MetLife

Specialty Markets 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
- Supplemental Life/AD&D
- PPO Dental
- DHMO
- Long Term Disability
- Short Term Disability
- Vision
- MetLaw (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): Amwins Connect Insurance Services

General Agency Writing Producer's Name (must be different than Broker's name above): Renuka Patel

General Agency Writing Producer's Social Security #: Renuka Patel BKR 4010133

GA Sales Office:[1] 1600 W. Hillsdale Blvd Ste 201, San Mateo, CA 94402

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 : CoPower

TPA Writing Producer First and Last Name: Renuka Patel

TPA Writing Producer's Social Security #: _____

TPA Sales Office:[2] 1600 W. Hillsdale Blvd Ste 201, San Mateo, CA 94402

TPA Contact Name: Fatima Valles Phone: 650-931-1719 Email: fatima.valles@amwins.com

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

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 (Group to be administered by CoPower, please fill out Payment/Invoice section on page 6)

__ 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 N/A Department Code to be displayed on bill N/A

Location/ Department Name N/A Department Code to be displayed on bill N/A

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

Group Administration

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

Group Information - CoPower communication is by electronic mail			
Company Name:			
Contact Name:		E-mail:	
If you wish to opt out of E-mail communication, check this box ☐ and provide mailing address below.			
Street Address:			
City:	State:	Zip:	
HR360 Enrollment *(Free Online HR Support)*: ☐ Yes ☐ No	Total # of Employees: _____	Total # of Eligible Employees: _____	
Group COBRA Status: ☐ Cal-COBRA ☐ Fed-COBRA	*Employed 2-19 (Cal-COBRA) or 20+ (Fed-COBRA) eligible employees on at least 50% of its working days in the previous calendar year*		
Domestic Partners allowed to enroll? ☐ Yes ☐ No	Children of Domestic Partners eligible to enroll? ☐ Yes ☐ No		

MetLife (2-99)			
Prior Carrier: ☐ None	Cancel Date:	Total # of Enrolling Employees: _____	
MetLife Plan Selection (*Dual Choice Dental available for groups of 10+*):			
☐ Dental _____	☐ Vision _____	☐ Life _____	☐ LTD _____

Payment/Invoice - CoPower communication is by electronic mail

Invoices If you wish to opt out of E-mail invoices, check this box ☐

Contact Name _____ E-mail address _____

The above information will be used to authenticate access to the invoice. You must notify CoPower if this contact or e-mail address changes.

Initial Payment Do you wish to have your initial payment debited from your company account?

☐ Yes Please complete the bank information below, enter the premium amount and attach a copy of a voided check.

☐ No Please submit a company check made payable to CoPower.

Ongoing Payment Do you wish to have your monthly invoice amount automatically debited from your company account?

☐ Yes Please complete the bank information below and attach a copy of a voided check. ***(****Allow up to one billing cycle to process your request. You must continue to submit your payment until your invoice indicates that the amount due will be debited from your account.)*

☐ No

Bank Account Information *(must be a Checking Account)*

Account Holder's Name (if different from above): _____

Name of Bank: _____

Bank Address: _____

Bank Routing Number: _____

Account Number: _____

Premium Amount – Number (e.g. $50): $ _____

Premium Amount – Written (e.g. fifty dollars) _____ dollars

I hereby authorize CoPower to initiate debits from the account identified above. I understand it remains in effect until I give written notice to CoPower, which I must do by the 20th of the month. If I want to change the banking information that CoPower debits, I will submit a new Direct Debit Authorization form by the 20th of the month. In the event a debit is made to my account in error, I authorize CoPower to make a correcting entry to my account. CoPower will notify me of payments returned for insufficient funds or close accounts, and repayment instructions.

Producer Statement (Must be completed for commissions. Producers (agent or agency) must have a signed Producer Agreement with CoPower.)

Producer's Signature:			Producer's Signature:		
Producer's Name (print):			Producer's Name (print):		
Federal Tax ID or SSN:			Federal Tax ID or SSN:		
Company Name:			Company Name:		
Address:			Address:		
City:			City:		
State:	Zip:	Date:	State:	Zip:	Date:
Telephone:		Fax:	Telephone:		Fax:
E-mail:			E-mail:		
Make commissions payable to: ☐ Producer ☐ Agency			Make commissions payable to: ☐ Producer ☐ Agency		
Multiple producer split: ☐ Yes ☐ No	Percentage of split: %		Multiple producer split: ☐ Yes ☐ No	Percentage of split: %	