



Employer Application

Applicant

Policy or Group Number
(for Aetna use only)

Company Name: <u>Nassau County Board of County Commissioners</u>			
Street Address: <u>96135 Nassau Place, Suite 5</u>			
City: <u>Yulee</u>	State: <u>FL</u>	Zip Code: <u>32097</u>	
Federal Tax ID Number: <u>59-1863042</u>			
Parent Company name (if applicable) _____			
The purpose of the application is to request:			
a.	<input checked="" type="checkbox"/>	issuance of new coverage	
b.	<input type="checkbox"/>	change in existing coverage	
c.	<input type="checkbox"/>	extension of existing coverage to additional groups of employees	
d.	<input type="checkbox"/>	replacement of existing group life insurance (FL contract situs only).	
e.	<input type="checkbox"/>	premium waiver	

Medical Coverage Selection: Provided or administered by Aetna Health Inc. and Aetna Life Insurance Company.

If offering a health plan with a deductible, is the employer, plan sponsor or a third party funding any of the deductible?

Yes*
 No

*If yes, how much? _____

	For Employees	For Dependents	For Retirees	Type of Coverage
Contributory	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	Medical
Non-Contributory	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Stand-Alone Aetna Vision Preferred Coverage Selection: Provided or administered by Aetna Life Insurance Company.

	For Employees	For Dependents	For Retirees	Type of Coverage
Contributory	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Aetna Vision Preferred
Non-Contributory	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Stand-Alone Dental Coverage Selection: Provided or administered by Aetna Health Inc. or Aetna Life Insurance Company

	For Employees	For Dependents	For Retirees	Type of Coverage
Contributory	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dental Coverage
Non-Contributory	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Life & Disability: Provided or Administered by Aetna Life Insurance Company

	For Employees	For Dependents	For Retirees	Type of Coverage
Contributory	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Basic Term Life Insurance Dependents' Maximum subject to state law
Non-Contributory	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Contributory	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Supplemental Term Life Insurance Dependents' Maximum subject to state law
Non-Contributory	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Contributory	<input type="checkbox"/>	<input type="checkbox"/>	Not Available	Accidental Death & Personal Loss Coverage
Non-Contributory	<input type="checkbox"/>	<input type="checkbox"/>	Available	
Contributory	<input type="checkbox"/>	<input type="checkbox"/>	Not Available	Supplemental Accidental Death & Personal Loss Coverage
Non-Contributory	<input type="checkbox"/>	<input type="checkbox"/>	Available	

Contributory	<input type="checkbox"/>	Not	Not	Long Term Disability
Non-Contributory	<input type="checkbox"/>	Available	Available	
Contributory	<input type="checkbox"/>	Not	Not	Short Term Disability
Non-Contributory	<input type="checkbox"/>	Available	Available	
Contributory	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other _____
Non-Contributory	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

General enrollment and eligibility section

Requested effective date: 1/1/2019 (Actual effective date will be assigned by Aetna if the application is accepted and a policy issued.)

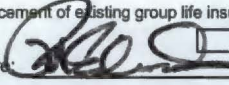
Applicant will utilize electronic enrollment (check one): Yes No

This application includes the following member employers.
 (Any entry in conflict with applicable law cannot be included): Additional sheets may be added if necessary.

_____ Located At _____
 _____ Located At _____
 _____ Located At _____

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.

Agent(s) of Record:
 I understand that the purpose of the application may be to request replacement of existing group life insurance.

Name: Pat Edwards Signature:  Yes No License #: _____

General Agent:
 Name: _____ Signature: _____ 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 plan documents (which consist of the Group Policy and/or Group Agreement). 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 and/or Group Agreement 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 and/or Group Agreement.

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. 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. See below for applicable provisions.

Applicant Acknowledgements and Agreements (Continued)

With the exception of Aetna Rx Home Delivery, all participating providers and vendors are independent contractors and are neither agents nor employees of Aetna. Aetna Rx Home Delivery, LLC, is a subsidiary of Aetna Inc. The availability of any particular provider cannot be guaranteed, and provider network composition is subject to change. Notice of the change shall be provided in accordance with applicable state law. Aetna does not provide health or dental care services and, therefore, cannot guarantee any results or outcome. Some benefits are subject to limitations or maximums.

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.

Applicant agrees to deliver or otherwise make available to enrollees all Aetna paper or on-line member documents and other plan related materials upon request by Aetna.

All data that may have a bearing on coverage or premiums will be open for Aetna to inspect while the Group Agreement and/or 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 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 may have violated state law.

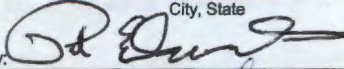
Signature Section

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

Florida Contract Situs: Any person who knowingly and with intent to injure, defraud, or deceive any insurer, files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree. Please refer to the Group Agreement and/or Group Policy for details regarding the method of delivery of the Certificate to subscribers by Aetna.

Signed at (location): Yulee, Florida
City, State

Nassau County
Applicant (Company Name)

By: 
Authorized Applicant Signature

Chairman
Official Title


Witness

10/08/18
Date

Your premium purchases insurance coverage from Aetna, as well as the services of any Aetna-appointed licensed independent agent or broker identified in the Application For Group Coverage. 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 the application is accepted by Aetna it becomes part of the issued Group Agreement and/or Group Policy.