

# 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.

**APPLICATION FOR GROUP INSURANCE** (10+ groups in ALL states and 2-9 in MD, NY & SD) or **REQUEST FOR PARTICIPATION** (2-9 groups in all states except MD, NY & SD) -- Original, signed and dated by effective date.

**DEPOSIT CHECK** equal to approximately 1<sup>st</sup> month's premium. (For 15<sup>th</sup> of month effective date, remit 1 1/2 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.

**e-Census** : 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)

**CORE BUY-UP OR ENHANCED OPTIONAL LIFE: Signed Portability Forms** (2 original copies); and if Optional/Buy-Up AD&D is purchased: **Signed MetLife 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).)

**DOMESTIC PARTNERSHIP** wording in contract?  No  Yes

## GROUP INFORMATION

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

**Effective Date:** \_\_\_\_\_ **Anniversary 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)

**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 in Group/Division:** \_\_\_\_\_ **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

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: \_\_\_\_\_

**CD ROM ADMINISTRATION MANUAL**  
**Mail Admin Manual to:**  Employer  Broker  TPA  GA

**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**  Yes  No (If dependent roosting is selected, all dependents must be included in enrollment)  
**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: \_\_\_\_\_

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.

	Employees	Dependents
	%	%
<input type="checkbox"/> <b>Basic Life/AD&amp;D</b>		
<input type="checkbox"/> <b>Core Buy-Up Life/AD&amp;D</b>	<b>Core: 100%/Buy-Up: 0%</b>	<b>0%</b>
<input type="checkbox"/> <b>Enhanced Optional Life/AD&amp;D</b>	<b>0%</b>	<b>0%</b>
<input type="checkbox"/> <b>Dental</b>	%	%
<input type="checkbox"/> <b>Voluntary Dental</b>	%	%
<input type="checkbox"/> <b>Short Term Disability (STD)</b>	%	N/A
<input type="checkbox"/> <b>Voluntary STD</b>	<b>0%</b>	<b>N/A</b>
<input type="checkbox"/> <b>Long Term Disability (LTD)</b>	%	N/A

<b>Disability Information</b>	<b>Employee Contribution:</b> <input type="checkbox"/> Pre-Tax <input type="checkbox"/> Post Tax		
<b>STD Checks Mailed to:</b> <input type="checkbox"/> Claimants (standard) <input type="checkbox"/> Policyholder			
<b>Tax reporting method for STD and LTD.</b> <input type="checkbox"/> W2 or <input type="checkbox"/> Quarterly Reporting			
<b>Basic Earnings Definition</b> (if nothing is checked, we will assume basic earnings only):			
<b>Basic Life/AD&amp;D</b>	<input type="checkbox"/> Include Commissions Only	<input type="checkbox"/> Include Bonuses Only *	<input type="checkbox"/> Commissions & Bonuses *
<b>STD</b>	<input type="checkbox"/> Include Commissions Only	<input type="checkbox"/> Include Bonuses Only	<input type="checkbox"/> Commissions & Bonuses
<b>LTD</b>	<input type="checkbox"/> Include Commissions Only	<input type="checkbox"/> Include Bonuses Only	<input type="checkbox"/> Commissions & Bonuses
<b>Average Commissions</b>	<input type="checkbox"/> 12 Months	<input type="checkbox"/> 24 Months	<input type="checkbox"/> 36 Months

\* Commissions and Bonuses are available for Sales Employees Only

<b>BILLING DETAIL</b>				
<b>Billing Administration:</b>	<input checked="" type="checkbox"/> List Bill* (under 200 lives)	<input type="checkbox"/> TPA Billed	<input type="checkbox"/> Self Administered (SAP)*	<input type="checkbox"/> Group Tape Feed

\*Under 100 lives: List Bill only. All Voluntary products must be list billed, regardless of size; 100-199 lives may choose List or SAP billing; All 200+ groups: SAP billing only.

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

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

<b>PRODUCER INFORMATION</b>		
<b>Currently appointed with MetLife?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No*	<b>Broker Code</b> (if available):	
<b>Writing Producer's Name:</b>	<b>Commission %:</b>	
<b>Commission Paid to:</b> <input type="checkbox"/> Individual <input type="checkbox"/> Corporation	<b>Corporate Federal Tax ID:</b>	
<b>Corporation Name:</b>	<b>Writing Producer's Social Security #:</b>	
<b>Producer Address:</b> <i>If commissions are paid to an entity or individual other than the producer, provide payee name, payee address, phone fax, and e-mail address.</i>		
<b>Legal Street Address :</b>		
<b>Payee Address</b> (if different from above):		
<b>City:</b>	<b>State:</b>	<b>ZIP:</b>
<b>Contact at Producer's Office – Name:</b>		
<b>Phone:</b>	<b>FAX:</b>	<b>E-Mail Address:</b>
<b>Strategic Alliance Information</b> <input type="checkbox"/> N/A <input type="checkbox"/> GA <input type="checkbox"/> TPA		
<b>Name and Code:</b>		
<b>Contact Name:</b>	<b>Contact Phone:</b>	<b>Contact FAX:</b>
<b>Contact E-Mail Address:</b>		
* If not currently appointed with MetLife, please attach the following: Commission Agreement, Producer Appointment Inquiry Form, appropriate state license(s), W-9 for individual payees, and Disclosure Notice (AL, DC, GA, MA, MS, OH, OK, PA and WV).		

<b>METLIFE CAREER AGENT INFORMATION</b> (if applicable)			
<b>Agent Name:</b>	<b>District #:</b>	<b>Employee #:</b>	<b>Territory #:</b>
<b>Region:</b>		<b>Agency #:</b>	<b>Index #:</b>
<b>Split Commission %</b> (if applicable):			

**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: \_\_\_\_\_  
**Coverages:**  
 Basic Life/AD&D Erisa Plan #:  Section 125  
 STD Erisa Plan #:  Section 125  
 LTD Erisa Plan #:  Section 125  
 Dental Erisa Plan #:  Section 125

**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.

**METLINK USER AUTHORIZATION INFORMATION** (if applicable – MetLink not available for groups with less than 10 lives.)  
**User Name (1):** First Name \_\_\_\_\_ Last Name \_\_\_\_\_ Business Email Address: \_\_\_\_\_  
Company Name: \_\_\_\_\_ Business Phone: \_\_\_\_\_  
Business Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_  
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

**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.

**By signing below, I certify that the Gramm-Leach-Bliley Privacy Notice has been distributed to all affected employees.**  
**If Dental coverage is selected:**  
 **By 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 – ie President)

\_\_\_\_\_  
Date