



## Joinder Agreement - Request for Participation

Life, disability, accidental death and dismemberment and/or out-of-state dental employee benefits are available through a Trust. If you have chosen life, disability, accidental death and dismemberment and/or out-of-state dental employee benefits, then by signing this Application, you are also signing the Joinder Agreement and agreeing to comply with the terms of the Request for Participation below:

**JOINDER AGREEMENT - REQUEST FOR PARTICIPATION** (For Life, disability, accidental death and dismemberment and out-of-state dental employee benefits): 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 there 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 tax filings 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 any business to be included for coverage under this group plan filed for Chapter 7, Chapter 11, or Chapter 13 bankruptcy?					<input type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, provide details.					
Has any business to be included been declined for coverage with Aetna or any other carrier in the past 12 months?					<input type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, provide details.					
Has your business been insured with Aetna within the past 12 months?					<input type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, provide group number. _____					
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 PEO?					<input type="checkbox"/> Yes <input type="checkbox"/> No
If Yes - Are you eligible to obtain coverage separate from the PEO?					<input type="checkbox"/> Yes <input type="checkbox"/> No
- Are you terminating your contract with the PEO?					<input type="checkbox"/> Yes <input type="checkbox"/> No
- What services do you receive from the PEO?					
- What tax identification number does the PEO use for reporting employees of the group enrolling to IRS?					

## 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	
<b>Total</b>							
Total number of eligible employees (must work a minimum of 30 hours per week).							
What is the normal work week you require a full-time employee to work to be eligible for coverage?							_____ hours per week
Of the total number of eligible employees, how many are:							
- waiving Aetna health benefits coverage because they are covered through their spouse's health benefit plan?							
- waiving Aetna health benefits due to coverage under another health benefit plan offered by this employer?							
- waiving Aetna health benefits coverage but do not have coverage elsewhere?							
Total number of eligible employees enrolling in the Aetna health benefits plan.							
Total number of full-time employees who are currently in the waiting period and not eligible.							
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

## Employer Contribution(s)

Coverage	Medical	Dental	Employee Life	Dependent Life	Disability
Employer's Contribution for Employee	%	%	%	NA	%
Employer's Contribution for Dependent	%	%	NA	%	NA

## COBRA/Tefra/Defra/State Continuation

Is your group subject to COBRA? (20 or more total employees during at least 50% of the working days in the previous calendar year)	<input type="checkbox"/> Yes <input type="checkbox"/> No
How many employees have terminated in the last 90 days?	
To the best of your knowledge, will any of these employee(s)/dependent(s) exercise their COBRA/State Continuation option?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, is the employee/dependent presently disabled?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is your group subject to Tefra/Defra? Under Tefra/Defra, Aetna is primary coverage for groups of 20 or more full-time and part-time employees (based on the total number of employees during 50% of the working days during the previous calendar year). Medicare is primary for groups of less than 20 full-time and part-time employees.	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is your group (check one).	<input type="checkbox"/> Medicare Primary <input type="checkbox"/> Aetna Primary

## 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).	<input type="checkbox"/> Yes <input type="checkbox"/> No
Waiting period for future employees: Kansas: <input type="checkbox"/> 0 Days <input type="checkbox"/> 30 Days <input type="checkbox"/> 60 Days <input type="checkbox"/> 90 Days Missouri: <input type="checkbox"/> 0 Days <input type="checkbox"/> 30 Days <input type="checkbox"/> 60 Days <input type="checkbox"/> 90 Days <input type="checkbox"/> 120 Days <input type="checkbox"/> 150 Days <input type="checkbox"/> 180 Days	

## Prior Carrier Information

	Health	Dental	Life	Disability
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		

## Workers' Compensation Information

Aetna's coverage is not a substitute for Workers' Compensation coverage. Proof of coverage is required. Please provide a copy of the Declaration Page including effective date.		
Name of current Workers' Compensation carrier:	Effective Date:	Renewal Date:
Is Workers' Compensation coverage provided on all employees?		<input type="checkbox"/> Yes <input type="checkbox"/> No
If No, please provide a list of all employees enrolling that are NOT covered by Workers' Compensation or similar legislation (including title).		

## Medical Information

Is any person to be covered unable to work due to illness or injury?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is any person unable to perform the normal duties of another person in the same employment class of the same age and sex?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If Yes is answered to either question, attach a sheet with the names of the individual(s), dates and degree of recovery.	

## 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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## 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 a crime 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 **Kansas** division of insurance and/or to the **Missouri** 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 in-state dental coverage(s) indicated above. I represent 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 may choose not to accept this agreement subject to any state requirements. 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 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.

Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person submits an endorsement form for insurance containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto may have violated state law.

*continued*

**Signature Section (Continued)**

Signed at (Location): _____ City, State _____	_____ Employer (Company Name)
By: _____ Authorized Signature	_____ Official Title
_____ Witness	_____ Date

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

**Agent/Broker Information**

I hereby represent 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 represent that I am licensed to sell Aetna Small Group products in the states of **Kansas/Missouri**.

I hereby represent 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.

Agent/Broker Name: _____	Tax ID or SSN for commissions to be paid: _____
Agency Name: _____	% of Credit: _____
Phone Number: (____) _____	Fax Number: (____) _____
Address: _____	City: _____ State: _____ Zip: _____
Signature: _____	Date: _____ E-Mail Address: _____

Agent/Broker Name: _____	Tax ID or SSN for commissions to be paid: _____
Agency Name: _____	% of Credit: _____
Phone Number: (____) _____	Fax Number: (____) _____
Address: _____	City: _____ State: _____ Zip: _____
Signature: _____	Date: _____ E-Mail Address: _____

General Agent Name: _____	Tax ID or SSN for commissions to be paid: _____
Phone Number: (____) _____	Fax Number: (____) _____
Address: _____	City: _____ State: _____ Zip: _____
Signature: _____	Date: _____ E-Mail Address: _____

**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 _____		