

# ASG CUSTOMER INFORMATION FORM

## INSTRUCTIONS:

**NEW:** Complete all fields for all submissions and include with other submission documents.

**REVISION:** Complete the following fields on page one: General Information Section, Customer Information: Name in item 1 and item 7. Exceptions and Comments. For the rest of the document, including other fields on page one, complete only those items that are changing and submit with all other submission documents.

## GENERAL INFORMATION:

Control Number: \_\_\_\_\_ SCD: \_\_\_\_\_ Effective Date: \_\_\_\_\_  
Case Type:  Custom  Trust Contract State: \_\_\_\_\_ Secondary Contract State: \_\_\_\_\_  
Sales Rep Name: \_\_\_\_\_ Sales Rep Phone Number: \_\_\_\_\_  
SFO Name/No: \_\_\_\_\_ CFO Name/No: \_\_\_\_\_

## CUSTOMER INFORMATION:

Internet Enrollment: The Internet IS being used for emply enrollment using:  EZenroll  EZlink

### 1. Employer Information (full legal name and address)

Name: \_\_\_\_\_  
Customer Contact: \_\_\_\_\_ Phone Number: \_\_\_\_\_  
Street: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Fax Number: \_\_\_\_\_  
Customer Email Address: \_\_\_\_\_ (Include for on-line Administration Manual)

### 2. Employer Classification:

Corporation  Non-Profit Corporation  Partnership  Sole Proprietor  Government Entity  
 Other: \_\_\_\_\_

### 3. SIC Number:

\_\_\_\_\_

### 4. Kind of Business:

\_\_\_\_\_

### 5. Trust Applied For (if applicable. For ASG Trust)

Agricultural, Forestry & Fishing  Mining  Construction  Manufacturing  
 Transportation, Communication and Public Utilities  Wholesale Trade  Retail Trade  
 Finance, Insurance and Real Estate  Service, Public Administration

### 6. If Small Group Reform Applies were state mandated benefits sold?

Yes  No

### 7. Revision Transaction:

New Benefit (Plan design submitted by Sales/Service Rep.)  
 Revision to existing benefit(s) - list: \_\_\_\_\_  
 Impact to employees  New  Existing  
 Other: \_\_\_\_\_

## EXCEPTIONS INFORMATION:

SMU - approved benefit exceptions:  NA  Denied  Approved (SMU Exception Email template included with submission)

Financial Underwriting approved pricing/rating exceptions:  No  Yes - Describe Below

Approved by: \_\_\_\_\_

## COMMENTS SECTION:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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Customer Name: \_\_\_\_\_

Control No: \_\_\_\_\_

**ACCOUNT STRUCTURE:** \*Attach separate page if special / additional account structure information exists.

Suffix Example: (10, 58)	Account (000, 700)	Associated Plans (A, AU)	Product (PPO, Life)	State (MA,CT)	# of EEs (32)

**ADMINISTRATION INFORMATION**

1. Was coverage transferred from Aetna/another carrier?  Yes  No

Last day of prior coverage: \_\_\_\_\_

If yes, please give the name of the prior carrier(s) & a claim office phone no: \_\_\_\_\_

Please also list the prior coverages being transferred: (Include a copy of the prior carrier's last premium statement and booklet-certificate or contract.)

Types of Benefits:

Medical

Dental

Prior Dental coverage included coverage for:

Term Life

Disability Income

Major Services Only

Major & Orthodontia Services

Prior Carrier Deductibles:

**Medical:** Individual \$ \_\_\_\_\_

Family: \$ \_\_\_\_\_

**Dental:** Individual \$ \_\_\_\_\_

Family: \$ \_\_\_\_\_

Ortho Maximum: \$ \_\_\_\_\_

If employer previously insured under Aetna group plan (including Aetna HMO), provide control number and HMO group number (if applicable), and the Suffix/Accounts which they were billed under: \_\_\_\_\_

2. Will other coverage be terminated?  Yes  No

3. Will employees be permitted a choice of enrolling for medical coverage through Aetna, AUSHC, Qualified Aetna or AUSHC HMO, or a non-AUSHC HMO?  Yes  No

If Yes, and HMO is an Aetna or AUSHC HMO: (Not required for non-Aetna, non-AUSHC HMO)

HMO network: \_\_\_\_\_ Group Number: \_\_\_\_\_ Effective Date: \_\_\_\_\_

**IMPORTANT** - If yes, indicate the number of employees electing HMO as they are considered eligible: \_\_\_\_\_

4. Is coverage being provided ONLY for clerical employees?  Yes  No

5. Are employees represented by a collective bargaining agreement excluded from coverage?  Yes  No

If yes, identify Union Name and Local Number: \_\_\_\_\_

**Exclusions:** Part-time employees (employees regularly working less than 25 hours of the employer's normal work week and temporary employees are automatically excluded; employees represented by a collective bargaining agreement may be excluded at the employer's option if coverage is available elsewhere.

**BILLING/CLAIM INFORMATION**

1. After original issue Billing and General correspondence sent to Employer address?  Yes  No

If no, complete mailing address (attach separate page for additional addresses)

Name: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Attn: \_\_\_\_\_

Street: \_\_\_\_\_

City: \_\_\_\_\_

State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

All Life Claims-Windsor (Claim Office Code 174)

All TDI Only - Portland, OR (Claim Office Code 050)

Small Group Disability Claim Office(s): (If TDI and LTD or LTD only)

Northeast Region: #304, Portland, ME

Mid Atlantic Region: #304, Portland, ME

Southeast Region: #304, Portland, ME

North Central: #050, Portland, OR

Southwest Region: #050, Portland, OR

West Region: #050, Portland, OR

Medical Claim Office Code(s): \_\_\_\_\_

Medical Claim Office Location(s): \_\_\_\_\_

Dental Claim Office Code(s): \_\_\_\_\_

Dental Claim Office Location(s): \_\_\_\_\_

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Control No: \_\_\_\_\_

## PLAN PROVISIONS

### 1. Probationary Period:

On Effective Date:  None  Same as "After Effective Date".

After Effective Date:  None  30 Days  90 Days  1 mo.  2 mos.  
 3 mos.  4 mos.  5 mos.  6 mos.

Coverage Begins On:  The very next day following completion of the probationary period  
 The 1st of the cal. mo. coinciding with or next following completion of the pro. Per.  
 The 1st of the calendar month coinciding with or next following the date of employment. (Only available when probationary period is None for both On and After Effective Date).

2. Is retiree coverage to be included? NOTE: Retiree coverage provided under the Aetna Group Trust extends coverage to both existing and future retirees. In addition, MC is recommended for retirees and their dependents.  Yes  No

Future Retirees Retirement Plan is in accordance with IRS Qualified Retirement Plan or Profit Sharing Plan and:

Reached age 55 with 10 years of service  Reached age 60 with 10 years of service

Retired Employees-Contributions:

Retired Employee Life Coverage (if part of Customer's Plan of Benefits):  Non-Contributory

All other Coverages: Employees:  Contrib  Non-Contrib Dependents:  Contrib  Non-Contributory

For existing retirees:  Life Insurance amount to be shown \$ \_\_\_\_\_  
 "Agreed upon by Employer and Aetna"

3. Active Employees Contributions: (Contributory) Employer shares cost of plan with employees or (Non-Contributory) Employer pays full cost of plan as follows:

A. Employee Life and AD&D Coverages (if part of Customer's Plan of Benefits):  Non-Contributory  
 Contributory (10+ lives only)

B. Medical and other coverages (except for Dental): Employees:  Contributory  Non-Contributory  
 Dependents:  Contributory  Non-Contributory

C. Dental Coverage:

Employees:  Non-Contributory  
 Contributory, employee contributes 100% (i.e., voluntary dental plan)  
 Contributory, employee contributes less than 100%

Dependents:  Non-Contributory  
 Contributory, employee contributes 100% (i.e., voluntary dental plan)  
 Contributory, employee contributes less than 100%

## ELIGIBILITY/PARTICIPATION (Participation requirements must be met before coverage can go into effect)

1. Total number of Full-time Eligible Employees: \_\_\_\_\_
2. Total number of Full-time Eligible Employees applying for coverage: \_\_\_\_\_
3. Total number of employees compensated via a 1099-MISC tax form applying for coverage. Requires BOTH Financial Underwriting and SMU approvals and must include 1099 questionnaire with enrollment form): \_\_\_\_\_

A Full-time Eligible Employee is one who works a normal work week of at least 25 hours (or less in accordance with specific state legislation) on a regular basis. Aetna may from time to time request evidence of the Employee's eligibility including but not limited to: payroll audits or tax records showing monetary compensation which is reported to the IRS, evidence of eligibility for Workers Compensation, evidence of actual hours worked and evidence of unemployment taxes paid by the employer.

4. Active employees age 65 and over and spouses age 65 and over of active employees will be covered as follows:
- Aetna will pay primary benefits (employer is subject to MSP\*)
  - Medicare will pay primary benefits (employer is not subject to MSP\*)

\* Employers are subject to Medicare Secondary payer (MSP legislation) if they have employed 20 or more full-time or part-time employees for 20 or more weeks during the current or preceding calendar year.

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Customer Name: \_\_\_\_\_

Control No: \_\_\_\_\_

## ELIGIBILITY/PARTICIPATION (Continued)

5. Medicare eligible due to disability will be covered as follows:

- Aetna will pay primary benefits (employer is subject to OBRA/OMBRA\*)  
 Medicare will pay primary benefits (employer is not subject to OBRA/OMBRA\*)

\* Employers are subject to OBRA/OMBRA if they have employed 100 or more full or part-time employees on 50% or more of their business days during the preceding calendar year.

## ERISA LANGUAGE (Custom Cases Only):

**ERISA language is optional language for Custom Business. If the information below is not completed, ERISA language will not be included in the Customer Booklet**

- Do not include ERISA language  
 Include ERISA language

If ERISA language is included, complete the following:

Employer Identification #: \_\_\_\_\_ Plan No.:  501  Other: \_\_\_\_\_

Type of Plan (e.g. Welfare): \_\_\_\_\_

Type of Administration:  Insured (Conventionally insured coverage)  
 Contract (alternate funded coverage)

Plan Administrator: (Cannot be AUSHC or any Aetna entity)

Agent of Service of Legal Process: (Cannot be AUSHC or any Aetna entity)

Name: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Note: Agent of Service cannot be AUSHC

End of Plan Year (month/day): \_\_\_\_\_

Source of Contribs (e.g. Employer and Employee): \_\_\_\_\_

Authorized Person(s) who may sign amendments: \_\_\_\_\_

Title: \_\_\_\_\_

\_\_\_\_\_

## GENERAL INFORMATION: Complete all items listed below:

Booklet-Certificates to be mailed to:

- Employer  Aetna Field Office  Other (specify street and number, not P.O. Box)

Administration Kits to be mailed to:

- Employer  Aetna Field Office  Other (specify street and number, not P.O. Box)

Address: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## COMMENTS SECTION:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_