



Small Employer Cover Sheet & Checklist New Business Case Information

Aetna Small Group Underwriting
4300 Centreway Place, Arlington, TX 76018
P.O. Box 91507 • Arlington, TX 76015-0007
Phone (866) 899-4379 • Fax (877) 362-0870

Case Name _____	Date Submitted (MM/DD/YY) _____
Broker Name _____	Broker Phone Number () _____
Broker Physical Address _____	
City _____	State _____ Zip Code _____
Broker Email Address _____	Broker Fax Number () _____
Proposed Effective Date (MM/DD/YY) _____	

SUBMISSION DATE

All new cases with 2 to 50 employees are preferred to be received by Aetna on or before the 5th business day prior to the requested effective date. Cases will be accepted until the last day of the month prior to the effective date. If a cutoff deadline occurs on a weekend, all new cases sold need to be received on the preceding Friday. If incomplete information is provided or if the submission is not complete until after the cut-off date, the case could be assigned a later effective date.

REQUIRED FOR NEW BUSINESS

<input type="checkbox"/> Employer Master Application	Must be completed, signed and dated by employer
<input type="checkbox"/> Copy of Sold Rates	Must be signed by the employer and attached to the new case submission
<input type="checkbox"/> Employer Disclosure	Appropriate Disclosure Form based on plan selected for TX must be signed and dated by the employer
<input type="checkbox"/> 50/50 Benefit Description Form	50/50 Benefit Description form signed and dated by the employer
<input type="checkbox"/> Enrollment/Change Form/ Medical Questionnaire	Original copy completed & signed by each employee enrolling for coverage & any continuees.

Employees waiving/declining coverage must complete the waiver section of the Enrollment/Change form. If coverage is being waived due to other coverage, the carrier name, telephone number and group number must be listed.

Copy of most recent **Quarterly Wage and Tax Statement (QWTS)** containing the names, salaries, etc. of all employees of the employer group.

- The QWTS must be signed and dated by the owner or officer of the company unless filed electronically. If filed electronically, please provide a copy of the electronic validation.
- Employees who have terminated or work part-time must be noted accordingly on the QWTS. Terminated employees must have the date of termination listed on the QWTS.
- Newly-hired employees not listed on the QWTS must provide the first and last month's payroll stub and registry/summary for each employee.

Sole Proprietor, Partners or Corporate Officers not reported on the Quarterly Wage and Tax form must submit a completed **Small Employer (2-50) Proof of Eligibility Form**. Also, as identified on the form, additional supporting documentation must be submitted.

If group coverage currently exists, a **copy of the most recent prior carrier bill** must be provided. Individuals contained on the bill should match those listed on the wage and tax statement. If not, please indicate on the bill why they are not on the wage and tax.

A **check** on company check stock for 100% of the first month's medical, dental, STD and life premiums payable to "Aetna Health Management, L.L.C." (Aetna's receipt of the check does not guarantee acceptance of the group)

Copy of the sold proposal including rates and plan design(s).

Verify contribution and participation requirements by product.

GENERAL INFORMATION

① If applying for PPO or Indemnity medical, please list the prior carrier individual deductible	\$ _____
② If applying for dental, does dental coverage currently exist?	<input type="checkbox"/> YES <input type="checkbox"/> NO
③ If yes and prior plan includes Orthodontia, please provide the prior plan Ortho Max	\$ _____
④ Please note that additional documentation may be required (Common ownership, newly formed business, etc.)	

BROKER / GENERAL AGENT COMMENTS

Broker Signature _____	Date (MM/DD/YY) _____
GA Signature _____	Date (MM/DD/YY) _____
All paperwork is enclosed and my submission is complete. I understand incomplete paperwork could delay the effective date of coverage.	
Plan Sponsor Signature _____	Date (MM/DD/YY) _____