



# 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 MetLife Legal Plans (must sell MetLife Dental or have MetLife Dental inforce)	Pet Insurance
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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:<sup>1</sup> \_\_\_\_\_

General Agency Contact Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Email: [pratibha.patel@amwins.com](mailto:pratibha.patel@amwins.com)

<sup>1</sup> 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:<sup>2</sup> \_\_\_\_\_

TPA Contact Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Email: pratibha.patel@amwins.com

<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: \_\_\_\_\_

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

*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 be reviewed on-line or downloaded into a spreadsheet.*

**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:

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

**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:**

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**ELIGIBILITY INFORMATION — CLASS 0002**

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

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

**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