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.

Delivering Superior Service Solutions

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 If Yes, attach a copy of the PEO agreement.**

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.

MetLife Small Business Center

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 Carier:

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
☐ Basic Life/AD&D	%	%
☐ Core Buy-Up Life/AD&D	Core: 100%/Buy-Up: 0%	0%
☐ Enhanced Optional Life/AD&D	0%	0%
☐ Dental PPO	%	%
☐ Dental DHMO	%	%
☐ 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 %:

☐ **Long Term Disability (LTD)**	**%**	☐ Pre-Tax ☐ Post-Tax
☐ **Short Term Disability (STD)**	**%**	☐ Pre-Tax ☐ Post-Tax
☐ **Voluntary STD***	**%**	☐ Pre-Tax ☐ 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	☐ Include Commissions Only	☐ Include Bonuses Only *	☐ Commissions & Bonuses *
STD	☐ Include Commissions Only	☐ Include Bonuses Only	☐ Commissions & Bonuses
LTD	☐ Include Commissions Only	☐ Include Bonuses Only	☐ Commissions & Bonuses
Average Commissions	☐ 12 Months	☐ 24 Months	☐ 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 125
Do 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:

☐ Basic Life/AD&D ERISA Plan #:	☐ STD ERISA Plan #:
☐ LTD ERISA Plan #:	☐ Dental ERISA Plan #:

PRODUCER INFORMATION

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	**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? ☐ **Yes** ☐ **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? ☐ **Yes** ☐ **No**		**User ID:**	

The following MetLink features will be assigned to all users:

? 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)

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.

COMMENTS

MyBenefits: Yes ☐ **No** ☐	**Request for MetDESK Onsite Workshop (Group Life customers only): Yes** ☐ **No** ☐

FORM COMPLETED BY:

☐ Employer (Benefits Administrator) ☐ Broker ☐ TPA ☐ GA ☐ Sales Rep

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.

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)

☐ Does not wish to have access to employee's Protected Health Information (PHI).

☐ 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. (*To be created by customer legal advisor)*

☐ 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.

☐ **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