

New Group Submission Checklist

To allow sufficient processing time, all submission materials need to be submitted prior to the requested effective date. If the insurance is currently in-force, please do not cancel coverage until receipt of risk acceptance letter from MetLife.

Making benefits administration easier requires a solid foundation. To help ensure that your case is set up correctly, you must submit the information requested below.

Required attachments:

- APPLICATION FOR GROUP INSURANCE** (Note state specific forms: FL, KS/MA, NJ, NY, OK, OR & VA all other states use Nationwide form.) If PA sold with PDP Dental attach an additional PA group application form.
- DEPOSIT CHECK** equal to approximately 1st month's premium. (For 15th of month effective date, remit 1 ½ month's premium.)
- RISK ASSESSMENT SUMMARY** (For all coverages except Dental)
- COPY OF SOLD PROPOSAL** (Confirmed by Sales Rep)
- PRIOR CARRIER'S BOOKLET & BILL** (For takeover groups)
- ENROLLMENT CARDS for Contributory Coverages** (Waiver Section must be completed for all employees waiving coverage.)
For Non-Contributory Coverages: Census list can replace cards, listing applicable employee information including: Full Name, Address, Marital Status, Social Security Number, Birth date, Gender, Hire Date, Job Title, Salary and Mode, Worksite Zip Code and Class.
- eCensus:** Enrollment cards should be maintained by employer. Census should be sent email to sales office.

If Applicable:

- STATEMENT OF HEALTH FORMS** for employees/dependents applying for life amounts greater than non-med max or employees not on prior plan. (State-specific forms for employees whose worksite zip code are in CA, CT, FL, IN, ME, MD, MN, NY, VT, VA or WI.)
- PROOF OF COBRA ELECTIONS** (Copy of dated COBRA election form) *Groups with fewer than 20 lives are not eligible for COBRA.*
- PROOF OF ACTIVE FULL-TIME EMPLOYMENT** for eligible employees age 70 and over (W-2/ Tax Wage Report or Employer Confirmation on Company letterhead or email from company rep) **Only applies to 2-99 lives, 100+ lives no proof req.**
- CORE BUY-UP OR ENHANCED OPTIONAL LIFE: Signed Portability Forms** (2 original copies); and if Optional/Buy-Up AD&D is purchased: **Signed TravelAssistance Agreement** and 24-hr contact name/phone #: _____
- EAP:** If Employee Assistance Program is sold with LTD: Signed MetLife EAP Agreement
- UNIONS** (If union employees are to be covered, please provide all applicable pages of the Collective Bargaining Agreement(s).)

Has the group entered into an agreement with a PEO (Professional Employer Organization)? Yes No **If Yes, are the employees employed by the PEO?** Yes No

GROUP INFORMATION

Group Name: (Full Legal Name – Please include exact abbreviations, punctuation and/or capitalization.)

Effective Date:

Renewal Date:

Industry:

GROUP'S HOME OFFICE ADDRESS INFORMATION

Street Address:

City:

State:

ZIP:

Situs State:

Employer Tax ID:

GROUP'S BILLING / MAILING ADDRESS INFORMATION (if different from home office address provided above)

Name:

Street Address:

City:

State:

ZIP:

EXECUTIVE CONTACT INFORMATION (Authorized to make plan changes)

Name:

E-Mail Address:

Phone Number:

FAX:

DIVISION CONTACT/BENEFIT ADMINISTRATOR INFORMATION

Name:

E-Mail Address:

Phone Number (include extension):

FAX:

of Employees employed by group:

of Employees eligible for coverage:

SIC Code:

If more space is needed, please attach a separate page.

PRIOR OR CURRENT COVERAGE WITH METLIFE? Yes No
If yes, MetLife Customer Number:
In-Force MetLife Coverages: Group Life STD LTD Dental Voluntary Life

PRIOR CARRIER COVERAGE? Yes No **Name of Prior Carrier:**
Coverages: Group Life STD LTD Dental Voluntary Life

Please complete the following subsidiary information if there are employees working for a subsidiary who are eligible for coverage.

SUBSIDIARIES (If more than one, please provide the following information for all subsidiaries.)
Subsidiary Name (1): **TIN:**
Separate Bill?* Yes No **Number of Employees:**
Street Address:
City: **State:** **ZIP:**
Contact Name: **Phone:** **Fax:**

Subsidiary Name (2): **TIN:**
Separate Bill?* Yes No **Number of Employees:**
Street Address:
City: **State:** **ZIP:**
Contact Name: **Phone:** **Fax:**

* Not applicable for groups with 2 – 9 lives.

If more space is needed, please attach a separate page.

CERTIFICATE INFORMATION
Issue: Same Certificates for entire group Division-specific Certificates Class-specific Certificates
Mail Certificates to: Employer Broker TPA GA Other: _____

ADDITIONAL ENROLLMENT INFORMATION:
Student Age (Dependent Life and Dental): 19/23 19/25* State-Mandated Other
**Only option available for groups with 2-9 lives.*

DEPENDENT ROSTERING
Initial Enrollment will include dependent information (name, gender, DOB, and relationship). Yes No
(Important: If dependent information is not included with initial enrollment, it may cause delays when claims are filed.)

DOMESTIC PARTNERSHIP Yes No

Employee Eligibility (restricted for 2-9 life groups):
 Standard (Full-time, active employees working at least 30 hours per week.)
 Other: _____
Present Employees (hired on or before the effective date):
 None* 30 Days 60 Days 90 Days One Month Three Months Other: _____
** Employees in the waiting period on the effective date of the policy will have the remainder of the waiting period waived.*
Future Employees:
 None 30 Days 60 Days 90 Days One Month Three Months Other: _____
Class Specific Waiting Period? Class 1: _____ Class 2: _____ Class 3: _____

Individual Effective Date (following waiting period): **Date Eligible** Coverage will end on the Employment Termination Date. **First of the Month** First of the Month following the waiting period. Coverage will end on the last day of the month following termination.

CLASS DESCRIPTIONS (restricted for 2-9 life groups)
 All Active full-time employees
 Other: Class 1: _____ Class 2: _____
 Other: Class 3: _____ Class 4: _____

Life and Dental Contributions *If more space is needed, please attach a separate page.*

Employer Contribution Percentage: (Minimum of 25% is required – except for Voluntary lines of coverage.)
 If the employer pays 100% of the premium, all eligible employees must participate.

Employer contribution % on Behalf Of:	Employees	Dependents
<input type="checkbox"/> Basic Life/AD&D	%	%
<input type="checkbox"/> Core Buy-Up Life/AD&D	Core: 100%/Buy-Up: 0%	0%
<input type="checkbox"/> Enhanced Optional Life/AD&D	0%	0%
<input type="checkbox"/> Dental PPO	%	%
<input type="checkbox"/> Dental DHMO	%	%
<input type="checkbox"/> Voluntary Dental	%	%

Disability Contributions and Reporting Information**Employer Contribution % on Behalf of Employees:** (Minimum of 25% is required – except for Voluntary lines of coverage.)

- Long Term Disability (LTD) %
 Short Term Disability (STD) %

Benefit Payments derived from Employer Contributions are 100% taxable for the Employee.
 If the **Employer** pays 100% of the premium, all eligible Employees must participate.

Employee Contribution %:

- | | | | |
|--|---|----------------------------------|-----------------------------------|
| <input type="checkbox"/> Long Term Disability (LTD) | % | <input type="checkbox"/> Pre-Tax | <input type="checkbox"/> Post-Tax |
| <input type="checkbox"/> Short Term Disability (STD) | % | <input type="checkbox"/> Pre-Tax | <input type="checkbox"/> Post-Tax |
| <input type="checkbox"/> Voluntary STD* | % | <input type="checkbox"/> Pre-Tax | <input type="checkbox"/> Post-Tax |

*Voluntary STD 100% Employee paid (Standard). The Employer may pay 0% to 25% of the premium and still qualify for coverage to the provided group.

Employee Pre-Tax contributions are 100% taxable for the Employee.

Employee Post-Tax contributions are 0% taxable for the Employee.

Note: The total Employer and Employee Contribution % for STD and/or LTD must each equal 100%

- Disability Tax Reporting for W2s:**
- MetLife will issue W2s for: LTD STD
 Customer will issues W2s for: LTD STD

- Mail Employee original W2s to:**
- Employee (Standard) Employer

The Employer will receive an Employer W2 report annually if MetLife issues the W2s.

Note: The benefits must be taxable or MetLife's system will not produce a W2.

Detailed Benefit Reports providing Employee payment and tax withholding information:**Report Mailing Frequency:**

- Quarterly (Standard) Monthly

Report Transaction Activity Aggregation:

- Cumulative (Standard) Non-Cumulative

Note: The Employer will receive both W2 (if MetLife issues) and Detailed Benefit Reports (monthly/quarterly).

- STD Checks Mailed to:** Claimants (Standard)

Note: If the Employer has more than one plan and the information for each plan is not identical, please complete and attach a Disability Contribution and Reporting Information sheet for each plan.

Basic Earnings Definition (if nothing is checked, we will assume basic earnings only):

- | | | | |
|----------------------------|---|---|--|
| Basic Life/AD&D | <input type="checkbox"/> Include Commissions Only | <input type="checkbox"/> Include Bonuses Only * | <input type="checkbox"/> Commissions & Bonuses * |
| STD | <input type="checkbox"/> Include Commissions Only | <input type="checkbox"/> Include Bonuses Only | <input type="checkbox"/> Commissions & Bonuses |
| LTD | <input type="checkbox"/> Include Commissions Only | <input type="checkbox"/> Include Bonuses Only | <input type="checkbox"/> Commissions & Bonuses |
| Average Commissions | <input type="checkbox"/> 12 Months | <input type="checkbox"/> 24 Months | <input type="checkbox"/> 36 Months |

* Commissions and Bonuses are available for Sales Employees Only

BILLING DETAIL

- Billing Administration:** List Bill* TPA Billed** Self Administered (SAP)*** Group Tape Feed ****

*Under 100 lives: List Bill only. All Voluntary products must be list billed, regardless of size. **C&A Agreement must be completed

All 200+ lives groups must be SAP billed, except for voluntary products. *250+ lives or min.75k annual premium. Restrictions: No MetLink, and No Voluntary products. Include Approval e-mail. Provide Group Tape Vendor Name:

EMPLOYEES NOT ACTIVELY AT WORK Please list any current employees **not actively working** (excluding employees on vacation) as of the effective date. These employees must be disclosed and **are not eligible** for coverage until they return to work.

- | | |
|--------------|----------------|
| Name: | Reason: |
| Name: | Reason: |
| Name: | Reason: |

Comments:

SECTION 125Do you have a Dental Section 125 Plan? Yes No**ERISA**Include ERISA in your certificate booklets? Yes No If you checked "Yes" above, answer the following:Plan Year Ends: Calendar Year Policy Year Fiscal Year-provide fiscal year date: _____Administrator: Employer Union Maintaining Plan Other - If other, please provide:

Name: _____

Address: _____

Coverage's:

<input type="checkbox"/> Basic Life/AD&D	ERISA Plan #:	<input type="checkbox"/> STD	ERISA Plan #:
<input type="checkbox"/> LTD	ERISA Plan #:	<input type="checkbox"/> Dental	ERISA Plan #:

PRODUCER INFORMATIONCurrently appointed with Metropolitan Life Insurance Co.? Yes No* Broker Code (if available):

Writing Producer's Name: Writing Producer's Social Security #:

Writing Producer's State Insurance License Number:

Commission Paid to: Individual Corporation Individual Commission %:
Split Commission %: (Complete 2nd Producer Info. below)

Corporation Name: Corporate Federal Tax ID:

Corporate Address:

Producer Address:*If commissions are paid to an entity or individual other than the producer, provide payee name, address, phone fax, and e-mail address.*

Broker's Resident Address:

Payee Address (if different from above):

City: State: ZIP:

Contact at Producer's Office - Name:

Phone: FAX: E-Mail Address:

Strategic Alliance Information N/A GA TPA

Broker Name: Broker Code: Social Security #:

Strategic Alliance Agency Name: Tax ID#:

Contact Name: Contact Phone: Contact FAX:

Contact E-Mail Address:

** If licensing paperwork is received, please fax the paperwork to the Licensing Unit at 1-800-556-9430.***2nd PRODUCER INFORMATION: (For split commissions)**Currently appointed with Metropolitan Life Insurance Co.? Yes No* Broker Code (if available):

Writing Producer's Name: Writing Producer's Social Security #:

Writing Producer's State Insurance License Number:

Commission Paid to: Individual Corporation Split Commission %:

Corporation Name: Corporate Federal Tax ID:

Corporate Address:

Producer Address:*If commissions are paid to an entity or individual other than the producer, provide payee name, address, phone fax, and e-mail address.*

Broker's Resident Address:

Payee Address (if different from above):

City: State: ZIP:

Contact at Producer's Office - Name:

Phone: FAX: E-Mail Address:

Strategic Alliance Information N/A GA TPA

Broker Name: Broker Code: Social Security #:

Strategic Alliance Agency Name: Tax ID#:

Contact Name: Contact Phone: Contact FAX:

Contact E-Mail Address:

** If licensing paperwork is received, please fax the paperwork to the Licensing Unit at 1-800-556-9430.***METLIFE CAREER AGENT INFORMATION (if applicable)**

Agent Name: Employee #: Territory #:

Region: District #: Agency #: Index #:

Split Commission % :

METLINK USER AUTHORIZATION INFORMATION (if applicable – MetLink not available for groups with less than 10 lives.)		
User (1): First Name	Last Name:	Business Email Address:
Company Name:		Business Phone:
Business Address:		
City:	State:	ZIP:
Brokers Only - Do you currently have an existing MetLink user ID? <input type="checkbox"/> Yes <input type="checkbox"/> No		User ID:
User (2): First Name	Last Name:	Business Email Address:
Company Name:		Business Phone:
Business Address:		
City:	State:	ZIP:
Brokers Only - Do you currently have an existing MetLink user ID? <input type="checkbox"/> Yes <input type="checkbox"/> No		User ID:
<p>The following MetLink features will be assigned to all users:</p> <ul style="list-style-type: none"> • Enrollment / Eligibility – Update and Inquiry • Resources (User Guide & Legislative releases) • On Line List Billing (access will be given ONLY if you are a List Bill customer) • STD / LTD Disability Claim Status Inquiry and Online filing (Access will be given ONLY if you have disability insurance) • Dental Claims Inquiry (Access will be given ONLY if you have dental insurance and are HIPAA certified) <p>Please note: MetLife dental customers must comply with all HIPAA requirements as well as become certified with MetLife in order to obtain access to the Dental Claim Inquiry feature of MetLink.</p>		
COMMENTS		

MyBenefits: Yes <input type="checkbox"/> No <input type="checkbox"/>	Request for MetDESK Onsite Workshop (Group Life customers only): Yes <input type="checkbox"/> No <input type="checkbox"/>
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<p>FORM COMPLETED BY: <input type="checkbox"/> Employer (Benefits Administrator) <input type="checkbox"/> Broker <input type="checkbox"/> TPA <input type="checkbox"/> GA <input type="checkbox"/> Sales Rep</p> <p>BENEFIT ADMINISTRATOR CALL Please Note: MetLife’s standard policy is for our Issue Underwriter to make a “Welcome Call” to the benefits administrator. This will ensure that the information we have is correct, and will answer any questions the group has before the policy is issued. BA should maintain enrollment cards if e-Census provided.</p>
<p>HIPAA Information: (This section pertains to MetLife Dental customers only) I am an authorized representative of the MetLife customer named on page 1. I have read and understand the SBC HIPAA Information For New MetLife Group Dental Insurance Customers. By my signature at end of this form, I confirm that the customer: (select ONE of the three options listed below)</p> <p><input type="checkbox"/> Does not wish to have access to employee’s Protected Health Information (PHI).</p> <p><input type="checkbox"/> Has submitted a copy of a signed HIPAA Plan Sponsor Certification Form indicating that the customer has already amended their plan document to include HIPAA language required to permit disclosure of PHI to the plan sponsor. <i>(To be created by customer legal advisor)</i></p> <p><input type="checkbox"/> Has reviewed and adopted the Sample SPD HIPAA Privacy Language for use in its summary plan description. The customer has submitted a completed and signed copy of the HIPAA Request Form.</p>

By checking this box and signing below, I certify that the Gramm-Leach-Bliley Privacy Notice has been distributed to all affected employees.
If Dental coverage is selected:
 By checking this box and signing below, I certify that I received a copy of the SBC HIPAA Information for New MetLife Group Dental Insurance Customers.

Signature of Benefit Administrator
(or any employee authorized to make plan changes – i.e. President)

Date