EM Benefits
New Group Submission Form

MetLife EM BENEFITS

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	Pet Insurance

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

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: _____ MetLink User ID: _____

User Email: _____

TPA INFORMATION (IF APPLICABLE)

TPA Name : Euclid Managers

TPA Writing Producer First and Last Name: _____

TPA Writing Producer's Social Security #: _____

TPA Sales Office:[2] _____

TPA Contact Name: Marcy Graefen Phone: 630-238-2915 Email: marcy@euclidmanagers.com

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

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 EMPLOYEES

Class 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 Month

For 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	_____ %	_____ %	_____ %	_____ %	_____ %	_____ % Pre Tax Post Tax	_____ % Pre Tax 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	_____ %	_____ %	_____ %	_____ %	_____ %	_____ % Pre Tax Post Tax	_____ % Pre Tax 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	_____ %	_____ %	_____ %	_____ %	_____ %	_____ % Pre Tax Post Tax	_____ % Pre Tax 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