



# Specialty Business New Group Submission Form

## CUSTOMER INFORMATION

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Legal Name of Company: \_\_\_\_\_

Legal Address of Company (No PO Boxes): \_\_\_\_\_

Address Line 2: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Employer Tax Identification Number (TIN): \_\_\_\_\_

SIC Code used to Rate Group: \_\_\_\_\_ Year Company Founded: \_\_\_\_\_

Effective Date: \_\_\_\_\_ **Broker Due Date: Next Business Day**

Number of eligible employees: \_\_\_\_\_

Coverage(s) sold:  Basic Life/AD&D  PPO Dental  Long Term Disability  Vision  
 Supplemental Life/AD&D  DHMO  Short Term Disability

Will MetLife be taking over voluntary elections from a prior carrier? If yes, a prior carrier's bill showing individual elections is required with submission.  Yes  No

Does this group have existing coverage with MetLife? If yes, please include the group #: \_\_\_\_\_

## BROKER INFORMATION

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Broker First and Last Name: \_\_\_\_\_

Social Security #: \_\_\_\_\_

Corporation Name: \_\_\_\_\_

Federal Tax ID: \_\_\_\_\_

Resident State: \_\_\_\_\_

Broker Address 1: \_\_\_\_\_

Broker Address 2: \_\_\_\_\_

Broker City, State, Zip: \_\_\_\_\_

Broker Contact Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Is Broker Appointed with MetLife?  Yes  No If no or unsure, please contact your MetLife Implementation team.

Commissions Paid to:  Writing Producer  Brokerage

## GENERAL AGENCY INFORMATION (IF APPLICABLE)

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General Agency Name (must be different than Broker corporation name above): \_\_\_\_\_

General Agency Writing Producer's Name (must be different than Broker's name above): \_\_\_\_\_

General Agency Writing Producer's Social Security #: \_\_\_\_\_

GA Sales Office:<sup>1</sup> \_\_\_\_\_

General Agency Contact Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Email: \_\_\_\_\_

<sup>1</sup> For GA's with multiple locations, please specify which GA sales office/location is attached to this sold case

Do you have an existing Broker or GA MetLink account?  Yes (if yes, please provide the MetLink id)  No

User First and Last Name: \_\_\_\_\_

User Email: \_\_\_\_\_

### TPA INFORMATION (IF APPLICABLE)

TPA Name : \_\_\_\_\_

TPA Writing Producer First and Last Name: \_\_\_\_\_

TPA Writing Producer's Social Security #: \_\_\_\_\_

TPA Sales Office:<sup>2</sup> \_\_\_\_\_

TPA Contact Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Email: \_\_\_\_\_

<sup>2</sup> For TPA's with multiple locations, please specify which TPA sales office/location is attached to this sold case

### THIRD PARTY ENTITY (TPE) (IF APPLICABLE — BENE ADMIN, ENROLLMENT FIRM, TECHNOLOGY, ETC.)

Third Party Entity Name: \_\_\_\_\_

Third Party Entity Writing Producer's Name: \_\_\_\_\_

Third Party Entity Producer's Social Security #: \_\_\_\_\_

Third Party Entity Contact Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Which party is setting up the group on the TPE?  General Agent  Broker

### METLIFE SALES INFORMATION

MetLife Local Office  
(to be completed by MetLife): \_\_\_\_\_

MetLife RMAE  
(to be completed by MetLife): \_\_\_\_\_

MetLife Small Market AE  
(to be completed by MetLife): \_\_\_\_\_

### PRIMARY CONTACT/BENEFIT ADMINISTRATOR INFORMATION

Contact First and Last Name: \_\_\_\_\_

Billing Address Line 1  
(if different than legal address above): \_\_\_\_\_

Billing Address Line 2: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Contact Email: \_\_\_\_\_

Contact Phone: \_\_\_\_\_

Should this contact have access to: MetLink®  Yes  No

Do you wish for your GA/Broker to have MetLink access to your account?  Yes  No

**CUSTOMER EXECUTIVE CONTACT INFORMATION** —  Same as Above

Contact First and Last Name: \_\_\_\_\_

Contact Email: \_\_\_\_\_

Contact Phone/Fax: \_\_\_\_\_

Should this contact have access to MetLink®:  Yes  No

*MetLink® – Our Online administration system designed to make benefits administration easier. MetLink provides convenient, real-time access to MetLife's systems – enabling you to efficiently add or modify employees employee information and look up dental or disability claim status. You can also view your current bill on-line, looking up billing history and run a listing of employees that can be reviewed on-line or downloaded into a spreadsheet.*

**ADDITIONAL SUBSIDIARY / DIVISION / MULTIPLE LOCATION** (Legal Names only)

Add Location information if you have employees who are actively at work and are eligible for coverage at additional location(s). (Please do not re-enter HQ address.)

Legal Company Name: \_\_\_\_\_

Employer Fed Tax ID #: \_\_\_\_\_ # of participants at this at this location \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Separate Bill?  Yes  No

Legal Company Name: \_\_\_\_\_

Employer Fed Tax ID #: \_\_\_\_\_ # of participants at this at this location \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Separate Bill?  Yes  No**BILLING DETAIL** List Bill or  SAP Bill (TPA business only)**DEPARTMENTAL BILLING** (Option to produce one bill with employees subtotaled by Location/Division) Yes  No

Location/ Department Name \_\_\_\_\_ Department Code to be displayed on bill \_\_\_\_\_

Location/ Department Name \_\_\_\_\_ Department Code to be displayed on bill \_\_\_\_\_

**Does this product have multiple classes?\***  Yes  No

If One Class only, please complete the All Employees Eligibility Section below.

If Multiple Classes, please skip All Employees Eligibility section and complete eligibility info for Class 1 and Class 2.

\*Multiple classes must be quoted by MetLife Underwriting

**ELIGIBILITY INFORMATION — ALL EMPLOYEES**Class Description: **All Active Full Time Employees** Number of hours worked: **30 hours****EMPLOYEE WAITING PERIODS**For Present Employees: \_\_\_\_\_ days/months  Date Eligible  First of the MonthFor Future Employees: \_\_\_\_\_ days/months  Date Eligible  First of the Month

**PREMIUM CONTRIBUTIONS — ALL EMPLOYEES**

**Employer Contribution Percentage** — If the employer pays 100% of the premium, all eligible employees must participate.

EMPLOYERS CONTRIBUTION ON BEHALF OF:	BASIC LIFE / AD&D	SUPPLEMENTAL LIFE/ADD	DENTAL PPO	DENTAL DHMO	VISION	LTD	STD
Employee	_____ %	_____ %	_____ %	_____ %	_____ %	_____ % <input type="checkbox"/> Pre Tax <input type="checkbox"/> Post Tax	_____ % <input type="checkbox"/> Pre Tax <input type="checkbox"/> Post Tax
Dependent	_____ %	_____ %	_____ %	_____ %	_____ %	n/a	n/a

**ELIGIBILITY INFORMATION — CLASS 1**

Class Description: \_\_\_\_\_ Number of hours worked: \_\_\_\_\_ hours

**EMPLOYEE WAITING PERIODS**

For Present Employees: \_\_\_\_\_ days/months  Date Eligible  First of the Month

For Future Employees: \_\_\_\_\_ days/months  Date Eligible  First of the Month

**PREMIUM CONTRIBUTIONS — CLASS 1**

**Employer Contribution Percentage** — If the employer pays 100% of the premium, all eligible employees must participate.

EMPLOYERS CONTRIBUTION ON BEHALF OF:	BASIC LIFE / AD&D	SUPPLEMENTAL LIFE/ADD	DENTAL PPO	DENTAL DHMO	VISION	LTD	STD
Employee	_____ %	_____ %	_____ %	_____ %	_____ %	_____ % <input type="checkbox"/> Pre Tax <input type="checkbox"/> Post Tax	_____ % <input type="checkbox"/> Pre Tax <input type="checkbox"/> Post Tax
Dependent	_____ %	_____ %	_____ %	_____ %	_____ %	n/a	n/a

**ELIGIBILITY INFORMATION — CLASS 2**

Class Description: \_\_\_\_\_ Number of hours worked: \_\_\_\_\_ hours

**EMPLOYEE WAITING PERIODS**

For Present Employees: \_\_\_\_\_ days/months  Date Eligible  First of the Month

For Future Employees: \_\_\_\_\_ days/months  Date Eligible  First of the Month

**PREMIUM CONTRIBUTIONS — CLASS 2**

**Employer Contribution Percentage** — If the employer pays 100% of the premium, all eligible employees must participate.

EMPLOYERS CONTRIBUTION ON BEHALF OF:	BASIC LIFE / AD&D	SUPPLEMENTAL LIFE/ADD	DENTAL PPO	DENTAL DHMO	VISION	LTD	STD
Employee	_____ %	_____ %	_____ %	_____ %	_____ %	_____ % <input type="checkbox"/> Pre Tax <input type="checkbox"/> Post Tax	_____ % <input type="checkbox"/> Pre Tax <input type="checkbox"/> Post Tax
Dependent	_____ %	_____ %	_____ %	_____ %	_____ %	n/a	n/a

**Domestic Partners: If your state does not require domestic partner and you would like it removed, please check here.**  Please Remove Domestic Partner

**Do you want to cover retirees?**  Yes  No

Prior approval from MetLife Underwriting is required if retirees are to be considered eligible.

Open Class — present and future retirees

Closed Class — those retired prior to the effective date

**EARNINGS DEFINITION**

Basic Earnings Only    W2    + Commissions    + Bonus

Average over    12 Months    24 Months    36 Months

**Section 125:** Is your policy covered under Section 125?    Yes    No

**ERISA INFORMATION**

**MetLife provides as a standard service for ERISA plans a document entitled "ERISA Information" that, together with your insurance certificate, can be used as your Summary Plan Description. This includes a grant of discretion to MetLife, as claims administrator. If you do not want MetLife to provide this "ERISA Information" please notify your broker so the appropriate modifications can be completed.**

**LIFE, SHORT TERM DISABILITY OR LONG TERM DISABILITY COVERAGES:**

Are there any significant health risks or pregnancies within this customer?    Yes    No

If "Yes", please provide details (do not include individual names):

**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: \_\_\_\_\_

**DISABILITY ONLY**

MetLife will issue W2's for LTD and STD    Customer will issue W2's for LTD and STD

The employer will receive an Employer W2 report annually if MetLife issues the W2's.

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

If you are using a payroll vendor, have you discussed with your Payroll Vendor who should be issuing W2s for taxable disability benefit payments (Third Party Sick Pay)? If you have not discussed this matter and obtained an agreement with your Payroll Vendor you may experience W2 and tax reporting issues at the end of the tax year.

**Are there any individuals being covered that are FICA exempt or partially FICA exempt?**    Yes    No

If you have both FICA exempt and non FICA exempt employees additional class structure may be required for your FICA exempt employees. Please identify all FICA exempt employees on your enrollment listing (census) and their exemption status (Social Security and/or Medicare)

**Please check all that apply:**    Social Security Exempt    Medicare Exempt    Social Security & Medicare Exempt

**Please explain why your employees are exempt from FICA (Social Security and/or Medicare):**

Municipality    Schools    Religious Organization    Other: \_\_\_\_\_

**Do the FICA exemptions described above apply to all covered employees?**    Yes    No

**AUTHORIZATIONS**

**MetLife will deliver the group insurance policy and certificates to the company via e-mail as Adobe pdf documents and confirms that it is able to save them as electronic records and print them (if requested) for distribution to individuals who become covered under the group insurance policy.**

**HIPAA Information (Dental & Vision Only):**

I am an authorized representative of the MetLife customer named above. By checking this box, I understand and confirm that no access will be given to employee's Protected Health Information (PHI).

This section is to be completed by the individual authorized by the company to sign the Application for Group Insurance in order to confirm that the company has requested or undertaken with respect to the implementation of MetLife insurance and/or service program(s). Please read carefully and complete by checking all boxes that apply.

By checking this box and signing below, I certify that I received a copy of the Intermediary Compensation Notice (included below)

By checking this box and signing below, I certify that the Gramm-Leach-Bliley Privacy Notice (included with their document) has been distributed to all affected employees.

\_\_\_\_\_  
Signature of Executive Contact or Benefit Administrator

\_\_\_\_\_  
Date