voluntary Plans:</b>	<input type="checkbox"/> Option V1: DMO®	<input type="checkbox"/> Option V2: Freedom-of-Choice	<input type="checkbox"/> Option V3: PPO Max 1000
	<input type="checkbox"/> Option V4: Aetna Dental Preventive Care <sup>SM</sup> , Indemnity	<input type="checkbox"/> Out-of-State PPO 1000	

Orthodontic coverage for dependent children is included in Standard Plan Options 1, 2, 4, 5, 6 & 7 and Voluntary Options 1 and 2. It is only available to groups with 10 or more eligible employees with a minimum of 5 enrolled employees.

**Life, Short Term Disability and Packaged Life and Disability Coverage Selections**

Groups with 10 to 50 employees may select one, two, or three options for Life, Short Term Disability and Packaged Life and Disability, with a minimum requirement of three employees in each option. If more than one option is selected, describe each class of employees, indicate the amount selected for each class and attached a list of employee names with each class designation. (Limited to 3 classes. The highest option selected can be no more than 5 times the lowest option.)

<b>All groups:</b>	<input type="checkbox"/> 10,000	<input type="checkbox"/> 15,000	<input type="checkbox"/> 20,000	<input type="checkbox"/> 50,000—(underwriting required for 2-9 lives)
<b>Groups with 10-50 Eligibles:</b>	<input type="checkbox"/> 75,000	<input type="checkbox"/> 100,000	<input type="checkbox"/> 125,000	
<b>Life Disability Packaged Plan:</b>	<input type="checkbox"/> Low	<input type="checkbox"/> Low 2	<input type="checkbox"/> Medium	<input type="checkbox"/> Medium 2 <input type="checkbox"/> High
<b>Short Term Disability:</b>	<input type="checkbox"/> Option 1	<input type="checkbox"/> Option 2	<input type="checkbox"/> 100	<input type="checkbox"/> 200 <input type="checkbox"/> 300 <input type="checkbox"/> 400 <input type="checkbox"/> 500
<b>Class Description:</b>	Class 1		Class 2	
			Class 3	
<b>Optional Dependent Term Life (10 to 50 eligible employees only):</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No			
<b>Waiver of Premium for totally disabled insured employees (totally disabled for a period of at least 6 months):</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No			

\*Life and Dental insurance products available only to groups with 2 to 50 eligible employees.

**JOINDER AGREEMENT - REQUEST FOR PARTICIPATION** (For life, disability, accidental death and dismemberment, medical and out-of-state dental employee benefits. Plan designs in addition to those mentioned above, are available under the trust.): 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 and discretionary authority 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.

**Business Eligibility**

<b>Affiliated Companies</b>					
Is your company a subsidiary of another company, an affiliate of another company, or under common control with another company?		<input type="checkbox"/> Yes <input type="checkbox"/> No			
Does your company file state or federal taxes with another company(ies) on a combined or consolidated basis?		<input type="checkbox"/> Yes <input type="checkbox"/> No			
Are any associated companies to be included that are commonly owned?		<input type="checkbox"/> Yes <input type="checkbox"/> No			
If Yes to any questions, complete the information below.					
<ul style="list-style-type: none"> <li>• A copy of the Quarterly Wage and Tax Statement must be provided for each group to be included for coverage.</li> <li>• If you file or are eligible to file multiple businesses under one tax ID number, all businesses must be included as one group.</li> </ul>					
Business Name	Tax Identification Number	Owner's Name	Ownership Percentage	Number of Employees	Is group to be included
					<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No
If you have answered "No" to "Is the group to be included" above, please explain why.					
Is your company a branch of another company, or does your company have branch offices?					<input type="checkbox"/> Yes <input type="checkbox"/> No
If Yes	- Is each branch office a separate legal entity?				<input type="checkbox"/> Yes <input type="checkbox"/> No
	- Is each branch a location of one legal entity?				<input type="checkbox"/> Yes <input type="checkbox"/> No
	- How many branch offices are there?				
	- Are taxes filed separately or as one common filing?				<input type="checkbox"/> Yes <input type="checkbox"/> No
	- Where is each branch located? (List each branch business address separately.)				Number of Employees at each location
Has your business been insured with Aetna within the past 12 months?					<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you use the services of a Payroll Company? If "Yes," provide the name of the payroll company.					<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you currently a client of a Professional Employer Organization (PEO)?					<input type="checkbox"/> Yes <input type="checkbox"/> No
If Yes	- Is group coverage available to you as a client of a PEO?				<input type="checkbox"/> Yes <input type="checkbox"/> No
	- Is the group considered a Co-Employer with the PEO?				<input type="checkbox"/> Yes <input type="checkbox"/> No
	- By enrolling for coverage as a small employer I am not in violation of any contractual breach of contract with the PEO.				<input type="checkbox"/> Yes <input type="checkbox"/> No

**Employer Eligibility/Employee Status**

Work Location (list by state)	Number of Employees						Other (Temporary, substitute, seasonal, etc.)
	Full-time	Part-time	Retired	COBRA	1099	Union	
What is the normal work week you require a full-time employee to work to be eligible for coverage?							_____ hours per week
Total number of eligible employees		Total number of employees enrolling		Total number of employees waiving		Total number of employees in benefit waiting period	
Are there excluded classes of employees other than part-time and temporary employees (for example, Union employees)? If "Yes," describe class(es) and/or the union local name and number.							<input type="checkbox"/> Yes <input type="checkbox"/> No
Is your group Medicare Primary (employed less than 20 employees during at least 50% of the preceding calendar year) or Aetna Primary (employed 20 or more employees during at least 50% of the preceding calendar year)?							<input type="checkbox"/> Medicare Primary <input type="checkbox"/> Aetna Primary

**Employer Contribution(s)**

	Medical 50% of EE cost or flat \$120 per EE Pick-A-Plan - 50% of EE cost or flat \$125 Value Pick - 25% of the EE or \$50	Dental 25% total cost or 50% EE cost Voluntary-0 to 50% EE only	Employee Life 2 to 9 - 100% 10 to 50 - 50%	Dependent Life No minimum required	Disability 2 to 9 - 100% 10 to 50 - 50%	Packaged Life and Disability 2 to 9 - 100% 10 to 50 - 50%
Employer Contribution for Employee						
Employer Contribution for Dependent						

**Benefit Waiting Period**

The eligibility date will be the first day of the policy month following the waiting period.

Waive the waiting period for present employees enrolling with the group (even those who have not met the full waiting period).  Yes  No

Waiting period for future employees:  0 Days  30 Days  60 Days  90 Days  120 Days  180 Days

**Prior Carrier Information**

	Health	Dental	Life	STD
Is this group transferring from another group carrier?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
If "Yes," provide Carrier Name				
Effective Date of Coverage				
Proposed Termination Date				
Is this total replacement?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
If prior carrier is Aetna, provide Group/Control Number				
Did your plan have a deductible?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Provide prior carrier deductibles:	<input type="checkbox"/> Individual \$ _____ <input type="checkbox"/> Family \$ _____	<input type="checkbox"/> Individual \$ _____ <input type="checkbox"/> Family \$ _____ <input type="checkbox"/> Ortho Max \$ _____		
Dental Only - Prior coverage included, check all that apply:		<input type="checkbox"/> Major Services <input type="checkbox"/> Orthodontia		

**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.

**Signature Section**

The undersigned employer 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 HIPPA requirements for Health coverage), unless otherwise specifically provided in the plan documents (which consist of the Group Policy and/or Booklet-Certificate). All statements herein shall be deemed representations and not warranties.

The undersigned employer 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. Undersigned employer agrees to make payroll and other records directly related to employee's coverage under the plan documents available to Aetna for inspection, at Aetna's expense, at employer's office, during regular business hours, upon reasonable advance request. This provision shall survive termination of the Group Policy.

Undersigned employer has selected, in accordance with applicable state law, the plan to be offered to employer's employees and employer has solely determined any/all health plan options for the employer's employees and the contribution amounts.

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

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.

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.

With the exception of Aetna Rx Home Delivery®, participating physicians, hospitals and other health care providers are independent contractors and are neither agents nor employees of Aetna. Undersigned employer 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. Aetna Rx Home Delivery, LLC, is a subsidiary of Aetna Inc.

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages.

Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

All data that may have a bearing on coverage or premiums will be open for Aetna to inspect while the plan documents are in force.

The availability of a plan or program may vary by geographic service area. Some benefits are subject to limitations or maximums.

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 Joinder Agreement and Application is accurate and complete.

I understand that the Application will form a part of the 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 Policy. I understand that Aetna will rely on the information I provide in determining eligibility for coverage, setting premium rates, compliance with applicable laws, and other purposes, and that any material misrepresentation or fraudulent statement may result in rescission of the group policy, termination of coverage, increase in premiums, or other consequences. Aetna reserves the right to audit and to request documentation as evidence of business activity at any time and from time to time in order to validate my compliance with eligibility and underwriting guidelines as well as validate the applicability of State and Federal laws. I understand that my failure to comply with any such request may also result in termination of coverage, increase in premiums, or other consequences.

**COLORADO INSURANCE LAW REQUIRES ALL CARRIERS IN THE SMALL GROUP MARKET TO ISSUE ANY HEALTH BENEFIT PLAN IT MARKETS IN COLORADO TO SMALL EMPLOYERS OF 2 – 50 EMPLOYEES, INCLUDING A BASIC OR STANDARD HEALTH BENEFIT PLAN, UPON THE REQUEST OF A SMALL EMPLOYER TO THE ENTIRE SMALL GROUP, REGARDLESS OF THE HEALTH STATUS OF ANY OF THE INDIVIDUALS IN THE GROUP. BUSINESS GROUPS OF ONE CANNOT BE REJECTED UNDER A BASIC OR STANDARD HEALTH BENEFIT PLAN DURING OPEN ENROLLMENT PERIODS AS SPECIFIED BY LAW.**

Signed at (Location): \_\_\_\_\_  
City, State

\_\_\_\_\_  
Employer (Company Name)

By: \_\_\_\_\_  
Authorized Signature

\_\_\_\_\_  
Official Title

\_\_\_\_\_  
Print Name of Authorized Applicant

\_\_\_\_\_  
Date

Questions regarding any of the above information should be directed to your Agent/Broker or Aetna Sales Representative.

**Agent/Broker Certification**

I hereby certify that I am not aware of any information not disclosed in this Joinder Agreement and Application by the client which may have bearing on this risk, including my knowledge that replacement life insurance is  is not  (check one) a part of this transaction.

I hereby certify that I am licensed to sell Aetna Small Group products in the state of Colorado.

I hereby certify that I have advised the client not to terminate any existing coverage until receiving written notice from Aetna that Aetna has accepted the this Joinder Agreement and Application.

Broker Name: <u>Steven J. Roper</u>		SSN: <u>326521705</u>	
Agency Name: <u>Roper Insurance</u>		TIN: <u>841590836</u>	
Pay commissions to: (check one) <input type="checkbox"/> Broker <input checked="" type="checkbox"/> Agency		Phone: <u>303-721-1145</u>	Fax: <u>303 721-1085</u>
Address: <u>116 Inverness Dr East # 265</u>		City: <u>Englewood</u>	State: <u>CO</u> ZIP: <u>80112</u>
Signature: _____	Date: _____	Email Address: <u>steve@ropeninsurance.com</u>	% of credit: <u>100</u>
Broker Name:		SSN:	
Agency Name:		TIN:	
Pay commissions to: (check one) <input type="checkbox"/> Broker <input type="checkbox"/> Agency		Phone:	Fax:
Address:		City:	State: ZIP:
Signature: _____	Date: _____	Email Address:	% of credit:
General Agent Name:		TIN:	
Phone:		Fax:	
Address:		City:	State: ZIP:
Signature: _____	Date: _____	Email Address:	% of credit:

**For Aetna Use Only**

Group Number _____	Control Number _____	SCD _____	Effective Date _____
Is Agent/Agency licensed and appointed? <input type="checkbox"/> Yes <input type="checkbox"/> No		Appointment Expiration Date _____	

**Colorado  
Commission Disclosure  
Small Group Accounts < 50 Lives**

As part of this health insurance solicitation, we are required by state law to advise you that should you purchase health insurance from me, that Roper Insurance & Financial Services will receive compensation in the form of a commission.

**Commission Schedules**

Aetna	6% or premium paid	
Anthem	\$25 per enrolled employee per month	
Destiny Health	\$25 per enrolled employee per month	
Guardian	<u>Annual Premium</u>	<u>Commission %</u>
	First \$50,000	5.0%
	Next \$200,000	3.5%
	Next \$250,000	2.0%
	Next \$2,000,000	1.0%
	Next \$2,500,000	0.5%
Humana	\$25 per enrolled employee per month	
Kaiser	\$24 - \$27 per Subscriber (based on production)	
PacifiCare	Health Maintenance Organization (HMO) - 4% of Premium	
	Preferred Provider Option (PPO) - 6% of Premium	
Principal Financial	<u>Annual Premium</u>	<u>Commission %</u>
	First \$150,000	5%
	Next \$100,000	3%
	Over \$250,000	1%
Rocky Mountain Health Plans	\$23 per enrolled employee per month	
United Healthcare	\$24 per enrolled employee per month	

**I acknowledge receipt of this notice:**

Signed: \_\_\_\_\_ date: \_\_\_\_\_

Print name: \_\_\_\_\_

Producer: \_\_\_\_\_ date: \_\_\_\_\_

Print name: \_\_\_\_\_