



Specialty Business Submission Checklist

REQUIRED SUBMISSION DOCUMENTATION

- Specialty Business New Group Submission Form*
- Application for Group Insurance* – (PPO Dental, Life and Disability, Vision)
- DHMO Group Application (if applicable)
- E-Census or Employee Enrollment Forms*
- Copy of Signed Proposal* – Please include entire proposal (rates and benefits)
- Non Standard Commission Agreement (if applicable)
- AXA Travel Assistance Agreement (if AXA is included on Basic or Supplemental Life)
- HIPAA Request Document
- Broker Compensation and Customer Privacy Notices
- Statement of Responsibility (Required for groups with 100+ eligible lives)
- Binder Check (Not required for TPA submissions, add-coverages, or contributory coverages where employees' contribution is 51% or more)
- Customer Authorization Form – Policy Holder (Customer) must sign and return form (if applicable)
- Third Party Entity Non Standard Commission Agreement – Third Party Entity must sign NSCA and return form (if applicable)

* indicates the document is required with all submissions.

DEADLINES

PPO Dental, Life, Vision, Disability — Please submit all completed forms no later than the 5th business day following the requested effective date. Cases submitted after the 5th business day will go through a late submission review for an exception.

DHMO — Please submit all completed forms no later than the 10th (off peak season) and the 5th (peak season) of the month prior to the effective date. No exceptions. Employees must be added to the provider's dental roster prior to the effective date of coverage.

Steps for Submitting Business:

1. Complete the required forms mentioned above
2. Scan and email all completed forms to imp_ratecard@metlife.com
 - **Specialty Business Submission Form** — May be completed by the TPA, GA, Broker or Customer. Customer signature is required. MetLife prefers the form typed, not handwritten.
 - **Application for Group Insurance** — Customer signature is required. The Application for Group Insurance is state specific.
 - **DHMO Group Application** — DHMO is available in TX, CA, NY, NJ and FL. Customer signature is required. The DHMO Group Application is state specific applications. If DHMO sells with Dental PPO and or another line of coverage, please submit the DHMO group application and the Application for Group Insurance for the other lines of coverages sold.
 - **E-Census or Employee Enrollment Forms** — A census is preferred for groups 10+ lives
 - **Copy of Signed Proposal:** Please include the entire proposal (rate and benefits). The proposal may be signed by the TPA, GA, Broker or Customer
 - **Non Standard Commission Agreement (NSCA)** — Required for all groups sold with a non-standard commission scale. Broker signature is required.
 - **AXA Travel Assistance Agreement** — Please submit this form if Basic or Supplemental Life is sold. Customer signature is required
 - **HIPAA Request Document** — If the group wishes to elect HIPAA plan sponsors, please complete this form.
 - **Broker Compensation and Customer Privacy Notices** — Includes the Customer Privacy Notice and the Intermediary Compensation Notice. For the Broker and Customer to review. Please do not return to MetLife. This packet is located on the Microsite under the "Additional Resources" section.
 - **Statement of Responsibility Form** — Required for groups with 100+ eligible lives or more. Customer signature required.
 - **Binder Check** — Not required for TPA submissions, add-coverages, or contributory coverages where the employees' contribution is 51% or more. The check should be in the amount of the group's estimated premium for the first month.
 - **Non Standard Commission Agreement (NSCA)** — Required for all groups sold with a non-standard commission scale for the broker. Broker signature is required. Required for all groups sold with a Third Party Entity based upon the Entities Compensation. Type of compensation is considered a service fee and the Third Party Entity signature is required.
 - **Customer Authorization Form** — Required for all groups sold with a Third Party Entity. Policy Holder (Customer) signature is required. (if applicable)



Specialty Business New Group Submission Form

CUSTOMER INFORMATION

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 MetLife Legal Plans (must sell MetLife Dental or have MetLife Dental in-force)

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 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: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

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: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
(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 EMPLOYEESClass 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



Metropolitan Life Insurance Company
200 Park Avenue, New York, New York

APPLICATION FOR GROUP INSURANCE

The applicant named below is applying for Group Insurance to provide coverage for the class(es) of persons specified below.

APPLICANT DATA

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

EFFECTIVE DATE

The effective date of the applied for group insurance will be _____, subject to MetLife's acceptance of this application and the applicant's payment of the Premium due on or before such date.

SITUS

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

COVERAGE DATA

Employees / Members

Dependents

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

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 all Group Policy forms issued pursuant to this application; including all 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 Authorized Representative)

(Print Name and Title of Authorized Representative)

Signed at: _____
(City) (State)

Date: _____

(Signature of Licensed MetLife Agent or Resident Agent as required by law) (Agent's State License No.)

(Print Name of Agent)



Benefits provided by SafeGuard Health Plans, Inc.,
a MetLife company
200 Park Avenue, New York, New York 10166

APPLICATION FOR GROUP DENTAL BENEFITS

The applicant named below is applying for a Group Contract to provide dental benefits for the persons specified below.

APPLICANT DATA

- 1. Full legal name of Applicant:
- 2. Address: City: State: Zip:

CONTRACT EFFECTIVE DATE

The Group Contract's effective date will be , subject to MetLife's acceptance of this application.

CONTRACT SITUS

The Group Contract will be issued for delivery in and governed by the laws of California.

COVERAGE DATA

**Employees / Members
Only**

**Employees / Members
and Dependents**

Dental Benefits _____

PREPAYMENT FEE DATA

Prepayment Fees 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 Contract, 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 or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any material fact thereto commits a fraudulent 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)

Assistant Vice President
(Representative's title)

Isaac Torres
(Print Name of Representative)

(SafeGuard Representative)



Group, Voluntary & Worksite Benefits

Metropolitan Life Insurance Company
200 Park Avenue
New York, NY 10166

Statement of Responsibility


MetLife will be responsible to the group policyholder for the performance of its administrative obligations under the group policy(ies), this agreement and any other written agreement between MetLife and the group policyholder. If MetLife uses a third party in connection with any of MetLife’s administrative obligations, MetLife will remain responsible to the group policyholder for the performance by the third party of those administrative obligations. The third party will work under the control and direction of MetLife and MetLife will be solely responsible for the acts, errors and omissions of the third party.

The group policyholder will be responsible to MetLife for the performance of its administrative obligations under the group policy(ies), this agreement and any other written agreement between MetLife and the group policyholder. If the group policyholder uses a third party in connection with any of the group policyholder’s administrative obligations, the group policyholder will remain responsible to MetLife for the performance by the third party of those administrative obligations. The third party will work under the control and the direction of the group policyholder and the group policyholder will be solely responsible for the acts, errors and omissions of the third party.

To be completed by Policyholder:

_____	_____
(Print Name and Title of Authorized Representative)	(Group Policyholder Name)
_____	_____
(Signature)	Date (MM/DD/YYYY)
Signed at:	
_____	_____
(City)	(State)

To be completed by Metropolitan Life Insurance Company:

	_____
Paul Piechnik Senior Vice President Group Benefits	Date (MM/DD/YYYY)