



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

APPLICATION FOR GROUP INSURANCE

The applicant named below is applying for a Group Policy to provide insurance for the persons specified below.

APPLICANT DATA

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

POLICY EFFECTIVE DATE

The Group Policy's effective date will be _____, subject to MetLife's acceptance of this application and the Applicant's payment of the Premium due on or before such date.

POLICY SITUS

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

COVERAGE DATA

	Employees / Members Only	Employees / Members and Dependents
<u>Basic Life (or Core)</u>	<input type="checkbox"/>	<input type="checkbox"/>
<u>Basic Life with AD&D (or Core)</u> (Note: Basic AD&D is not available for Dependents)	<input type="checkbox"/>	<input type="checkbox"/>
<u>Enhanced Optional Life</u>	<input type="checkbox"/>	<input type="checkbox"/>
<u>Enhanced Optional Life with AD&D</u>	<input type="checkbox"/>	<input type="checkbox"/>
<u>Buy Up Life</u>	<input type="checkbox"/>	<input type="checkbox"/>
<u>Buy Up Life with AD&D</u>	<input type="checkbox"/>	<input type="checkbox"/>
<u>Dental</u>	<input type="checkbox"/>	<input type="checkbox"/>
<u>Long Term Disability</u>	<input type="checkbox"/>	
<u>Short Term Disability</u>	<input type="checkbox"/>	

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 the Group Policy, 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 for insurance or a 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 Legal Representative)

(Print Name and Title of Legal Representative)

Signed at: _____
(City) (State)

Date: _____

(Signature of Witness)

(Print Name of Witness)

(Signature of Licensed MetLife Agent or Resident Agent as required by law)

(Agent's State License No.)

(Print Name of Agent)

New Group Submission Checklist



GROUP INFORMATION	Requested Renewal Date:
Full Legal Group Name: (Please include exact abbreviations, punctuation and/or capitalization.)	

GROUP'S HEADQUARTERS ADDRESS		
Street Address:		
City:	State:	ZIP:
Situs State:	Employer Tax ID:	

MAILING ADDRESS <input type="checkbox"/> Same as Headquarters Address <small>– All correspondence with the exception of Renewal Letters and Certificates will be mailed to this address</small>		
Company Name:		
Street Address:		
City:	State:	ZIP:

EXECUTIVE CONTACT INFORMATION (Authorized to make plan changes)	
First/Last Name:	E-Mail Address:
Phone Number:	FAX:

DIVISION CONTACT/BENEFIT ADMINISTRATOR INFORMATION <input type="checkbox"/> Same as Executive Contact	
First/Last Name:	E-Mail Address:
Phone Number:	FAX:

Please complete the following subsidiary information if there are employees working for a subsidiary who are eligible for coverage.

SUBSIDIARIES (If more than two, please provide the following information for all subsidiaries.)		
Subsidiary Name (1):	Federal Tax ID:	
Separate Bill? <input type="checkbox"/> Yes <input type="checkbox"/> No	Number of Employees:	
Street Address:		
City:	State:	ZIP:
Contact First/Last Name:	Phone:	Fax:

SUBSIDIARIES (If more than two, please provide the following information for all subsidiaries.)		
Subsidiary Name (2):	Federal Tax ID:	
Separate Bill? <input type="checkbox"/> Yes <input type="checkbox"/> No	Number of Employees:	
Street Address:		
City:	State:	ZIP:
Contact First/Last Name:	Phone:	Fax:

If more space is needed, please attach a separate page.

DEPARTMENTAL BILLING – Option to produce one bill with employees subtotaled by location/department	
Location/Department Name	Department Code to be displayed on bill [maximum of 8 characters]

New Group Submission Checklist



Prior Coverage with MetLife? Yes No **Current Coverage with MetLife?** Yes No

If yes, please provide MetLife Customer Number:
 Current coverage(s) : Group Life Voluntary Life Dental Long Term Disability Short Term Disability

CLASS DESCRIPTIONS AND WAITING PERIODS

Class 1: All Active Full Time Employees Class Specific, fill in class descriptions below

Class Description:
 Working: 20 30 40 Other _____ hours per week
Waiting Period: None* 1 3 6 9 30 60 90 Other _____
 Days Weeks Months Years
Individual Effective Date: Date Eligible First of the Month

Class 2: Class Description:
 Working: 20 30 40 Other _____ hours per week
Waiting Period: None* 1 3 6 9 30 60 90 Other _____
 Days Weeks Months Years
Individual Effective Date: Date Eligible First of the Month

Class 3: Class Description:
 Working: 20 30 40 Other _____ hours per week
Waiting Period: None* 1 3 6 9 30 60 90 Other _____
 Days Weeks Months Years
Individual Effective Date: Date Eligible First of the Month

Class 4: Class Description:
 Working: 20 30 40 Other _____ hours per week
Waiting Period: None* 1 3 6 9 30 60 90 Other _____
 Days Weeks Months Years
Individual Effective Date: Date Eligible First of the Month

*Employees in the waiting period on the effective date of the policy will have the remainder of the waiting period waived.

Student Age Limit

Dental: 19/23 19/25 State Mandated Other _____
 Dependent Life: 19/23 19/25 State Mandated Other _____

Employer Contribution Percentage

If the employer pays 100% of the premium, all eligible employees must participate.

LIFE AND DENTAL CONTRIBUTIONS

	EMPLOYER'S Contribution on behalf of:		# of Employees Eligible
	Employees	Dependents	
<input type="checkbox"/> Basic Life/AD&D	%	%	
<input type="checkbox"/> Core Buy-Up Life/AD&D	Core: 100% / Buy-Up: 0%	0%	
<input type="checkbox"/> Enhanced Optional Life/AD&D	0%	0%	
<input type="checkbox"/> Dental PPO	%	%	
<input type="checkbox"/> Dental HMO	%	%	
<input type="checkbox"/> Voluntary Dental	%	%	

DISABILITY CONTRIBUTIONS AND REPORTING INFORMATION			
	Employer's Contribution on behalf employee:		# of Employees Eligible
<input type="checkbox"/> Long Term Disability	%	<input type="checkbox"/> Pre-Tax <input type="checkbox"/> Post-Tax	
<input type="checkbox"/> Short Term Disability	%	<input type="checkbox"/> Pre-Tax <input type="checkbox"/> Post-Tax	
<input type="checkbox"/> Voluntary Short Term Disability*	%	<input type="checkbox"/> Pre-Tax <input type="checkbox"/> Post-Tax	
*Voluntary STD 100% Employee paid (Standard). The Employer may pay 0% to 25% of the premium and still qualify for coverage to the provided group. Employee Pre-Tax contributions are 100% taxable for the Employee. Employee Post-Tax contributions are 0% taxable for the Employee.			
Disability Tax Reporting for W2s:		<input type="checkbox"/> MetLife will issue W2s for: <input type="checkbox"/> LTD <input type="checkbox"/> STD <input type="checkbox"/> Customer will issues W2s for: <input type="checkbox"/> LTD <input type="checkbox"/> STD	
The Employer will receive an Employer W2 report annually if MetLife issues the W2s. Note: The benefits must be taxable or MetLife's system will not produce a W2.			

BASIC EARNINGS DEFINITION (if nothing is checked, we will assume Basic Earnings only):			
Basic Life/AD&D	<input type="checkbox"/> Salary + Commissions*	<input type="checkbox"/> Salary + Bonuses*	<input type="checkbox"/> Salary + Commissions & Bonuses *
STD	<input type="checkbox"/> Salary + Commissions*	<input type="checkbox"/> Salary + Bonuses*	<input type="checkbox"/> Salary + Commissions & Bonuses *
LTD	<input type="checkbox"/> Salary + Commissions*	<input type="checkbox"/> Salary + Bonuses*	<input type="checkbox"/> Salary + Commissions & Bonuses *
Commissions and/or Bonuses Averaged Over	<input type="checkbox"/> 12 Months	<input type="checkbox"/> 24 Months	<input type="checkbox"/> 36 Months
* Commissions and Bonuses are available for Sales Employees Only			
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:	

DOMESTIC PARTNER
Do you want Domestic Partnership to be covered? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, select coverage <input type="checkbox"/> Life <input type="checkbox"/> Dental

SECTION 125
Do you have a Dental Section 125 Plan? <input type="checkbox"/> Yes <input type="checkbox"/> No

ERISA			
Include ERISA in your certificate booklets? <input type="checkbox"/> Yes <input type="checkbox"/> No If you checked "Yes," answer the following:			
Plan Year Ends:	<input type="checkbox"/> Calendar Year	<input type="checkbox"/> Policy Year	<input type="checkbox"/> Fiscal Year-provide fiscal year date: _____
Administrator:	<input type="checkbox"/> Employer	<input type="checkbox"/> Union Maintaining Plan	
	<input type="checkbox"/> Other - If other, please provide: Name: Address:		
Coverages:	<input type="checkbox"/> Basic Life/AD&D ERISA Plan #:	<input type="checkbox"/> STD ERISA Plan #:	
	<input type="checkbox"/> LTD ERISA Plan #:	<input type="checkbox"/> Dental ERISA Plan #:	

New Group Submission Checklist



METLINK USER AUTHORIZATION INFORMATION (MetLink not available for groups with less than 10 lives.)			
User (1): First Name	Last Name:	Business Email Address:	
Company Name:		Business Phone:	
Business Address:			
City:		State:	ZIP:
User (2): First Name	Last Name:	Business Email Address:	
Company Name:		Business Phone:	
Business Address:			
City:		State:	ZIP:
User (3): First Name	Last Name:	Business Email Address:	
Company Name:		Business Phone:	
Business Address:			
City:		State:	ZIP:
If user is the Broker –		If yes, please provide current user ID:	
Do you currently have an existing MetLink user ID? <input type="checkbox"/> Yes <input type="checkbox"/> No			
The following MetLink features will be assigned to all users : <ul style="list-style-type: none"> • Enrollment / Eligibility – Update and Inquiry • On Line List Billing (access will be given ONLY if you are a List Bill customer) • STD / LTD Disability Claim Status Inquiry and Online filing (Access will be given ONLY if you have disability insurance) • Dental Claims Inquiry (Access will be given ONLY if you have dental insurance and are HIPAA certified) 			
Please note: MetLife dental customers must comply with all HIPAA requirements as well as become certified with MetLife in order to obtain access to the Dental Claim Inquiry feature of MetLink.			
COMMENTS			

If Dental coverage is selected:

By checking this box and signing below, I certify that I received a copy of the Small Market HIPAA Information for New MetLife Group Dental Insurance Customers

HIPAA Information (Dental Only):

I am an authorized representative of the MetLife customer named on page 1. I have read and understand the Small Market HIPAA Information For New MetLife Group Dental Insurance Customers. By my signature at end of this form, I confirm that the customer:

(select ONE of the three options listed below)

Does not wish to have access to employee's Protected Health Information (PHI).

Has submitted a copy of a signed HIPAA Plan Sponsor Certification Form indicating that the customer has already amended their plan document to include HIPAA language required to permit disclosure of PHI to the plan sponsor. (*To be created by customer legal advisor*)

Has reviewed and adopted the Sample SPD HIPAA Privacy Language for use in its summary plan description. The customer has submitted a completed and signed copy of the HIPAA Request Form.

By checking this box and signing below, I certify that the Gramm-Leach-Bliley Privacy Notice (included at the end of this document) has been distributed to all affected employees.

By checking this box and signing below, I certify that I received a copy of the Intermediary Compensation Notice (included at the end of this document)

Signature of Executive Contact or Benefit Administrator

Date

New Group Submission Checklist



PRODUCER INFORMATION (1)			
Commission Paid to: <input type="checkbox"/> Individual <input type="checkbox"/> Corporation		Individual Commission %: Split Commission %: [Complete additional Producer page(s)]	
WRITING PRODUCER INFORMATION			
Writing Producer's First/Last Name:		Writing Producer's Social Security #:	
Producer's email address:		Producer Resident State:	
Street Address:			
City:	State:	ZIP:	
Contact at producer's office: First/Last Name:		Phone:	Fax:
Contact's email address:			
CORPORATION INFORMATION			
Corporation Name:		Corporate Federal Tax ID:	
Street Address:			
City:	State:	ZIP:	
STRATEGIC ALLIANCE INFORMATION		<input type="checkbox"/> N/A <input type="checkbox"/> GA <input type="checkbox"/> TPA	
Broker Name:		Social Security #:	
Strategic Alliance Agency Name:		Agency Tax ID#:	
Contact Name:		Contact Phone:	Contact FAX:
Contact E-Mail Address:			
METLIFE CAREER AGENT INFORMATION <input type="checkbox"/> N/A			
Agent Name:		Employee #:	Territory #:
Region:	District #:	Agency #:	Index #:

New Group Submission Checklist



PRODUCER INFORMATION (2)			
Currently appointed with Metropolitan Life Insurance Co.? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Commission Paid to: <input type="checkbox"/> Individual <input type="checkbox"/> Corporation		Split Commission %:	
WRITING PRODUCER INFORMATION			
Writing Producer's First/Last Name:		Writing Producer's Social Security #:	
Producer's email address:			Producer Resident State:
Street Address:			
City:	State:	ZIP:	
Contact at producer's office: First/Last Name:		Phone:	Fax:
Contact's email address:			
CORPORATION INFORMATION			
Corporation Name:		Corporate Federal Tax ID:	
Street Address:			
City:	State:	ZIP:	



As part of MetLife's commitment to ensuring that our customers understand the compensation we may pay to intermediaries, we have provided our Intermediary Compensation Notice below. If you have any questions about intermediary compensation, please contact MetLife using the contact information provided below.

We look forward to helping you meet your benefits objectives in the months and years ahead.

INTERMEDIARY COMPENSATION NOTICE

MetLife enters into arrangements concerning the sale, servicing and/or renewal of MetLife group insurance and certain other group-related products ("Products") with brokers, agents, consultants, third-party administrators, general agents, associations, and other parties that may participate in the sale, servicing and/or renewal of such Products (each an "Intermediary"). MetLife may pay your Intermediary compensation, which may include base compensation, supplemental compensation and/or a service fee.

MetLife may pay compensation for the sale, servicing and/or renewal of Products, or remit compensation to an Intermediary on your behalf. Your Intermediary may also be owned by, controlled by or affiliated with another person or party, which may also be an Intermediary and who may also perform marketing and/or administration services in connection with your Products and be paid compensation by MetLife.

Base compensation, which may vary from case to case and may change if you renew your Products with MetLife, may be payable to your Intermediary as a percentage of premium or a fixed dollar amount. In addition, supplemental compensation may be payable to your Intermediary. Under MetLife's current supplemental compensation plan, the amount payable as supplemental compensation may range from 0% to 2.25% of premium. The supplemental compensation percentage may be based on: (1) the number of Products sold or inforce through your Intermediary during a prior one-year period; (2) the amount of premium or fees with respect to Products sold or inforce through your Intermediary during a prior one-year period; and/or (3) a fixed percentage of the premium for Products as set by MetLife. The supplemental compensation percentage will be set by MetLife prior to the beginning of each calendar year and it may not be changed until the following calendar year. As such, the supplemental compensation percentage may vary from year to year, but will not exceed 2.25% under the current supplemental compensation plan.

The cost of supplemental compensation is not directly charged to the price of our Products except as an allocation of overhead expense, which is applied to all eligible group insurance products, whether or not supplemental compensation is paid in relation to a particular sale or renewal. As a result, your rates will not differ by whether or not your Intermediary receives supplemental compensation. If your Intermediary collects the premium from you in relation to your Products, your Intermediary may earn a return on such amounts. Additionally, MetLife may have a variety of other relationships with your Intermediary or its affiliates that involve the payment of compensation and benefits that may or may not be related to your relationship with MetLife (e.g., consulting or reinsurance arrangements).

More information about the eligibility criteria, limitations, payment calculations and other terms and conditions under MetLife's base compensation and supplemental compensation plans can be found on MetLife's Web site at whymetlife.com/brokercompensation. Questions regarding Intermediary compensation can be directed to ask4met@metlifeservice.com, or if you would like to speak to someone about Intermediary compensation, please call (800) ASK 4MET.

Privacy Notice

If you submit a request for insurance (enrollment form) we will evaluate it. We will review the information you give to us and we may confirm it or add to it in the ways explained below.

This Privacy Notice is given to you on behalf of Metropolitan Life Insurance Company.

Please read this Privacy Notice carefully. It describes in broad terms how we learn about you and how we treat the information we get about you. (If anyone else is to be insured under the coverage you've requested, what we say here also applies to information about him or her.) We are required by law to give you this notice.

Why We Need Information: We need to know about you (and anyone else to be insured) so that we can provide the insurance and other products and services you've requested. We may also need it to administer your business with us, evaluate claims, process transactions and run our business. And we need information from you and others to help us verify identities in order to help prevent money laundering and terrorism.

What we need to know includes address, age and other basic information. We may also need more information. This may include information about finances, employment, health, hobbies or business conducted with us, with other MetLife companies (our "affiliates") or with other companies. Our affiliates currently include life, car and home insurers, securities firms, broker-dealers, a bank, a legal plans company and financial advisors.

How We Get Information: What we know about you (and anyone else to be insured) we get mostly from you. But we may also have to find out more from other sources to make sure that what we know is correct and complete. Those sources may include adult relatives, employers, consumer reporting agencies, health care providers and others. Some sources may give us reports and may disclose what they know to others. We may ask for medical information. The Authorization that you sign when you request insurance permits these sources to tell us about you. We may also, at our expense:

- Ask for a medical exam
- Ask health care providers to give us health data, including information about alcohol or drug abuse

We may also ask a consumer reporting agency for a "consumer report" about you (or anyone else to be insured). Consumer reports may tell us about a lot of things, including information about:

- Reputation
- Driving record
- Finances
- Work and work history
- Hobbies and dangerous activities

The information may be kept by the consumer reporting agency and later given to others as permitted by law. The agency will give you a copy of the report it provides to us, if you ask the agency and can provide adequate identification. If you write to us and we have asked for a consumer report about you, we will tell you so and give you the name, address and phone number of the consumer reporting agency.

Another source of information is MIB Group, Inc. ("MIB"). It is a non-profit association of life insurance companies. We and our reinsurers may give MIB health or other information about you. If you apply for life or health coverage from another member of MIB, or claim benefits from another member company, MIB will give that company any information that it has about you. If you contact MIB, it will tell you what it knows about you. You have the right to ask MIB to correct its information about you. You may do so by writing to MIB, Inc., P.O. Box 105, Essex Station, Boston, MA 02112, by calling MIB at (866) 692-6901 (TTY (866) 346-3642 for the hearing impaired), or by contacting MIB at www.mib.com.

How We Protect Information: Because you entrust us with your personal information, we treat what we know about you confidentially. Our employees are told to take care in handling your information. They may get information about you only when there is a good reason to do so. We also take steps to make our computer databases secure and to safeguard the information we have.

How We Use and Disclose Information: We may use what we know to help us serve you better. We may use it, and disclose it to our affiliates and others, for any purpose allowed by law. Generally, we will disclose only the information we consider reasonably necessary to disclose. For instance, we may use your information, and disclose it to others, in order to:

- Help us evaluate your request for a product or service
- Help us process claims and other transactions
- Confirm or correct what we know about you
- Help us prevent fraud, money laundering, terrorism and other crimes by verifying what we know about you
- Help us comply with the law
- Help us run our business
- Process information for us
- Perform research for us
- Audit our business

When we disclose information to others to perform business services for us, they are required to take appropriate steps to protect this information. And they may use the information only for the purposes of performing those business services. Other reasons we may disclose what we know about you include:

- Doing what a court or government agency requires us to do; for example, complying with a search warrant or subpoena;
- Telling another company what we know about you, if we are or may be selling all or any part of our business or merging with another company;
 - Giving information to the government so that it can decide whether you may get benefits that it will have to pay for;
 - Telling a group customer about its members' claims or cooperating in a group customer's audit of our service;
 - Telling your health care provider about a medical problem that you have but may not be aware of;
 - Giving your information to a peer review organization if you have health insurance with us; and
 - Giving your information to someone who has a legal interest in your insurance, such as someone who lent you money and holds a lien on your insurance or benefits.

How we use and disclose information depends on the products and services you have with us or are covered under. It also depends on laws that apply to those products and services. Unless restricted by law or by agreement, we may use what we know about you to offer you our other products and services. We may share your information with other companies to help us. Here are our other rules on using your information to market products and services:

- We will not share information about you with any of our affiliates for use in marketing its products to you, unless we first notify you. You will then have an opportunity to tell us not to share your information by "opting out."
- Before we share what we know about you with another financial services company to offer you products or services through a joint marketing arrangement, we will let you "opt-out."
- We will not disclose information to unaffiliated companies for use in selling their products to you, except through such joint marketing arrangements.
- We will not share your health information with any other company, even one of our affiliates, to permit it to market its products and services to you.

How You Can See and Correct Your Information: Generally, we will let you review what we know about you if you ask us in writing. (Because of its legal sensitivity, we will not show you anything that we learned in connection with a claim or lawsuit.) In some circumstances we may disclose what we know about your health through your health care provider. If you tell us that what we know about you is incorrect, we will review it. If we agree with you, we will correct our records. If we do not agree with you, you may tell us in writing, and we will include your statement if we give this information to anyone outside MetLife.

You Can Get Other Material from Us: In addition to any other privacy notice we may give you, we must give you a summary of our privacy policy once each year. You may have other rights under the law. If you want to know more about our privacy policy, please visit our website, www.metlife.com, or write to Metropolitan Life Insurance Company, c/o MetLife Privacy Office - Inst, P.O. Box 489, Warwick, RI 02887-9954. When writing to us, please identify the specific product or service you have with us

Privacy Notice

If you submit a request for insurance (enrollment form) we will evaluate it. We will review the information you give to us and we may confirm it or add to it in the ways explained below.

This Privacy Notice is given to you on behalf of Metropolitan Life Insurance Company.

Please read this Privacy Notice carefully. It describes in broad terms how we learn about you and how we treat the information we get about you. (If anyone else is to be insured under the coverage you've requested, what we say here also applies to information about him or her.) We are required by law to give you this notice.

Why We Need Information: We need to know about you (and anyone else to be insured) so that we can provide the insurance and other products and services you've requested. We may also need it to administer your business with us, evaluate claims, process transactions and run our business. And we need information from you and others to help us verify identities in order to help prevent money laundering and terrorism.

What we need to know includes address, age and other basic information. We may also need more information. This may include information about finances, employment, health, hobbies or business conducted with us, with other MetLife companies (our "affiliates") or with other companies. Our affiliates currently include life, car and home insurers, securities firms, broker-dealers, a bank, a legal plans company and financial advisors.

How We Get Information: What we know about you (and anyone else to be insured) we get mostly from you. But we may also have to find out more from other sources to make sure that what we know is correct and complete. Those sources may include adult relatives, employers, consumer reporting agencies, health care providers and others. Some sources may give us reports and may disclose what they know to others. We may ask for medical information. The Authorization that you sign when you request insurance permits these sources to tell us about you. We may also, at our expense:

- Ask for a medical exam
- Ask health care providers to give us health data, including information about alcohol or drug abuse

We may also ask a consumer reporting agency for a "consumer report" about you (or anyone else to be insured). Consumer reports may tell us about a lot of things, including information about:

- Reputation
- Driving record
- Finances
- Work and work history
- Hobbies and dangerous activities

The information may be kept by the consumer reporting agency and later given to others as permitted by law. The agency will give you a copy of the report it provides to us, if you ask the agency and can provide adequate identification. If you write to us and we have asked for a consumer report about you, we will tell you so and give you the name, address and phone number of the consumer reporting agency.

Another source of information is MIB Group, Inc. ("MIB"). It is a non-profit association of life insurance companies. We and our reinsurers may give MIB health or other information about you. If you apply for life or health coverage from another member of MIB, or claim benefits from another member company, MIB will give that company any information that it has about you. If you contact MIB, it will tell you what it knows about you. You have the right to ask MIB to correct its information about you. You may do so by writing to MIB, Inc., P.O. Box 105, Essex Station, Boston, MA 02112, by calling MIB at (866) 692-6901 (TTY (866) 346-3642 for the hearing impaired), or by contacting MIB at www.mib.com.

How We Protect Information: Because you entrust us with your personal information, we treat what we know about you confidentially. Our employees are told to take care in handling your information. They may get information about you only when there is a good reason to do so. We also take steps to make our computer databases secure and to safeguard the information we have.

How We Use and Disclose Information: We may use what we know to help us serve you better. We may use it, and disclose it to our affiliates and others, for any purpose allowed by law. Generally, we will disclose only the information we consider reasonably necessary to disclose. For instance, we may use your information, and disclose it to others, in order to:

- Help us evaluate your request for a product or service
- Help us process claims and other transactions
- Confirm or correct what we know about you
- Help us prevent fraud, money laundering, terrorism and other crimes by verifying what we know about you
- Help us comply with the law
- Help us run our business
- Process information for us
- Perform research for us
- Audit our business

When we disclose information to others to perform business services for us, they are required to take appropriate steps to protect this information. And they may use the information only for the purposes of performing those business services. Other reasons we may disclose what we know about you include:

- Doing what a court or government agency requires us to do; for example, complying with a search warrant or subpoena;
- Telling another company what we know about you, if we are or may be selling all or any part of our business or merging with another company;
- Giving information to the government so that it can decide whether you may get benefits that it will have to pay for;
- Telling a group customer about its members' claims or cooperating in a group customer's audit of our service;
- Telling your health care provider about a medical problem that you have but may not be aware of;
- Giving your information to a peer review organization if you have health insurance with us; and
- Giving your information to someone who has a legal interest in your insurance, such as someone who lent you money and holds a lien on your insurance or benefits.

How we use and disclose information depends on the products and services you have with us or are covered under. It also depends on laws that apply to those products and services. Unless restricted by law or by agreement, we may use what we know about you to offer you our other products and services. We may share your information with other companies to help us. Here are our other rules on using your information to market products and services:

- We will not share information about you with any of our affiliates for use in marketing its products to you, unless we first notify you. You will then have an opportunity to tell us not to share your information by "opting out."
- Before we share what we know about you with another financial services company to offer you products or services through a joint marketing arrangement, we will let you "opt-out."
- We will not disclose information to unaffiliated companies for use in selling their products to you, except through such joint marketing arrangements.
- We will not share your health information with any other company, even one of our affiliates, to permit it to market its products and services to you.

How You Can See and Correct Your Information: Generally, we will let you review what we know about you if you ask us in writing. (Because of its legal sensitivity, we will not show you anything that we learned in connection with a claim or lawsuit.) In some circumstances we may disclose what we know about your health through your health care provider. If you tell us that what we know about you is incorrect, we will review it. If we agree with you, we will correct our records. If we do not agree with you, you may tell us in writing, and we will include your statement if we give this information to anyone outside MetLife.

You Can Get Other Material from Us: In addition to any other privacy notice we may give you, we must give you a summary of our privacy policy once each year. You may have other rights under the law. If you want to know more about our privacy policy, please visit our website, www.metlife.com, or write to Metropolitan Life Insurance Company, c/o MetLife Privacy Office - Inst, P.O. Box 489, Warwick, RI 02887-9954. When writing to us, please identify the specific product or service you have with us.

HIPAA REQUEST FORM

If you wish to include in your booklet certificate the HIPAA privacy language shown on the specimen "Sample Dental Booklet Certificate/SPD Language" provided to you by MetLife, please answer the following question(s), sign, and return this form to MetLife at the following address:

MetLife
4150 N. Mulberry Drive/Suite 300
Kansas City, MO 64116

Please provide the following information:

- a. Are there employees of the Plan Sponsor that may access PHI (Protected Health Information) provided by the Plan? If there are, please provide their title(s) or other identifiers below. Please do not provide their names, only title or other identifier.

- b. Should the term "Privacy Officer" be included in Section III. (C) "Sharing of PHI with the Plan Sponsor" of the Dental Plan Document?

Yes No

- c. Should Section IV. "Participant's Rights" be included in the Dental Plan Document? (this is an optional section).

Yes No

- d. Should Section V. "Privacy Complaints/Issues" be included in the Dental Plan Document? (this is an optional section).

Yes No

As a duly authorized representative of the Customer named below and its group dental plan, and consistent with such Customer's decision to amend its plan document to incorporate HIPAA privacy provisions, I hereby request that MetLife include in Customer's booklet certificate HIPAA privacy language reflecting Customer's choices on this form.

Customer Name _____

Customer Number _____

Authorized Signature _____

Date _____



As part of MetLife's commitment to ensuring that our customers understand the compensation we may pay to intermediaries, we have provided our Intermediary Compensation Notice below. If you have any questions about intermediary compensation, please contact MetLife using the contact information provided below.

We look forward to helping you meet your benefits objectives in the months and years ahead.

INTERMEDIARY COMPENSATION NOTICE

MetLife enters into arrangements concerning the sale, servicing and/or renewal of MetLife group insurance and certain other group-related products ("Products") with brokers, agents, consultants, third-party administrators, general agents, associations, and other parties that may participate in the sale, servicing and/or renewal of such Products (each an "Intermediary"). MetLife may pay your Intermediary compensation, which may include base compensation, supplemental compensation and/or a service fee.

MetLife may pay compensation for the sale, servicing and/or renewal of Products, or remit compensation to an Intermediary on your behalf. Your Intermediary may also be owned by, controlled by or affiliated with another person or party, which may also be an Intermediary and who may also perform marketing and/or administration services in connection with your Products and be paid compensation by MetLife.

Base compensation, which may vary from case to case and may change if you renew your Products with MetLife, may be payable to your Intermediary as a percentage of premium or a fixed dollar amount. In addition, supplemental compensation may be payable to your Intermediary. Under MetLife's current supplemental compensation plan, the amount payable as supplemental compensation may range from 0% to 2.25% of premium. The supplemental compensation percentage may be based on: (1) the number of Products sold or inforce through your Intermediary during a prior one-year period; (2) the amount of premium or fees with respect to Products sold or inforce through your Intermediary during a prior one-year period; and/or (3) a fixed percentage of the premium for Products as set by MetLife. The supplemental compensation percentage will be set by MetLife prior to the beginning of each calendar year and it may not be changed until the following calendar year. As such, the supplemental compensation percentage may vary from year to year, but will not exceed 2.25% under the current supplemental compensation plan.

The cost of supplemental compensation is not directly charged to the price of our Products except as an allocation of overhead expense, which is applied to all eligible group insurance products, whether or not supplemental compensation is paid in relation to a particular sale or renewal. As a result, your rates will not differ by whether or not your Intermediary receives supplemental compensation. If your Intermediary collects the premium from you in relation to your Products, your Intermediary may earn a return on such amounts. Additionally, MetLife may have a variety of other relationships with your Intermediary or its affiliates that involve the payment of compensation and benefits that may or may not be related to your relationship with MetLife (e.g., consulting or reinsurance arrangements).

More information about the eligibility criteria, limitations, payment calculations and other terms and conditions under MetLife's base compensation and supplemental compensation plans can be found on MetLife's Web site at whymetlife.com/brokercompensation. Questions regarding Intermediary compensation can be directed to ask4met@metlifeservice.com, or if you would like to speak to someone about Intermediary compensation, please call (800) ASK 4MET.

By checking this box and signing below, I certify that I received a copy of the Intermediary Compensation Notice

Full Legal Name of Group

*Signature of Executive Contact or Benefit
Administrator*

Date



Metropolitan Life Insurance Company, New York, NY
 Small Market Administration
 P.O. Box 14593, Lexington, KY 40512-4593
 Fax: 1-888-505-7446

ENROLLMENT FORM FOR GROUP INSURANCE
SECTION TO BE COMPLETED BY EMPLOYEE

(PLEASE PRINT)

Name of Employee Last First Middle				Social Security No.		Date of Birth (Mo./Day/Yr.)		<input type="checkbox"/> Male <input type="checkbox"/> Female	
Employee's Address Street				City State Zip Code		Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			
Employee's E-mail Address				Phone No. (include area code)					
Name of Employer				Customer Number		Division	Class	Dept Code	
Employer's Street Address			City		State	Zip Code	Employee's Work Location		
Date of Hire (Mo./Day/Yr.)		<input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time		Employee's Occupation			Coverage Effective Date (Mo./Day/Yr.)		
Work Status: <input type="checkbox"/> New Hire <input type="checkbox"/> Active <input type="checkbox"/> Retired <input type="checkbox"/> Disabled <input type="checkbox"/> Rehire <input type="checkbox"/> On Layoff/Leave of Absence		Hours Worked Per Week		<input type="checkbox"/> Hourly Paid <input type="checkbox"/> Annual <input type="checkbox"/> Monthly			Salary \$		
<input type="checkbox"/> Original COBRA Effective Date (Mo./Day/Yr.) _____									
Reason for Enrollment: <input type="checkbox"/> New Coverage <input type="checkbox"/> New Hire/First Time Eligible <input type="checkbox"/> Change in Enrollment <input type="checkbox"/> Family Status Change (not applicable to new enrollments) Date (Mo./Day/Yr.) _____									
COVERAGE REQUEST DATA: I have received and read a copy of my employer's current announcement of the group plan. I want to be covered under the group plan for the benefits for which I am or may become eligible, requested below. I request the following coverage:									
Employee Coverage <input type="checkbox"/> Dental <input type="checkbox"/> Dental Dual Option (Select one option): <input type="checkbox"/> Low Plan <input type="checkbox"/> High Plan <input type="checkbox"/> Voluntary Dental									
Dependent Spouse Coverage (Note: Dependent coverage is provided under the same plan the employee has chosen.) <input type="checkbox"/> Dental/Dental Dual Option/Voluntary Dental									
Dependent Child Coverage (Note: Dependent coverage is provided under the same plan the employee has chosen.) <input type="checkbox"/> Dental/Dental Dual Option/Voluntary Dental									
<input type="checkbox"/> I wish to DECLINE any coverage not checked above for which I may be eligible. For Dental and/or Dependent Dental Coverage, a waiting period may be required before I and/or a dependent can be enrolled. Reason for declining employee and/or dependent coverage (i.e. benefits elsewhere, cost, other): _____									
If applying for Dependent coverage (Spouse or Child), complete the following:									
Number of dependents (including spouse) _____									
Name of Spouse (Last, First, MI)			Date of Birth			Sex (M/F)			
_____			_____			_____			
Name(s) of Child(ren) (Last, First, MI)			Date of Birth			Sex (M/F)		Is child a full-time student?	
_____			_____			_____		<input type="checkbox"/> Yes	
_____			_____			_____		<input type="checkbox"/> Yes	
_____			_____			_____		<input type="checkbox"/> Yes	
_____			_____			_____		<input type="checkbox"/> Yes	

DECLARATION SECTION

Each person signing below declares that all the information given in this enrollment form is true and complete to the best of his/her knowledge and belief.

The employee declares that he or she is actively at work on the date of this enrollment form.

For Changes Requested After Initial Enrollment Period Expires

I understand that if dental coverage is not elected, a waiting period may be required before I can enroll for such coverage after the initial enrollment period has expired.

For Payroll Deduction Authorization By the Employee

I authorize my employer to deduct the required contributions from my pay for the coverage requested in this enrollment form. This authorization applies to such coverage until I rescind it in writing.

Fraud Warning:

If you reside in or are applying for insurance under a policy issued in one of the following states, please read the applicable warning.

New York [only applies to Accident and Health Benefits (AD&D/Disability/Dental)]: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Florida: Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

Massachusetts: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, and may subject such person to criminal and civil penalties.

New Jersey: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

Oklahoma: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Kansas, Oregon, and Vermont: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto may be guilty of insurance fraud, and may be subject to criminal and civil penalties.

Puerto Rico: Any person who, knowingly and with the intent to defraud, presents false information in an insurance request form, or who presents, helps or has presented, a fraudulent claim for the payment of a loss or other benefit, or presents more than one claim for the same damage or loss, will incur a felony, and upon conviction will be penalized for each violation with a fine no less than five thousand (5,000) dollars nor more than ten thousand (10,000), or imprisonment for a fixed term of three (3) years, or both penalties. If aggravated circumstances prevail, the fixed established imprisonment may be increased to a maximum of five (5) years; if attenuating circumstances prevail, it may be reduced to a minimum of two (2) years.

Virginia and Washington: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

All other states:

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or a 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 may be a crime and may subject such person to criminal and civil penalties.

Signature(s): The employee must sign in all cases. Each person signing below acknowledges that they have read and understand the statements and declarations made in this enrollment form.

Employee Signature

Print Name

Date Signed (Mo./Day/Yr.)

Privacy Notice

If you submit a request for insurance (enrollment form) we will evaluate it. We will review the information you give to us and we may confirm it or add to it in the ways explained below.

This Privacy Notice is given to you on behalf of Metropolitan Life Insurance Company.

Please read this Privacy Notice carefully. It describes in broad terms how we learn about you and how we treat the information we get about you. (If anyone else is to be insured under the coverage you've requested, what we say here also applies to information about him or her.) We are required by law to give you this notice.

Why We Need Information: We need to know about you (and anyone else to be insured) so that we can provide the insurance and other products and services you've requested. We may also need it to administer your business with us, evaluate claims, process transactions and run our business. And we need information from you and others to help us verify identities in order to help prevent money laundering and terrorism.

What we need to know includes address, age and other basic information. We may also need more information. This may include information about finances, employment, health, hobbies or business conducted with us, with other MetLife companies (our "affiliates") or with other companies. Our affiliates currently include life, car and home insurers, securities firms, broker-dealers, a bank, a legal plans company and financial advisors.

How We Get Information: What we know about you (and anyone else to be insured) we get mostly from you. But we may also have to find out more from other sources to make sure that what we know is correct and complete. Those sources may include adult relatives, employers, consumer reporting agencies, health care providers and others. Some sources may give us reports and may disclose what they know to others. We may ask for medical information. The Authorization that you sign when you request insurance permits these sources to tell us about you. We may also, at our expense:

- Ask for a medical exam
- Ask health care providers to give us health data, including information about alcohol or drug abuse

We may also ask a consumer reporting agency for a "consumer report" about you (or anyone else to be insured). Consumer reports may tell us about a lot of things, including information about:

- Reputation
- Driving record
- Finances
- Work and work history
- Hobbies and dangerous activities

The information may be kept by the consumer reporting agency and later given to others as permitted by law. The agency will give you a copy of the report it provides to us, if you ask the agency and can provide adequate identification. If you write to us and we have asked for a consumer report about you, we will tell you so and give you the name, address and phone number of the consumer reporting agency.

Another source of information is MIB Group, Inc. ("MIB"). It is a non-profit association of life insurance companies. We and our reinsurers may give MIB health or other information about you. If you apply for life or health coverage from another member of MIB, or claim benefits from another member company, MIB will give that company any information that it has about you. If you contact MIB, it will tell you what it knows about you. You have the right to ask MIB to correct its information about you. You may do so by writing to MIB, Inc., P.O. Box 105, Essex Station, Boston, MA 02112, by calling MIB at (866) 692-6901 (TTY (866) 346-3642 for the hearing impaired), or by contacting MIB at www.mib.com.

How We Protect Information: Because you entrust us with your personal information, we treat what we know about you confidentially. Our employees are told to take care in handling your information. They may get information about you only when there is a good reason to do so. We also take steps to make our computer databases secure and to safeguard the information we have.

How We Use and Disclose Information: We may use what we know to help us serve you better. We may use it, and disclose it to our affiliates and others, for any purpose allowed by law. Generally, we will disclose only the information we consider reasonably necessary to disclose. For instance, we may use your information, and disclose it to others, in order to:

- Help us evaluate your request for a product or service
- Help us process claims and other transactions
- Confirm or correct what we know about you
- Help us prevent fraud, money laundering, terrorism and other crimes by verifying what we know about you
- Help us comply with the law
- Help us run our business
- Process information for us
- Perform research for us
- Audit our business

When we disclose information to others to perform business services for us, they are required to take appropriate steps to protect this information. And they may use the information only for the purposes of performing those business services. Other reasons we may disclose what we know about you include:

- Doing what a court or government agency requires us to do; for example, complying with a search warrant or subpoena;
- Telling another company what we know about you, if we are or may be selling all or any part of our business or merging with another company;
- Giving information to the government so that it can decide whether you may get benefits that it will have to pay for;
- Telling a group customer about its members' claims or cooperating in a group customer's audit of our service;
- Telling your health care provider about a medical problem that you have but may not be aware of;
- Giving your information to a peer review organization if you have health insurance with us; and
- Giving your information to someone who has a legal interest in your insurance, such as someone who lent you money and holds a lien on your insurance or benefits.

How we use and disclose information depends on the products and services you have with us or are covered under. It also depends on laws that apply to those products and services. Unless restricted by law or by agreement, we may use what we know about you to offer you our other products and services. We may share your information with other companies to help us. Here are our other rules on using your information to market products and services:

- We will not share information about you with any of our affiliates for use in marketing its products to you, unless we first notify you. You will then have an opportunity to tell us not to share your information by "opting out."
- Before we share what we know about you with another financial services company to offer you products or services through a joint marketing arrangement, we will let you "opt-out."
- We will not disclose information to unaffiliated companies for use in selling their products to you, except through such joint marketing arrangements.
- We will not share your health information with any other company, even one of our affiliates, to permit it to market its products and services to you.

How You Can See and Correct Your Information: Generally, we will let you review what we know about you if you ask us in writing. (Because of its legal sensitivity, we will not show you anything that we learned in connection with a claim or lawsuit.) In some circumstances we may disclose what we know about your health through your health care provider. If you tell us that what we know about you is incorrect, we will review it. If we agree with you, we will correct our records. If we do not agree with you, you may tell us in writing, and we will include your statement if we give this information to anyone outside MetLife.

You Can Get Other Material from Us: In addition to any other privacy notice we may give you, we must give you a summary of our privacy policy once each year. You may have other rights under the law. If you want to know more about our privacy policy, please visit our website, www.metlife.com, or write to Metropolitan Life Insurance Company, c/o MetLife Privacy Office - Inst, P.O. Box 489, Warwick, RI 02887-9954. When writing to us, please identify the specific product or service you have with us