# GA New Group Submission Application

MetLife

## 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 ☐ PPO Dental ☐ Vision ☐ ER Sponsored Short Term Disability
☐ Supplemental Life ☐ DHMO ☐ Long Term Disability ☐ Voluntary Short Term Disability

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 assigned Client Acquisition Associate

Commissions Paid to: ☐ Writing Producer ☐ Brokerage

GA/TPA Name : _____

GA/TPA Writing Producer First & Last Name: _____

GA/TPA Local Sales Office Address: _____

GA/TPA Contact Name: _____ Email: _____

## METLIFE SALES INFORMATION: TO BE COMPLETED BY METLIFE, INTERNAL USE ONLY

MetLife Sales Office: _____

MetLife Sales Rep: _____

MetLife Contact: _____

Metlife CAA Email: _____

## PRIMARY CONTACT/BENEFIT ADMINISTRATOR INFORMATION — ☐ Same as Above

Contact First and Last Name: _____

Billing Address Line 1 *(if different than above)*: _____

Billing Address Address Line 2: _____

City, State, Zip: _____

Contact Email: _____

Contact Email/Phone/Fax: _____

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

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.*

## ELIGIBILITY INFORMATION

Class Description: **All Active Full Time Employees** Number of hours worked: **30 hours**

| WAITING PERIOD | COVERAGE EFF DATE |
|---|---|
| _____ Days | ☐ Date Eligible _____ |
| _____ Months | ☐ 1st of Month Following Waiting Period |

Do you want the above waiting period to be waived for new hires and make them effective on the policy effective date? ☐ Yes ☐ No

If you have additional classes or if class description or number of hours worked differs from above, please provide the eligibility information mentioned above for each class in the space provided below.

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

## PREMIUM CONTRIBUTIONS

**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 | VOLUNTARY STD | ER SPONSORED STD |
|---|---|---|---|---|---|---|---|---|
| **Employee** | _____ % | _____ % | _____ % | _____ % | _____ % | _____ % ☐ Pre Tax ☐ Post Tax | _____ % ☐ Pre Tax ☐ Post Tax | _____ % ☐ Pre Tax ☐ Post Tax |
| **Dependent** | _____ % | _____ % | _____ % | _____ % | _____ % | n/a | n/a | n/a |

## EARNINGS DEFINITION

☐ Basic Earnings Only ☐ + 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.**

**Special Case Notes (FOR METLIFE INTERNAL USE ONLY):**

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

Are there any significant health risks 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 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