



Metropolitan Life Insurance Company
One Madison Avenue, New York, New York 10010-3690

APPLICATION FOR GROUP INSURANCE

The applicant named below is applying for a Group Policy to provide insurance for the persons specified below.

APPLICANT DATA

- 1. Full legal name of Applicant: _____ (the "Policyholder")
- 2. Address: _____ City _____ State _____ Zip _____

POLICY EFFECTIVE DATE

The Group Policy's effective date will be _____, subject to MetLife's acceptance of this application and the Applicant's payment of the Premium due on or before such date.

POLICY SITUS

The Group Policy will be issued for delivery in and governed by the laws of _____.

COVERAGE DATA

	Employees / Members Only	Employees / Members and Dependents
Basic Life (or Core) _____	<input type="checkbox"/>	
Enhanced Optional Life (or Buy-Up) _____	<input type="checkbox"/>	<input type="checkbox"/>
Dependent Life (or Buy-Up) _____		<input type="checkbox"/>
Accidental Death & Dismemberment _____	<input type="checkbox"/>	<input type="checkbox"/>
Dental _____	<input type="checkbox"/>	<input type="checkbox"/>
Long Term Disability _____	<input type="checkbox"/>	
Short Term Disability _____	<input type="checkbox"/>	

PREMIUM DATA

Premiums will be paid: monthly quarterly annually other: _____

Attached is an advance payment of: \$ _____.

AGREEMENT

The Applicant signing below agrees to accept the terms and provisions of the Group Policy, including its Exhibits, amendments and endorsements, if any.

Fraud Warning. Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

(Signature of Applicant's Legal Representative)

(Print Name and Title of Legal Representative)

Signed at: _____
(City) (State)

Date: _____

(Signature of Witness)

(Print Name of Witness)

(Signature of Licensed Agent or Resident Agent as required by law)

(Agent's State License No.)

(Print Name of Agent)

Sold Case Checklist and Case Information Form (CIF)



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

- Application for Group Insurance (10+ groups in ALL states and 2-9 in MD, NY & SD) -Original, signed & dated by effective date**
or Request for Participation (2-9 groups in all states except in MD, NY & SD) -Original, signed & dated by effective date
 - 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** for Dental
 - Copy of **Sold Proposal**
 - For takeover groups, Prior carrier's **booklet** and **bill**
 - Contributory Coverages:** Enrollment cards – Waiver Section must be completed for all employees waiving coverage
 - Non-Contributory Coverages:** Census List can replace cards, listing applicable information including: Full Name, Social Security Number, Birthdate, Gender, Hire Date, Job Title, Salary and mode, work site zip code and Class.
- If Applicable:*
- Statement of Health** for ee's/dependents applying for life amounts greater than non-med. max. or ee's not on prior plan (contributory only) (State specific forms for ee's whose work site zip code is in CA, CT, FL, IN, ME, MD, MN, NY, VT, VA or WI)
 - Proof of **COBRA Elections** (Copy of dated COBRA election form)
 - For eligible employees **age 70 and over**, Proof of Active full-time employment (W-2 or Tax Wage Report)
 - For **Core Buy-up Life or Enhanced Optional Life**, signed **Portability** forms (2 original copies)
-If AD&D is purchased, Signed **Assist America Agreement** and **24 hour contact** name/phone #: _____
 - 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 (need policyholder letter requesting this contract wording)
 - Domestic Partnership Affidavit** - for any employee who wishes to cover a Domestic Partner.

Employer Information	Requested Effective Date:	Anniversary Date	Situs State:	For MetLife Use:	
				Group #:	
	Full Legal Name of Group: <small>(exactly as to be shown in contract with exact abbreviations, punctuation, or capitalization)</small>			# of Employees at Headquarters:	
	Headquarter's Address:		Mailing Address (if different):		
	City:	State:	Zip:	City:	State: Zip:
	Executive Contact: <small>(Authorized to make plan changes)</small>		Phone:	Fax :	
			Ext.:	E-mail:	
Benefit Administrator:		Phone:	Fax :		
		Ext.:	E-mail:		
SIC Code:	Nature of Business/Industry:		Federal Employer Tax ID #:		

Certificates & Manuals	<input type="checkbox"/> Same Certificates for Entire Group <input type="checkbox"/> Division Specific Certificates <input type="checkbox"/> Class Specific Certificates		
	Mail Certificates to:	<input type="checkbox"/> Employer <input type="checkbox"/> Broker <input type="checkbox"/> G.A. <input type="checkbox"/> T.P.A. <input type="checkbox"/> Other _____	
	Send Administration Manual via:	<input type="checkbox"/> CD-Rom <input type="checkbox"/> Paper <small>System Requirements: Windows 95, 98 or NT 4.0 or greater; Internet Explorer 4.0 or greater; Netscape 4.0 or greater</small>	
	Send Administration Manual to:	<input type="checkbox"/> Employer <input type="checkbox"/> Broker <input type="checkbox"/> G.A. <input type="checkbox"/> T.P.A. <input type="checkbox"/> Other _____ Special Instructions (i.e., a manual for each Division):	
	Is other group coverage(s) in-force with MetLife? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide coverage(s) & Customer #: _____		

Provide details for other locations (besides headquarters). Note: we can only send separate bills to locations with 10+ covered employees.

Multiple Locations/ Divisions/Subsidiaries	Location/Division/Subsidiary/Affiliate	Complete Mailing Address	Tax ID #	Total # of ee's	Separate Bill
					Yes / No
					Yes / No
					Yes / No

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

Billing & Employee Eligibility	<input type="checkbox"/> List Bill (<100 Lives) <input type="checkbox"/> Billed by MetLife T.P.A.	
	<input type="checkbox"/> Self Administered (SAP) (100-199 Lives may choose List or SAP; All 200+ SAP Bill Only)	
	<input type="checkbox"/> Standard: Full-time active employees working at least 30 hours per week.	
	Other:	
Student Age: (Dependent Life and Dental only)		<input type="checkbox"/> 19/23 <input type="checkbox"/> 19/25 <input type="checkbox"/> 26/26 (Utah only)

Employer Contribution %*	Sold Coverages:	Basic Life/AD&D	Core Buy-Up Life/AD&D	Enhanced Optional Life/AD&D	Dental	Short Term Disability	Long Term Disability
	Employees:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Dependents:					N/A	
	Is Employee Contribution for LTD and/or STD deducted before or after taxes?					<input type="checkbox"/> Pre-Tax	<input type="checkbox"/> Post-Tax

*minimum 25% Employer Contribution required towards Employee Coverages-- Except for Voluntary Dental, LTD, Buy-up and Enhanced which can be 100% Employee-Paid.

Disability Only	Tax Reporting Method for LTD and STD Coverage:	<input type="checkbox"/> Quarterly reports	<input type="checkbox"/> W-2
	STD checks are issued to:	<input type="checkbox"/> Claimants (standard)	<input type="checkbox"/> Policyholder

ERISA (primarily applies to groups with 100+ employees) & Section 125	Do you want ERISA in your certificate booklets? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please provide the following:
	ERISA plan number(s): Life _____ STD _____ LTD _____ Dental _____	
	Plan Administrator: <input type="checkbox"/> Employer <input type="checkbox"/> Union Maintaining Plan <input type="checkbox"/> Other - provide Administrator Name & Address:	
	Plan Year End: <input type="checkbox"/> Calendar Year <input type="checkbox"/> Fiscal Year _____ <input type="checkbox"/> Policy Year	
Is any coverage applied for part of a Section 125 plan? <input type="checkbox"/> No <input type="checkbox"/> Yes - for: <input type="checkbox"/> Life <input type="checkbox"/> STD <input type="checkbox"/> LTD <input type="checkbox"/> Dental		

Eligibility	Eligibility Waiting Period (Length of time employee must be continuously employed prior to coverage eligibility.)	Present Employees (Hired on or before original effective date) <input type="checkbox"/> None <input type="checkbox"/> 30 Days <input type="checkbox"/> 60 Days <input type="checkbox"/> 90 Days <input type="checkbox"/> 1 Month <input type="checkbox"/> 3 Months <input type="checkbox"/> Other:
		Future Employees (Hired after original effective date) <input type="checkbox"/> None <input type="checkbox"/> 30 Days <input type="checkbox"/> 60 Days <input type="checkbox"/> 90 Days <input type="checkbox"/> 1 Month <input type="checkbox"/> 3 Months <input type="checkbox"/> Other:
	Class Specific Waiting Periods:	Class 1: _____ Class 2: _____ Class 3: _____
	Individual Effective Date (following Eligibility Waiting Period)	<input type="checkbox"/> Date Eligible (Coverage Ends on the Date Employment Terminates)

Basic Earnings Definition	Applicable to:	Applicable to Class(es):
<input type="checkbox"/> Basic Earnings Only (Standard) For Life/AD&D, salespersons' earnings equal 12 mo. average comm's &/or bonuses	<input type="checkbox"/> Life <input type="checkbox"/> LTD <input type="checkbox"/> STD	
<input type="checkbox"/> Basic Earnings (Including Commissions & Bonuses) Average over: <input type="checkbox"/> 24 months (Standard) <input type="checkbox"/> 12 months <input type="checkbox"/> 36 months	<input type="checkbox"/> Life <input type="checkbox"/> LTD <input type="checkbox"/> STD	
<input type="checkbox"/> Basic Earnings + Commissions (excluding Bonuses) Average over: <input type="checkbox"/> 24 months (Standard) <input type="checkbox"/> 12 months <input type="checkbox"/> 36 months	<input type="checkbox"/> Life <input type="checkbox"/> LTD <input type="checkbox"/> STD	
<input type="checkbox"/> Basic Earnings + Bonuses (excluding Commissions) Average over: <input type="checkbox"/> 24 months (Standard) <input type="checkbox"/> 12 months <input type="checkbox"/> 36 months	<input type="checkbox"/> Life <input type="checkbox"/> LTD <input type="checkbox"/> STD	

Please list any employees **not actively working** as of the effective date and provide reason:

Comments:

Form completed by (print name): Benefit Administrator Broker
 G.A./T.P.A Other: _____

Broker Information	Payee:	Full Legal Name of Individual or Corporation to be paid Commissions:		Commission % *:	
		Full Address:			
		<input type="checkbox"/> Individual	<input type="checkbox"/> Corporation (Note: individual writing agent info. also required)		
		Individual SS #:	Corporate Tax ID #:		
			Indiv. Writing Agent SS # (license copy required):		
		<input type="checkbox"/> Currently appointed with MetLife Broker Code: _____ (if available)			
If Not currently appointed, please attach: Commission Agreement, Producer Appointment Inquiry Form, copy of appropriate state license(s), W-9 for individual payees & Disclosure Notice in following states only: AL, DC, GA, MA, MS, OH, OK, PA and WV.					
Broker: Phone: _____ Fax: _____ E-mail: _____		Broker contact for ?s: Phone: _____ Fax: _____ E-mail: _____			

G.A. or T.P.A (Strategic Alliance)	<input type="checkbox"/> G.A. <input type="checkbox"/> T.P.A. _____
	G.A./T.P.A Location &/or Coding: _____
	G.A./T.P.A. contact for questions: _____ Phone: _____

*Please note additional broker information in either the above Comments section or attach an additional page.

For MetLife Use:

Sales Office:	Sales Rep or Mgr:	Sales Specialist:	Issue Underwriter:
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