MetLife

New Group Submission Form

CUSTOMER INFORMATION

Legal Name of Company/DBA: _____

Legal Address (No PO Boxes): _____

Address Line 2: _____

City, State, Zip: _____

Employer Tax Id 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
- ☐ Supplemental Life/AD&D
- ☐ Accident
- ☐ Critical Illness
- ☐ Hospital
- ☐ PPO Dental
- ☐ DHMO (not available on SBS)
- ☐ Identity Fraud Protection (Not available on SBS)
- ☐ Long Term Disability
- ☐ Short Term Disability
- ☐ Vision
- ☐ Pet Insurance
- ☐ MetLife Legal Plans (must sell MetLife Dental or have MetLife Dental inforce)

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

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)

General Agency Name (must be different than Broker Corp name above): _____

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

General Agency Writing Producer's SSN#: _____ BKC: _____ BKR: _____

GA Sales Office:[1] _____

General Agency Contact Name: _____ Phone: _____ Email: _____

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

If you wish to have access to Customer Account Information via Online Portal, please check the box below

☐ SBS Portal ☐ MetLink

User First and Last Name: _____

User Email Address: _____

Existing Username: _____

SBS Portal/MetLink® – Our Online administration system designed to make benefits administration easier. SBS Portal/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 reviewed on-line or downloaded to a spreadsheet.

TPA INFORMATION (IF APPLICABLE)

TPA Name : _____

TPA Writing Producer First & Last Name : _____

TPA Writing Producer's SSN#: _____ BKC: _____ BKR: _____

TPA Sales Office:[2] _____

TPA Contact Name: _____ Phone: _____ Email: _____

[2] 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: _____

MetLife Regional Market AE: _____

MetLife Small Market AE: _____

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 Online access? ☐ Yes ☐ No

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CUSTOMER EXECUTIVE CONTACT INFORMATION — Same as Above

Contact First and Last Name: _____

Contact Email: _____

Contact Phone/Fax: _____

Should this contact have Online access? ☐ Yes ☐ No

SBS Portal/MetLink® – Our Online administration system designed to make benefits administration easier. SBS Portal/ 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 reviewed on-line or downloaded to a spreadsheet.

ADDITIONAL LOCATION / SUBSIDIARY / DIVISION (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: _____

Contact Name: _____

Contact Email: _____

Employer Fed Tax ID: _____ # of participants at this at this location _____

Street Address: _____

City: _____ State _____ Zip _____

Separate Bill? ☐ Yes ☐ No

Legal Company Name: _____

Contact Name: _____

Contact Email: _____

Employer Fed Tax ID: _____ # of participants at this at this location _____

Street Address: _____

City: _____ State _____ Zip _____

Separate Bill? ☐ Yes ☐ No

BILLING DETAIL

☐ List Bill ☐ SAP Bill *(TPA business only)*

Would you like to receive paper bills and billing correspondence by mail? ☐ Yes ☐ No

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: Enter Hours

EMPLOYEE WAITING PERIODS

Do you wish to waive the eligibility waiting period for your current employees? ☐ Yes ☐ No

Coverage	Waiting Periods				Employer contributions on behalf of:		
	Format *	Value**	Select Option**		Employee	Dependent	Pre/Post Tax
Basic Life/AD&D	☐ First of Month ☐ Date Exact		☐ Days	☐ Months	%	%	N/A
Supplemental Life	☐ First of Month ☐ Date Exact		☐ Days	☐ Months	%	%	N/A
Dental PPO	☐ First of Month ☐ Date Exact		☐ Days	☐ Months	%	%	N/A
Dental DHMO (Not available on SBS)	☐ First of Month ☐ Date Exact		☐ Days	☐ Months	%	%	N/A
Vision	☐ First of Month ☐ Date Exact		☐ Days	☐ Months	%	%	N/A
Long Term Disability	☐ First of Month ☐ Date Exact		☐ Days	☐ Months	%	N/A	☐ Pre-Tax ☐ Post-Tax
Short Term Disability	☐ First of Month ☐ Date Exact		☐ Days	☐ Months	%	N/A	☐ Pre-Tax ☐ Post-Tax
Critical Illness	☑ First of Month		☐ Days	☐ Months	%	N/A	☑ Post-Tax
Group Accident	☑ First of Month		☐ Days	☐ Months	%	N/A	☑ Post-Tax
Hospital Indemnity	☑ First of Month		☐ Days	☐ Months	%	N/A	☑ Post-Tax
MetLife Legal	☑ First of Month	0	☑ Days		%	N/A	N/A

NOTE FOR SBS GROUPS ONLY:
*DATE EXACT NOT AVAILABLE
** WHEN OPTION OF DAYS IS SELECTED, THE VALUE MUST BE BETWEEN 0-31

ELIGIBILITY INFORMATION — CLASS 0001

Class Description: _____ Number of hours worked: Enter Hours

EMPLOYEE WAITING PERIODS

Do you wish to waive the eligibility waiting period for your current employees? ☐ Yes ☐ No

Coverage	Waiting Periods				Employer contributions on behalf of:		
	Format *	Value**	Select Option**		Employee	Dependent	Pre/Post Tax
Basic Life/AD&D	☐ First of Month ☐ Date Exact		☐ Days	☐ Months	%	%	N/A
Supplemental Life	☐ First of Month ☐ Date Exact		☐ Days	☐ Months	%	%	N/A
Dental PPO	☐ First of Month ☐ Date Exact		☐ Days	☐ Months	%	%	N/A
Dental DHMO (Not available on SBS)	☐ First of Month ☐ Date Exact		☐ Days	☐ Months	%	%	N/A
Vision	☐ First of Month ☐ Date Exact		☐ Days	☐ Months	%	%	N/A
Long Term Disability	☐ First of Month ☐ Date Exact		☐ Days	☐ Months	%	N/A	☐ Pre-Tax ☐ Post-Tax
Short Term Disability	☐ First of Month ☐ Date Exact		☐ Days	☐ Months	%	N/A	☐ Pre-Tax ☐ Post-Tax
Critical Illness	☑ First of Month		☐ Days	☐ Months	%	N/A	☑ Post-Tax
Group Accident	☑ First of Month		☐ Days	☐ Months	%	N/A	☑ Post-Tax
Hospital Indemnity	☑ First of Month		☐ Days	☐ Months	%	N/A	☑ Post-Tax
MetLife Legal	☑ First of Month	0	☑ Days		%	N/A	N/A

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ELIGIBILITY INFORMATION — CLASS 0002

Class Description: _____ Number of hours worked: Enter Hours

EMPLOYEE WAITING PERIODS

Do you wish to waive the eligibility waiting period for your current employees? ☐ Yes ☐ No

Coverage	Waiting Periods				Employer contributions on behalf of:		
	Format *	Value**	Select Option**		Employee	Dependent	Pre/Post Tax
Basic Life/AD&D	☐ First of Month ☐ Date Exact		☐ Days	☐ Months	%	%	N/A
Supplemental Life	☐ First of Month ☐ Date Exact		☐ Days	☐ Months	%	%	N/A
Dental PPO	☐ First of Month ☐ Date Exact		☐ Days	☐ Months	%	%	N/A
Dental DHMO (Not available on SBS)	☐ First of Month ☐ Date Exact		☐ Days	☐ Months	%	%	N/A
Vision	☐ First of Month ☐ Date Exact		☐ Days	☐ Months	%	%	N/A
Long Term Disability	☐ First of Month ☐ Date Exact		☐ Days	☐ Months	%	N/A	☐ Pre-Tax ☐ Post-Tax
Short Term Disability	☐ First of Month ☐ Date Exact		☐ Days	☐ Months	%	N/A	☐ Pre-Tax ☐ Post-Tax
Critical Illness	☑ First of Month		☐ Days	☐ Months	%	N/A	☑ Post-Tax
Group Accident	☑ First of Month		☐ Days	☐ Months	%	N/A	☑ Post-Tax
Hospital Indemnity	☑ First of Month		☐ Days	☐ Months	%	N/A	☑ Post-Tax
MetLife Legal	☑ First of Month	0	☑ Days		%	N/A	N/A

NOTE FOR SBS GROUPS ONLY:
*DATE EXACT NOT AVAILABLE
** WHEN OPTION OF DAYS IS SELECTED, THE VALUE MUST BE BETWEEN 0-31

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 (not available for SBS)? ☐ 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 ☐ Bonuses

Average over ☐ 12 Months ☐ 24 Months ☐ 36 Months

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.

Plan Year Ends: ☐ Policy Year ☐ Calendar Year ☐ Fiscal Year If Fiscal Year, provide the Month: Enter Month

Section 125: Is your policy covered under Section 125? ☐ YES ☐ NO

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 (Not Available on SBS)? ☐ 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 (Not Available on SBS)? ☐ 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 access will be given to employee's Protected Health Information (PHI). Please complete the HIPAA request form.

Do you wish for your GA/Broker/Third Party Administrator to have Online access to your account? ☐ Yes ☐ No

NO CLAIMS INFORMATION

If Life, Disability, Critical Illness, Accident and/or Hospital included in sale, have there been any claims incurred between the coverage effective date and the date you completed this form? ☐ Yes ☐ No

If yes, please provide details below for all claims that have incurred. If you have more than on a separate sheet.

Product	Date of Expected/Incurred Claim	Nature of the Claim	Additional Comments

This section is to be completed by the individual authorized by the company to sign the Application for Group Insurance or the Request for

Participation 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 (copy provided with submission documents)

☐ By checking this box and signing below, I certify that the Privacy Notice (copy provided with submission documents) has been distributed to all affected employees.

Signature of Executive Contact or Benefit Administrator Date