Contractual Validation Form - Atlanta HMO/QPOS (Two-Nine Eligible Lives)

(This form must accompany all new case submissions. All information must be submitted 30 days prior to the effective date to ensure ID cards are received prior to effective date.)

Aetna U.S. Healthcare - Small Business Center
841 Prudential Drive, 6th Floor West, F602
Jacksonville, FL 32207
Phone: (800) 223-2125 Fax: (800) 814-5677

New Business Case Information:

Case Name: _____ Date Submitted: ____/____/____
Proposed Effective Date: _____
Producer Name: _____ Phone Number: (___) _____
Fax Number: (___) _____
Producer Assistant Name: _____ Phone Number: (___) _____
General Agent Name: _____ Phone Number: (___) _____
Fax Number: (___) _____

If any of the information listed below is excluded or incomplete when the case is submitted, all materials will be returned to the producer for completion.

Required documentation for new business case installation:

- ☐ Employer master application
- ☐ Employee individual application
- ☐ Employer Verification Form *Note: must be signed by employer.*
- ☐ Original copy of **completed** Individual Health Statement for each employee.
- ☐ If group coverage currently exists, copy of recent prior carrier bill. Individuals on the bill should match those listed on the wage and tax statement
- ☐ Copy of most recent calendar year wage and tax statement containing the names, salaries, etc. of all employees of the employer group. Employees who have terminated and work part time must be noted
- ☐ Copy of rate quote(s) including:
  - Complete proposal including rate and plan design
  - Employer signature on signable rate page and supporting rate documentation

  Rates must match the enrollment reported and effective date. If discrepancy exists please include documentation to support the discrepancy
- ☐ **COPY** of binder check and completed Binder Submission Form. Send originals to address on form.
- ☐ Broker of Record letter and commission forms

Additional Information:

To whom will the Aetna US Healthcare contract be issued?
☐ Sole Proprietorship ☐ Partnership ☐ Corporation ☐ Association ☐ Professional Employer Organization
☐ Other _____
Does group coverage currently exist? ☐ Yes ☐ No
If Yes, Indicate Carrier _____ Effective Date ____/____/____
At any time has the group been covered under an Aetna US Healthcare plan or affiliate? ☐ Yes ☐ No
If Yes, provide coverage dates: From _____to_____
Total eligible lives _____
How many employees are enrolled in the current employer sponsored medical plan; or if no prior coverage exists, how many employees are likely to enroll in this plan? _____
How many eligible employees are not expected to enroll because they have spousal or individual coverage? _____
Do all eligible employees work 25 hours or more? ☐ Yes ☐ No
What percentage of the cost of the plan will the employer contribute? Employee only _____% Dependent ____%

Broker Signature: _____ **Date:** _____