

MetLife Small Business Center
MMA - Case Information Form
Revised 8/16/2000

Type of Case:	<input type="checkbox"/> New Business	<input type="checkbox"/> Revision	<input type="checkbox"/> Addition
Full Legal Name of Group:	_____		
Effective Date:	_____	Customer #:	_____
		Experience # :	5050001
SBC Sales Office:	<u>Detroit</u>	SBC Sale Rep / Manager:	_____

COVERAGES:	<input type="checkbox"/> Basic Life	<input type="checkbox"/> AD&D	<input type="checkbox"/> Dependent Life	<input type="checkbox"/> Dental	<input type="checkbox"/> Long Term Disability
	<input type="checkbox"/> Short Term Disability				

PRODUCER INFORMATION	Is Producer Appointed? <input type="checkbox"/> Yes <input type="checkbox"/> No
-----------------------------	---

Name of Individual or Corporation to be paid Commissions: _____ (Provide FULL LEGAL name)		
If Corporation, list individual writing producer: _____		
<u>Tax ID# for Compensation Purposes:</u>		
Individual Tax ID (SS#): _____	Corporate Federal Tax ID#: _____	
	Sub Producer SS #: _____	
<u>Street Address:</u>	<u>P.O. Box (if preferred for mailing address):</u>	
_____	_____	
_____	_____	
_____	_____	
Contact at producer's office: _____	Phone#: _____	Fax#: _____
Additional Broker or GA: <input type="checkbox"/> yes <input type="checkbox"/> no (If yes, provide above information and applicable commission % for each)		

COMMISSION AGREEMENT

<input type="checkbox"/> Standard Graded
--

Comments: _____

MetLife Small Business Center
MMA - Case Information Form
Revised 8/16/2000

GROUP INFORMATION	Customer #: _____
--------------------------	--------------------------

Type of Industry: _____ **SIC Code:** _____ **State of Situs:** _____

Employer Tax ID#: _____

Full Legal Name of Group: _____
(as to be shown on the certificate with exact abbreviations, punctuation, or capitalization)

Headquarter's Address:

Street Address

City

State

Zip

of Headquarter's employees _____

PO Box, City, State & Zip

Please check the appropriate box to indicate which address should be used for correspondence/premium statements

Telephone Number: _____

Fax Number: _____

Executive Correspondent: _____
(Authorized to make plan changes) Provide Telephone/Fax #'s if different than above

E-mail address: _____

Benefit Administrator: _____
Provide Telephone/Fax #'s if different than above

E-mail address: _____

List below other Company locations. Please indicate each location that requires a separate bill. If more space is required, please attach a separate page.

Sep Bill	Location Name	Location Address	# of Covered EE's	Tax ID #
<input type="checkbox"/>				
<input type="checkbox"/>				
<input type="checkbox"/>				
<input type="checkbox"/>				
<input type="checkbox"/>				
<input type="checkbox"/>				
<input type="checkbox"/>				

Billing Administration: List Bill

MetLife Small Business Center
MMA - Case Information Form
Revised 8/16/2000

ELIGIBILITY WAITING PERIOD (Length of time an employee must work prior to eligibility for coverage)	Customer #:
---	--------------------

<u>Present Employees</u> (Original Issue Group)	<u>Applicable to Class</u> (Specify class #)	<u>Future Employees</u> (Those Hired After the Original Effective Date of Group)	<u>Applicable to Class</u> (Specify class #)
<input type="checkbox"/> None		<input type="checkbox"/> None	
<input type="checkbox"/> 30 Days		<input type="checkbox"/> 30 Days	
<input type="checkbox"/> 90 Days		<input type="checkbox"/> 90 Days	
<input type="checkbox"/> 1 Month		<input type="checkbox"/> 1 Month	
<input type="checkbox"/> 3 Months		<input type="checkbox"/> 3 Months	
<input type="checkbox"/> Other		<input type="checkbox"/> Other	

INDIVIDUAL EFFECTIVE DATE (following waiting period)

1st of Month – (Coinciding with or next following)
(Coverage Ends on the Last Day of the Month Following Termination of Employment, Except for Disability Which Ends on Date of Termination)

BASIC EARNINGS DEFINITION

Basic Earnings Only (Standard for SBC) Applicable to which coverage:
 Other – Commissions* Yes No Life LTD STD
 Bonuses* Yes No Life LTD STD
Averaged over _____ **Months**
 Other – _____
*must be provided with enrollment census for each individual employee

COVERAGE / EMPLOYER CONTRIBUTION %

Basic Life AD&D %	Short Term Disability %	Long Term Disability %	Employee Dental %	Dependent Dental %			

– Is the Employee Contribution for LTD and/or STD deducted before or after taxes? Before After
– Quarterly reports are standardly provided for Tax Reporting for LTD and STD Coverage.
– Is this part of a Section 125 plan? Yes No
– Do you want ERISA included in your booklet? Yes No
 If yes, provide ERISA Plan # (s): Life _____ STD _____ LTD _____ Dental _____
Please list any employees not actively working as of the effective date and provide reason:

Comments: