

SERFF Tracking Number: AENX-126280327 State: Arkansas
Filing Company: Aetna Life Insurance Company State Tracking Number: 43329
Company Tracking Number: GH AR0229401F01
TOI: H16G Group Health - Major Medical Sub-TOI: H16G.001C Any Size Group - Other
Product Name: 2009 Retiree Markets
Project Name/Number: 2009 Retiree Markets/GH AR0229401F01

Filing at a Glance

Company: Aetna Life Insurance Company

Product Name: 2009 Retiree Markets

TOI: H16G Group Health - Major Medical

Sub-TOI: H16G.001C Any Size Group - Other

Filing Type: Form

SERFF Tr Num: AENX-126280327 State: Arkansas

SERFF Status: Closed-Approved-
Closed State Tr Num: 43329

Co Tr Num: GH AR0229401F01

Author: SPI AetnaSPI

Date Submitted: 08/25/2009

State Status: Approved-Closed

Reviewer(s): Rosalind Minor

Disposition Date: 09/09/2009

Disposition Status: Approved-
Closed

Implementation Date:

Implementation Date Requested:

State Filing Description:

General Information

Project Name: 2009 Retiree Markets

Project Number: GH AR0229401F01

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Filing Status Changed: 09/09/2009

Status of Filing in Domicile:

Date Approved in Domicile:

Domicile Status Comments:

Market Type: Group

Group Market Size: Large

Group Market Type: Employer

Explanation for Other Group Market Type:

State Status Changed: 09/09/2009

Created By: SPI AetnaSPI

Corresponding Filing Tracking Number:

Deemer Date:

Submitted By: SPI AetnaSPI

Filing Description:

The enclosed enrollment form is intended to be used with Aetna's new Supplemental Retiree Medical product, approved by the Department on 6/09/2009, under form codes GR-9N-GM 01-005 01 et. al.

Company and Contact

Filing Contact Information

Christine Deotte, Correspondence Analyst

151 Farmington Avenue

Mail Stop RW61

DeotteC@Aetna.com

860-273-1393 [Phone]

860-952-2069 [FAX]

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Hartford, CT 06156

Filing Company Information

Aetna Life Insurance Company	CoCode: 60054	State of Domicile: Connecticut
151 Farmington Avenue	Group Code: 1	Company Type:
Hartford, CT 06156	Group Name: Aetna	State ID Number:
(860) 273-7546 ext. [Phone]	FEIN Number: 06-6033492	

Filing Fees

Fee Required? Yes
 Fee Amount: \$50.00
 Retaliatory? No
 Fee Explanation:
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Aetna Life Insurance Company	\$50.00	08/25/2009	30096921

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	09/09/2009	09/09/2009

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Disposition

Disposition Date: 09/09/2009

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Cover Letter	Approved-Closed	Yes
Supporting Document	AR - NAIC TRANSMITTAL DOCUMENT	Approved-Closed	Yes
Supporting Document	AR - NAIC FORM FILING ATTACHMENT	Approved-Closed	Yes
Form	Group Retiree Enrollment Form	Approved-Closed	Yes

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Form Schedule

Lead Form Number:

Schedule Item	Form Number	Form Type Form Name	Action	Action Specific Data	Readability	Attachment
Approved- Closed 09/09/2009	GR-68543- 01	Application/ Group Retiree Enrollment Form	Initial		0.000	GR-68543- 01.PDF



Aetna Supplemental Retiree Medical Plan Enrollment Form

[Aetna Life Insurance Company
PO Box 13547, Pensacola, FL 32591-3547]

ENROLLMENT FORM INSTRUCTIONS:

PLEASE PRINT CLEARLY and MAKE A COPY OF THIS FORM FOR YOUR RECORDS.

To be considered complete, all sections on this form must be filled out, unless marked optional. You must sign and date this form. Incomplete forms could delay processing your enrollment. A signature and date are required.

MAIL YOUR COMPLETED FORM USING THE ENCLOSED, POSTAGE-PAID ENVELOPE

For information, call [1-800-307-4830]; TTY/TDD (Hearing Impaired) [1-888-760-4748]

Hours of Service: Monday through Friday – 8:00 a.m. to 6:00 p.m. (all time zones)

RETIREE/DEPENDENT: Please read the following carefully before completing this form:

- You must meet the eligibility criteria established by your former employer, be enrolled in Medicare Parts A & B, and continue to pay Medicare Part A premium (if applicable) and Medicare Part B premium to be eligible to enroll in and remain enrolled in this plan.
- If you are an active employee, you are not eligible to enroll in this plan, even if you are enrolled in Medicare.
- You do not need more than one Aetna Supplemental Retiree Medical Plan.
- Your state may offer you counseling services and advice regarding your health insurance. For more information about Medicare and other insurance, review the "Guide to Health Insurance for People with Medicare" published by the federal government and available at www.medicare.gov.

Form Completion Instructions: Please complete all Sections (Sections 1 through 6), as noted.

- Section 1: This section requests that you tell us about the employer who is providing you with this retiree health benefits plan. The employer's name and address are required.
- Section 2: Provide the personal information required in this section.
- Section 3: Using your Medicare card, provide us with your Medicare insurance information.
- Section 4: Plan options: Select only one plan option offered by the retiree's former employer.
- Section 5: Answer all questions in this section to the best of your knowledge.
- Section 6: Read this section carefully before signing.

PLEASE MAKE A COPY OF THIS FORM FOR YOUR RECORDS

MAIL YOUR COMPLETED FORM USING THE ENCLOSED, POSTAGE-PAID ENVELOPE

[Aetna Life Insurance Company
PO Box 13547
Pensacola, FL 32591-3547]



Aetna Supplemental Retiree Medical Plan Enrollment Form

[Aetna Life Insurance Company
PO Box 13547, Pensacola, FL 32591-3547]

AETNA USE ONLY			
Effective Date	Rep Code(s)	ID Number	
Plan Number	Control	Suffix	Account

1 Former Employer Information
Former Employer Name (REQUIRED)
Former Employer Address - Primary Location of Business or Organization (REQUIRED)

2 Retiree/Dependent Personal Information (Please Print Clearly)			
Last Name	First Name	MI	
Social Security Number	<input type="checkbox"/> Male <input type="checkbox"/> Female	Birth Date (MM/DD/YYYY)	
Are you applying as a dependent of an eligible retiree? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Provide name of eligible retiree (Last, First)			
ALL AETNA CORRESPONDENCE WILL BE MAILED TO THIS ADDRESS Home Address (Number, Street, Apartment No.)			
City	State	ZIP Code	County
Billing Address (if different from above)			
Home Telephone Number ()	Primary Language Spoken (optional)		
Email Address (optional)			

3 Medicare Information – Please fill out this information exactly as it appears on your Medicare card	
MEDICARE	HEALTH INSURANCE
CENTERS FOR MEDICARE & MEDICAID SERVICES	
NAME OF BENEFICIARY	
MEDICARE CLAIM NUMBER	
- - -	
IS ENTITLED	EFFECTIVE DATE
HOSPITAL (PART A)	_____
MEDICAL (PART B)	_____

4 Aetna Supplemental Retiree Medical Plan Selection
Plan Options – Please check appropriate box for plan selection.
<input type="checkbox"/> Plan A <input type="checkbox"/> Plan B <input type="checkbox"/> Plan C <input type="checkbox"/> Plan F <input type="checkbox"/> Plan High Deductible F <input type="checkbox"/> Plan K <input type="checkbox"/> Plan L

5 If you received a proof of prior coverage notice from your prior insurer, please include a copy with your enrollment form. PLEASE ANSWER ALL QUESTIONS.	
<p>Please Mark Yes or No with an "X"</p> <p>To the best of your knowledge,</p> <p>(1) Did you turn age 65 in the last 6 months? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>(2) If you had coverage from any Medicare plan other than the Original Medicare plan within the last 63 days (for example, a Medicare Advantage plan or a Medicare HMO or PPO), fill in your start and end dates below. (If you are still covered under this plan, leave "END" blank.)</p> <p>START / / END / / </p>	<p>(3) Have you had coverage under any other health insurance plan within the past 63 days? (for example, an employer, union or individual plan) <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>(a) IF YES, with which insurance company and what kind of policy? _____</p> <p>(b) IF YES, what were your dates of coverage under the policy? (If you are still covered under the other policy, leave "END" blank.)</p> <p>START / / END / / </p>

PLEASE MAKE A COPY OF THIS FORM FOR YOUR RECORDS AS PER INSTRUCTIONS

Name	Social Security Number
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6 CONDITIONS OF ENROLLMENT – PLEASE READ CAREFULLY BEFORE SIGNING. Please sign and date where indicated on this page.

Retiree/Dependent Acknowledgments and Agreements

I agree to or with the following:

1. The Aetna Supplemental Retiree Medical Plan is not a Medicare Supplement insurance plan or Medigap plan. This is an employer group retiree medical plan and may provide benefits that are different from a Medicare Supplement plan. The Aetna Supplemental Retiree Medical Plan covers only Medicare-approved charges, up to the Medicare allowable amount, unless otherwise noted in the plan documents. You must use a health care provider that is eligible to receive reimbursement under Medicare in order to receive benefits under this plan, except as otherwise noted in the plan documents.
2. I acknowledge that by enrolling in the Aetna Supplemental Retiree Medical Plan, coverage is underwritten or administered by Aetna Life Insurance Company (referred to as "Aetna"). CHCS Services, Inc. is currently the third party administrator (TPA) for the Aetna Supplemental Retiree Medical Plan.
3. I agree to make any necessary payments as required for coverage.
4. I acknowledge that I am enrolled in Medicare Parts A and B and I understand that I must continue to pay Medicare Part A premium (if applicable) and Part B premium to remain enrolled in this plan.
5. I understand and agree that this enrollment form may be transmitted to Aetna or its agent by my former employer or its agent. I authorize any physician, other healthcare professional, hospital or any other healthcare organization ("Providers") to give Aetna or its agent information concerning the medical history, services or treatment provided to anyone listed on this enrollment form, including those involving mental health, substance abuse, or HIV/AIDS. I further authorize Aetna to use such information and to disclose such information to affiliates, providers, payors, other insurers, third party administrators, vendors, consultants and governmental authorities with jurisdiction when necessary for my care or treatment, payment for services, the operation of my health plan, or to conduct related activities. I have discussed the terms of this authorization with my spouse and competent adult dependents and I have obtained their consent to those terms. I understand that this authorization is provided under state law and that is not an "authorization" within the meaning of the federal Health Insurance Portability and Accountability Act. This authorization will remain valid for the term of the coverage and so long thereafter as allowed by law. I understand that I am entitled to receive a copy of this authorization upon request and that a photocopy is as valid as the original.
6. The plan documents will determine the rights and responsibilities of member(s) and will govern in the event that they conflict with any benefits comparison, summary, or other description of the plan.
7. I understand and agree that all providers and vendors are independent contractors and are neither agents nor employees of Aetna.

Misrepresentation

Any person who knowingly and with intent to injure, defraud or deceive 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 commits a fraudulent insurance act, which is a crime and subject such person to criminal and civil penalties.

Attention Arkansas and West Virginia Residents: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application is guilty of a crime and may be subject to fines and confinement in prison.

Attention Colorado Residents: It is unlawful 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 Colorado division of insurance within the department of regulatory agencies.

Attention Kentucky Residents: 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 commits a fraudulent act, which is a crime and may subject such person to criminal and civil penalties.

Attention Tennessee Residents: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

I understand that my signature (or the signature of the person authorized to act on behalf of the individual under the laws of the State where the individual resides) on this application means that I have read and understand the contents of this application, including the CONDITIONS OF ENROLLMENT section on this form. If signed by an authorized individual, this certifies that: 1) this person is authorized under State law to complete this application and 2) documentation of this authority is available upon request by Aetna.

Retiree/Dependent's Signature: _____ Application Date: _____

Power of Attorney or Legal Guardian Signature*: _____

* If Retiree/Dependent is unable to sign, a court-appointed legal guardian or a designee authorized by State law must sign above. Please attach a copy of the document that designates this person as the Retiree/Dependent's representative.

PLEASE MAKE A COPY FOR YOUR RECORDS AS PER INSTRUCTIONS

<i>SERFF Tracking Number:</i>	<i>AENX-126280327</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Aetna Life Insurance Company</i>	<i>State Tracking Number:</i>	<i>43329</i>
<i>Company Tracking Number:</i>	<i>GH AR0229401F01</i>		
<i>TOI:</i>	<i>H16G Group Health - Major Medical</i>	<i>Sub-TOI:</i>	<i>H16G.001C Any Size Group - Other</i>
<i>Product Name:</i>	<i>2009 Retiree Markets</i>		
<i>Project Name/Number:</i>	<i>2009 Retiree Markets/GH AR0229401F01</i>		

Supporting Document Schedules

		Item Status:	Status
			Date:
Bypassed - Item:	Flesch Certification	Approved-Closed	09/09/2009
Bypass Reason:	N/A - application/enrollment form		
Comments:			

		Item Status:	Status
			Date:
Satisfied - Item:	Application	Approved-Closed	09/09/2009
Comments:	Application is included as a filed form.		

		Item Status:	Status
			Date:
Satisfied - Item:	Cover Letter	Approved-Closed	09/09/2009
Comments:	8/25 Cover letter		
Attachment:	Cover Letter.PDF		

		Item Status:	Status
			Date:
Satisfied - Item:	AR - NAIC TRANSMITTAL DOCUMENT	Approved-Closed	09/09/2009
Comments:	NAIC Transmittal form		
Attachment:	AR - NAIC TRANSMITTAL DOCUMENT.PDF		

		Item Status:	Status
			Date:
Satisfied - Item:	AR - NAIC FORM FILING	Approved-Closed	09/09/2009

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ATTACHMENT

Comments:

NAIC Form Filing Att.

Attachment:

AR - NAIC FORM FILING ATTACHMENT.PDF



Christine E. Deotte
Product & Regulatory Approvals
Law & Regulatory Affairs
151 Farmington Ave., RW61
Hartford, CT 06156
(860) 273-1393 or (800) 872-3862
Fax No: (860) 273- 6939]
DeotteC@aetna.com

August 25, 2009

Julia Benafield Bowman
Insurance Commissioner
Compliance - Life & Health
Arkansas Department of Insurance
1200 West Third Street
Little Rock, AR 72201-1904

**Subject: Aetna Life Insurance Company – NAIC 60054
Group Accident and Health
Group Employer Enrollment Form: GR-68543-01.**

Dear Ms. Benafield Bowman:

The attached group employer enrollment form is being submitted to your Department for review and approval on a general use basis. This form is new and is not intended to replace any form currently on file with the Department. These forms are in final printed format and are neither drafts nor proofs.

The enclosed enrollment form is intended to be used with Aetna's new Supplemental Retiree Medical product, approved by the Department on 6/08/2009, under form codes GR-9N-GM 01-005 01 et. al.

An Aetna Life Insurance Company EFT in the amount of \$50.00 is enclosed in payment of your Department's filing fee.

We trust that you will find everything in order, and we look forward to your response.

If you have any questions regarding this filing, please do not hesitate to contact me at the address e-mail address or telephone number noted above.

Sincerely,

A handwritten signature in cursive script that reads "Christine E. Deotte".

Christine E. Deotte
Product & Regulatory Approvals Department
/Enclosures

Life, Accident & Health, Annuity, Credit Transmittal Document

1.	Prepared for the State of	Arkansas
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2.	Department Use Only	
	State Tracking ID	

3. Insurer Name & Address	Domicile	Insurer License Type	NAIC Group #	NAIC #	FEIN #	State #
Aetna Life Insurance Company 151 Farmington Avenue Hartford CT 06156	CT		001	60054	06-6033492	

4. Contact Name & Address	Telephone #	Fax #	E-mail Address
Christine E. Deotte 151 Farmington Avenue, Mail Stop RW61 Hartford CT 06156	860-273-1393	860-952-2069	DeotteC@Aetna.com

5. Requested Filing Mode	<input checked="" type="checkbox"/> Review & Approval <input type="checkbox"/> File & Use <input type="checkbox"/> Informational <input type="checkbox"/> Combination (please explain): _____ <input type="checkbox"/> Other (please explain): _____
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6. Company Tracking Number	GH AR0229401F01
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7.	<input checked="" type="checkbox"/> New Submission <input type="checkbox"/> Resubmission Previous file # _____
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8. Market	<input type="checkbox"/> Individual <input type="checkbox"/> Franchise	
	Group	<input type="checkbox"/> Small <input checked="" type="checkbox"/> Large <input type="checkbox"/> Small and Large <input checked="" type="checkbox"/> Employer <input type="checkbox"/> Association <input type="checkbox"/> Blanket <input type="checkbox"/> Discretionary <input type="checkbox"/> Trust <input type="checkbox"/> Other: _____

9. Type of Insurance	H16G Group Health - Major Medical
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10. Product Coding Matrix Filing Code	H16G.001C Any Size Group - Other
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11. Submitted Documents	<input checked="" type="checkbox"/> FORMS <input type="checkbox"/> Policy <input type="checkbox"/> Outline of Coverage <input type="checkbox"/> Certificate <input checked="" type="checkbox"/> Application/Enrollment <input type="checkbox"/> Rider/Endorsement <input type="checkbox"/> Advertising <input type="checkbox"/> Schedule of Benefits <input type="checkbox"/> Other: _____ <input type="checkbox"/> RATES <input type="checkbox"/> New Rate <input type="checkbox"/> Revised Rate <input type="checkbox"/> FILING OTHER THAN FORM OR RATE: Please explain: _____ SUPPORTING DOCUMENTATION <input type="checkbox"/> Articles of Incorporation <input type="checkbox"/> Third Party Authorization <input type="checkbox"/> Association Bylaws <input type="checkbox"/> Trust Agreement <input type="checkbox"/> Statement of Variability <input type="checkbox"/> Certifications <input type="checkbox"/> Actuarial Memorandum <input type="checkbox"/> Other: _____
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12.	Filing Submission Date	August 25, 2009
13.	Filing Fee (If required)	Amount _____ Check Date _____ Retaliatory <input type="checkbox"/> Yes <input type="checkbox"/> No Check Number _____
14.	Date of Domiciliary Approval	n/a
15.	Filing Description:	
	The enclosed enrollment form is intended to be used with Aetna's new Supplemental Retiree Medical product, approved by the Department on 6/09/2009, under form codes GR-9N-GM 01-005 01 et. al.	

16.	Certification (If required)	
I HEREBY CERTIFY that I have reviewed the applicable filing requirements for this filing, and the filing complies with all applicable statutory and regulatory provisions for the state of <u>Arkansas</u> .		
Print Name <u>Christine E. Deotte</u> Title <u>P&RA Compliance Specialist</u>		
Signature <u>Christine E. Deotte</u> Date <u>08/25/2009</u>		

17.	Form Filing Attachment	
This filing transmittal is part of company tracking number	GH AR0229401F01	
This filing corresponds to rate filing company tracking number		

	Document Name	Form Number		Replaced Form Number
	Description			Previous State Filing Number
01	Group Retiree Enrollment Form	GR-68543-01	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
02			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
03			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
04			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
05			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
06			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
07			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
08			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
09			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
10			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
11			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	