



SERFF Tracking Number: META-125588806 State: Arkansas  
 Filing Company: Metropolitan Life Insurance Company. State Tracking Number: 38561  
 Company Tracking Number: B07-55 RW LW  
 TOI: H111 Individual Health - Disability Income Sub-TOI: H111.003 Long Term - Unrelated to marketing  
 with employer or association groups  
 Product Name: Individual Disability Income Insurance  
 Project Name/Number: IDIAPP06-1-AR/B07-55 RW

## Company and Contact

### Filing Contact Information

Robert E. Winograd, Sr. Contract Anayst  
 501 Route 22 (908) 253-2288 [Phone]  
 Bridgewater, NJ 08807

### Filing Company Information

Metropolitan Life Insurance Company.	CoCode: 65978	State of Domicile: New York
1MetLife Plaza	Group Code: -99	Company Type: Life
Long Island City, NY 11101-4015	Group Name:	State ID Number:
(111) 111-1111 ext. [Phone]	FEIN Number: 13-5581829	
	-----	

## Filing Fees

Fee Required?	Yes
Fee Amount:	\$40.00
Retaliatory?	No
Fee Explanation:	\$20.00 Per submitted Form. (2 Forms)
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Metropolitan Life Insurance Company.	\$40.00	04/01/2008	19170975

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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	04/03/2008	04/03/2008

*SERFF Tracking Number:*      *META-125588806*                      *State:*                      *Arkansas*  
*Filing Company:*              *Metropolitan Life Insurance Company.*              *State Tracking Number:*      *38561*  
*Company Tracking Number:*      *B07-55 RW LW*  
*TOI:*                      *H111 Individual Health - Disability Income*              *Sub-TOI:*                      *H111.003 Long Term - Unrelated to marketing  
with employer or association groups*

*Product Name:*                      *Individual Disability Income Insurance*  
*Project Name/Number:*              *IDIAPP06-1-AR/B07-55 RW*

## **Disposition**

Disposition Date: 04/03/2008

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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<b>Item Type</b>	<b>Item Name</b>	<b>Item Status</b>	<b>Public Access</b>
<b>Supporting Document</b>	Certification/Notice	Approved-Closed	Yes
<b>Supporting Document</b>	Application	Approved-Closed	Yes
<b>Supporting Document</b>	Health - Actuarial Justification	Approved-Closed	Yes
<b>Supporting Document</b>	Outline of Coverage	Approved-Closed	Yes
<b>Supporting Document</b>	NAIC Transmittal Form	Approved-Closed	Yes
<b>Supporting Document</b>	Cover Letter	Approved-Closed	Yes
<b>Form</b>	Application	Approved-Closed	Yes
<b>Form</b>	Application Supplement	Approved-Closed	Yes

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## Form Schedule

Lead Form Number: IDIAPP06-1-AR

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed	IDIAPP06-1-AR	Application/ Enrollment Form	Application Enrollment Form	Initial		50	IDIAPP06-1-AR 021607 (Pages 1-16).pdf
Approved-Closed	IDIAPP06-2-BOE	Application/ Enrollment Form	Application Enrollment Supplement Form	Initial		50	IDIAPP06-2-BOE 021607.pdf

**Application  
for Individual  
Disability  
Income  
Insurance  
Part A.**

**PAGE 1**

**1. (a)** Proposed Insured

Full Name First/Given Middle Last/Surname

Suffix (eg., Jr.) Prof. Desig. (Maiden name if applicable) Sex Date of Birth Age

(b) State of Birth \_\_\_\_\_  
(Country, if other than U.S.)

(c) Are you a United States citizen?  YES  NO

**IF NO**, how long have you been a resident of the United States?

\_\_\_\_\_ Years \_\_\_\_\_ Months

Status of your visa (if applicable)  Temporary  Permanent

(d) Social Security Number \_\_\_\_\_

(e) Driver's License Number \_\_\_\_\_ State of Issue \_\_\_\_\_

(f) Do you read and write English?  YES  NO

**IF NO**, primary language you read and write \_\_\_\_\_

**2. Residence:**

Number Street

City State Zip

**3. (a) Business Address:**

Number Street

City State Zip

(b) Mail correspondence to:  Home  Business

(c) Employer's or Business Name: \_\_\_\_\_

(d) Type of Business: \_\_\_\_\_

**Business Owners Only**

(e) What is your percentage of ownership?  
\_\_\_\_\_

(f) How long have you been an owner?  
\_\_\_\_\_

(g) How long has the business existed?  
\_\_\_\_\_

(h) Number of employees in the business:  
\_\_\_\_\_

(i) How is the business organized?  Sole Proprietor  Partnership  C Corporation  
 S Corporation  PA  PC  LLC  LLP

# Application for Individual Disability Income Insurance

## PAGE 2

If you answer No to question (f) or Yes to questions (g), (h) or (i), provide the information in the space allotted. If additional space is needed use the supplemental information section below and on page 10, if necessary.



**4. (a) Primary Occupation:**

**(b)** Your exact duties and the percentage of time devoted to each duty including amount and type of travel, foreign and domestic:

\_\_\_\_\_ %

\_\_\_\_\_ %

\_\_\_\_\_ %

\_\_\_\_\_ %

**(c)** How many employees do you supervise?

\_\_\_\_\_

**(d)** How long have you been employed in your present occupation?

\_\_\_\_\_

**(e)** How long have you been employed by your present employer?

\_\_\_\_\_

**(f)** Are you actively at work at least 30 hours per week in the above occupation?  **YES**  **NO**

**IF NO,** give details. \_\_\_\_\_

**(g)** Do you have any other full or part-time jobs?  **YES**  **NO**

**IF YES,** please give duties, hours worked and travel required.

\_\_\_\_\_

**(h)** Do you plan to change jobs in the next six months?  **YES**  **NO**

**IF YES,** give details. \_\_\_\_\_

**(i)** Are you aware of any fact that could change your occupational status or financial stability?  **YES**  **NO**

**IF YES,** give details. \_\_\_\_\_

**Supplemental Information Section**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

# Application for Individual Disability Income Insurance

**PAGE 3**

## 5. Base Disability Policy and Optional Benefits Applied For:

- Omni Advantage     Omni Select     Omni Essential
- Monthly Benefit \$ \_\_\_\_\_ Premiums  Level  Step Rate
- Maximum Benefit Period (years)  2  5  To Age 65 (N/A for B)  To Age 70\*
- Elimination Period (days)  60  90  180  365\*\*  730\*\*
- Additional Monthly Indemnity (AMI)**
- Monthly Benefit \$ \_\_\_\_\_
- Maximum Benefit Period (years)  2  5  To Age 65 (N/A for B)  To Age 70\*
- Elimination Period (days)  60  90  180  365\*\*  730\*\*

### Disability Income Optional Benefits

- Social Insurance Offset Benefit    Monthly Benefit \$ \_\_\_\_\_
- Elimination Period (days)  60  90  180  365\*\*  730\*\*
- Guaranteed Insurability Option\* \$ \_\_\_\_\_
- Catastrophic Benefit Monthly Amount \$ \_\_\_\_\_
- Good Health Benefit/Refund of Premium
- Residual with Recovery Benefit\*  24 mos.  36 mos.
- Residual without Recovery Benefit\*
- Long-Term Care Guaranteed Purchase Option
- Cost Of Living Adjustment 3% Simple With Buy-Up
- Cost Of Living Adjustment 1-7% Compound With Buy-Up
- Lifetime (N/A in 3A,2A, A, B)  Lifetime for AMI (N/A in 3A, 2A, A, B)
- Automatic Increase Benefit\*
- Your Occupation (N/A in 5I, 4M, 4A, 3A, 2A, A, B) (N/A in Essential)
- Transitional Your Occupation (N/A Essential)
  - 5 year (N/A in 3A, 2A, A, B)                       10 year (N/A in 3A,2A, A, B)
  - To Age 65 (N/A in 3A, 2A, A, B)
- Other \_\_\_\_\_

### Priority Plus Disability Income Insurance\*

- Monthly Benefit \$ \_\_\_\_\_
- Maximum Benefit Period (years)  2  5  To Age 65 (N/A for B)  To Age 70\*
- To Age 70\* Elimination Period (days)  60  90  180  365\*\*  730\*\*
- Social Insurance Substitute (SIS) Monthly Amount \$ \_\_\_\_\_
- Residual
- Supplemental Monthly Benefit (SMB) Monthly Amount \$ \_\_\_\_\_
- Elimination Period (days)  60  90  180
- Additional Monthly Indemnity (AMI) \$ \_\_\_\_\_
- Monthly Benefit \$ \_\_\_\_\_
- Benefit Period (years)  2  5  To Age 65 (N/A for B)  To Age 70\*
- Elimination Period (days)  60  90  180  365\*\*  730\*\*

### Business Overhead Expense Insurance

#### Mortgage Comp Fixed Term Disability Income Insurance (N/A for B)

- Monthly Benefit \$ \_\_\_\_\_
- Duration of Policy (years)  10\*\*\*  15  20  30
- Note: Applicant's Age + Duration Must Not Exceed Age 65*
- Elimination Period (days)  60  90  180
- Mortgage or Loan Date \_\_\_\_\_ Mortgage or Loan Amount \$ \_\_\_\_\_
- % of Mortgage for which you are responsible \_\_\_\_\_%
- Name and Address of Mortgage or/Lending Institution: \_\_\_\_\_

### Buy-Sell Insurance

\* (N/A A,B)  
 \*\* (365 & 730 - Not available with a 2yr B.P.)  
 \*\*\* Class A 10-year Duration Only

Complete the BOE Supplemental Application 

Complete the Buy-Sell Supplemental Application 



# Application for Individual Disability Income Insurance

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**11. Financial Information:**

(Income as reported to IRS for Federal Income Tax Purposes)

	Current Year (Annualized)	Last Year	Two Years Ago
<b>Employee/Salaried Earnings</b>			
(a) Base Salary (W-2 Income)	\$ _____	\$ _____	\$ _____
(b) Commissions	\$ _____	\$ _____	\$ _____
(c) Bonus, Profit Sharing or Incentive Payments	\$ _____	\$ _____	\$ _____
<b>Owner/Shareholder Earnings</b>			
(d) Sole Proprietor net business earnings/losses	\$ _____	\$ _____	\$ _____
(e) Partnership/S-Corporation net business earnings/losses	\$ _____	\$ _____	\$ _____
(f) Net share of corporate earnings/losses	\$ _____	\$ _____	\$ _____
<b>Total Earned Income (Sum of Lines a through f)</b>	<b>\$ _____</b>	<b>\$ _____</b>	<b>\$ _____</b>

**Other Income; Unearned Income**

(g) Dividends and Interest	\$ _____	\$ _____	\$ _____
(h) Net rental income before depreciation	\$ _____	\$ _____	\$ _____
(i) Other (identify source) _____	\$ _____	\$ _____	\$ _____

**Current Net Worth**

(j) Does your net worth exceed \$3,000,000?  YES  NO

	Assets
Cash, Savings, Stocks & Bonds -----	\$ _____
Personal Property (such as jewelry, furnishings) -----	\$ _____
Personal Residence -----	\$ _____
Other Real Estate -----	\$ _____
Business Interest(s) -----	\$ _____
Other (specify source) _____ -----	\$ _____
Less: <b>Indebtedness</b> -----	\$ _____
	<b>Total \$ _____</b>

(If "Yes" give details below. Amounts expressed to the nearest \$100,000 are acceptable)



**Application  
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If you answered  
yes to any of these  
questions, please  
provide information  
in the space allotted.  
(Use Supplemental  
Information Section  
page 10, if necessary.)

**(k)** Which tax forms are being submitted with this application?  
 1040s and all schedules       W-2s       Other \_\_\_\_\_

**(l)** In the past five years have you or any business in which you held at least a 5% interest filed for bankruptcy?       **YES**       **NO**  
**IF YES, give details, including date of discharge, status and type.**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**12. (a)** Have you: had a driver's license suspended or revoked in the last 3 years; been convicted of 3 or more moving violations; been convicted of driving while impaired or intoxicated?       **YES**       **NO**

**IF YES, give details, including date of discharge, status and type.**

**(b)** Other than above, have you been convicted of any felony or misdemeanor, or do you have any charges pending?       **YES**       **NO**

**IF YES, give details.**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**13.** Has any application for a policy of Life, Health or Disability Insurance on you ever been postponed, rated, modified, declined, rescinded or required an extra premium?       **YES**       **NO**

**IF YES, give details.**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**14. (a)** Please provide the status of any licenses required by your profession:

In Effect: \_\_\_\_\_ Not In Effect: \_\_\_\_\_ Not Applicable: \_\_\_\_\_

**(b)** If you indicated that your license is "In Effect" in response to Question 14(a), has your license ever been: subject to any disciplinary action, revoked, suspended, or are there any charges currently pending against your license?       **YES**       **NO**  
 **NOT APPLICABLE**

If you indicated that your license is "**Not in Effect**" in response to Question 14(a) or "**Yes**" to Question 14(b), please provide information in the space allotted below:

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**15.** Have you flown as a pilot, student pilot, or crew member in the last 2 years or do you intend to do so in the next 12 months?       **YES**       **NO**

**IF YES, complete the Aviation Questionnaire.**

**16.** Have you ever engaged in or do you plan to engage in: Automotive, Motorcycle (including off road use) or Power Boat Racing; Bobsledding; Snowboarding; Skiing; Underwater Cave Exploration; Water Skiing; White Water Rafting; Spelunking; Ballooning; Scuba Diving; Sky Diving; Bungee Jumping; Hang Gliding (including Slope Soaring, Parakiting, Ultralighting, etc.); Mountain Climbing; Parachuting; Snowmobile Racing; Slalom Racing; Rodeo Activities; Karate or Martial Arts?       **YES**       **NO**

**IF YES, complete the Avocation Questionnaire.**

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**Statements By the Proposed Insured**

1. (a) Height \_\_\_\_\_ (b) Weight \_\_\_\_\_
2. How much time have you lost from work during the past 5 years because of accident or sickness? \_\_\_\_\_ Give details below.  None
3. Date you last used tobacco in any form: Date \_\_\_\_\_ Type \_\_\_\_\_  
 Never used tobacco
4. (a) Please provide the name, address and phone number of your personal/primary care physician(s) as well as the date and reason for your last consultation.  
If none, check here

Name, Address and Phone Number	Date	Reasons for Consultation: Nature, Severity and Frequency of Symptoms; Diagnosis, Treatment and Current Status of Condition

(b) In addition, in the past 5 years, has any Acupuncturist, Chiropractor, Counselor, Health Facility, Practitioner, Psychiatrist, Psychologist, Social Worker, or Therapist examined or treated you?  YES  NO

Give details below for each instance:

**(Use Supplemental Information Section, page 10 if more space is needed)**

Name, Address and Phone Number of each Acupuncturist, Chiropractor, Counselor, Health Facility, Physician, Practitioner, Psychiatrist, Psychologist, Social Worker or Therapist	Date	Reasons for Consultation: Nature, Severity and Frequency of Symptoms; Diagnosis, Treatment and Current Status of Condition

# Application for Individual Disability Income Insurance

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If you answered  
yes to any of these  
questions, please  
provide information  
in the space allotted.  
(Use Supplemental  
Information Section  
page 10, if necessary.)

**5. Have you EVER** received treatment, attention or advice for; been told that you had; or had any known indication of:

- |  |                              |                             |
|--|------------------------------|-----------------------------|
| (a) Any disease or disorder of the heart; arteries or veins; chest pains; high (hypertension) or low (hypotension) blood pressure?   | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| (b) Arthritis; any disease, disorder or deformity of the bones, muscles, tendons, or joints, including the spine; any neck or back problems or disorders; carpal tunnel syndrome; any auto immune diseases such as Lupus or Scleroderma? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| (c) Any mental, nervous or emotional problem, condition or disorder, including anxiety, depression or stress?  | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| (d) Stroke, embolism, thrombosis?  | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| (e) Cancer, tumor or polyp?  | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| (f) Diabetes, high blood sugar or low blood sugar (Hypoglycemia)?  | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| (g) Any disease or disorder of the lungs or respiratory system, asthma, allergy, emphysema, or Chronic Obstructive Pulmonary Disease?  | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| (h) Any disease or disorder of the liver, gall bladder, pancreas, digestive tract, including intestines; ulcer, colitis, hemorrhoids, or hernia?   | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| (i) Memory loss, loss of concentration, fatigue, neurologic disorder, unconsciousness, loss of cognition, dizziness, paralysis or numbness, impairment of nervous system, epilepsy, seizures, migraine headaches or post polio syndrome? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| (j) Any disease or disorder of the urinary tract or kidney; sugar, albumin or blood in urine?  | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| (k) Any physical deformity or physical impairment?   | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| (l) Any disease or disorder of the skin?   | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| (m) Any disease or disorder of glands; anemia, leukemia, bleeding or clotting disorder or other blood disorders?   | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| (n) Any disease or disorder of the prostate or testes; uterus, ovaries or breasts; pre-term labor or infertility?  | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| (o) Any disease or disorder or impairment of the eyes, ears, mouth, nose or throat; any loss of vision or hearing?   | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| (p) Endocrine disorders or goiter or disease or disorder of the thyroid gland?   | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| (q) Any sexually transmitted disease, Positive HIV test; Acquired Immune Deficiency Syndrome or other immune deficiency?   | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| (r) Adult Attention Deficit Disorder, Adult Attention Hyperactivity Disorder, Alzheimer's Disease, Chronic Fatigue Syndrome, Epstein-Barr Virus, Fibromyalgia, Lyme Disease, Myalgia or Encephalitis?                                    | <input type="checkbox"/> YES | <input type="checkbox"/> NO |

**6. Have you EVER:**

- |  |                              |                             |
|--|------------------------------|-----------------------------|
| (a) Been advised to have any medical test or surgical operation that was not performed, or had any medical test or surgical operation performed, or gone to a hospital, doctor's office, clinic, dispensary or sanatorium for observation, examination or treatment; and this information has not been revealed by previous questions? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| (b) Been advised to modify or restrict eating, drinking, or living habits because of any health conditions?  | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| (c) Had persistent cough, pneumonia, chest discomfort, muscle weakness, unexplained weight loss of 10 pounds or more, swollen glands, patches in the mouth, visual disturbance, recurring diarrhea, fever or infection?  | <input type="checkbox"/> YES | <input type="checkbox"/> NO |

# Application for Individual Disability Income Insurance

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If you answered yes to any of these questions, please provide information in the space allotted. (Use Supplemental Information Section below and on page 10, if necessary.)

7. (a) Are you currently disabled, or do you expect to be disabled?  YES  NO
- (b) Have you received or applied for disability, workers' compensation, or military disability benefits from any source in the past 5 years?  YES  NO
- (c) Are you pregnant?  YES  NO  
**IF YES, expected delivery date?** \_\_\_\_\_
- (d) Within the last five years, have you taken any prescription medications, over the counter herbal medications, or been advised by a physician to take any medications, or are you now taking any prescription medications or over the counter herbal medications?  YES  NO  
**IF YES, give details.**
- \_\_\_\_\_
- \_\_\_\_\_

8. **Have you EVER:**  
 used heroin, cocaine, marijuana, barbiturates or other drugs, except as  YES  NO prescribed by a physician or other practitioner; abused alcohol or drugs; or received treatment or advice regarding the use of alcohol or drugs from a physician, other practitioner, or organization which assists those who have an alcohol or drug problem?

9. **For any "Yes" answer to Questions 5 through 8, give details: (Use Supplemental Information Section if more space is needed)**

Item No.	Name, Address and Phone Number of each Acupuncturist, Chiropractor, Counselor, Health Facility, Physician, Practitioner, Psychiatrist, Psychologist, Social Worker or Therapist	Date	Reasons for Consultation: Nature, Severity and Frequency of Symptoms; Diagnosis, Treatment and Current Status of Condition

**(Supplemental Information Section for Applicant)**

Provide additional application information on this page. This information will be included in the Policy.




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**Agreement**

I have read this application and any supplemental applications or amendments, and to the best of my knowledge and belief, I agree that: (a) All statements and answers are true and complete; and (b) All of the information is correctly recorded in the application; and (c) Such written statements may be relied on by MetLife in order to determine if I qualify for issue of a policy.

I understand that the application seeks full disclosure of the information sought; and that no one has the right to alter or exclude or to direct me to alter or exclude any information from the application.

I understand that paying my insurance premiums monthly may result in a higher yearly out-of-pocket cost than a less frequent premium mode.

I understand that this application, any paramedical application, and any supplemental applications or amendments will become a part of any policies issued as a result of this application.

I understand that MetLife will rely on the fact that coverage under any policies listed in Part A, Question 10 on page 4 will end on the Effective Date of Termination shown. If such coverage does not end at that time, any policy issued as a result of this application will be void from the beginning; all premiums will be returned; and no benefits will be payable. MetLife has the right to contact any listed insurer after the Effective Date of Termination to confirm that coverage has ended.

**Submission of Application Without Payment of Premium and Conditional Premium Receipt**

The policy will not be in effect and MetLife will not have liability until (a) a policy is delivered and is accepted by me; and (b) the full first premium due is paid. The policy will then be in effect as of its date of issue if at the time it is delivered:

- (a) the condition of my health, the amount of my income, and the status of my employment or occupation are the same as given in the application; and
- (b) I, the proposed insured, have not received any medical advice or treatment from a physician or other medical practitioner since the date of this application.

If there are any exceptions to (a) or (b), the policy will not be in effect and I will give MetLife details in writing.

**Submission of Application With Payment of Premium and Conditional Premium Receipt**

If I submit (1) month's premium and receive a Conditional Premium Receipt at the time I sign and submit this Application, coverage under a policy and the Conditional Premium Receipt will not be in effect and MetLife will have no liability until either MetLife issues the policy as applied for by me, or MetLife issues the policy other than as applied for by me and which is accepted by me.

If I become disabled while the Conditional Premium Receipt is in effect, the Maximum Benefit Period for all disability benefits paid under a Disability Income Insurance Policy issued to me as a result of that disability is 24 months. If I become disabled during the same time period under the terms of a Business Overhead Expense Policy, there is a limitation as to the amount of expenses for which I will be reimbursed under the policy issued to me. If I become disabled during the same time period under the terms of a Disability Buy-Sell Insurance Policy, there is a limitation on the amount of the Buy-Out Benefit I will receive under the policy issued to me.

**Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines or confinement in prison.**

Signature of Witness (Licensed Resident Agent)	Place	Mo. Day Yr.	Signature of Proposed Insured
<b>X</b>			<b>X</b>

**Application  
for Individual  
Disability  
Income  
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**Personal History Interview**

As part of your application process, MetLife, or someone it designates, will telephone you to verify information in this application, including your occupation, medical history and income. This phone call will take between 15 and 20 minutes to complete. Please indicate below, the best way to reach you.

**Home:**

		<input type="checkbox"/> AM <input type="checkbox"/> PM	(    )
Day of Week	Date	Time	Phone

**Work:**

		<input type="checkbox"/> AM <input type="checkbox"/> PM	(    )
Day of Week	Date	Time	Phone

**Other:**

		<input type="checkbox"/> AM <input type="checkbox"/> PM	(    )
Day of Week	Date	Time	Phone

**IDI Bank Draft Authorization**

Be sure to enclose a voided blank check for the account you wish to use and sign this authorization.

I authorize:

- (1) MetLife to initiate monthly deductions from my checking account, by electronic or other means, as payment for the coverage level selected; and
- (2) the financial institution on which my enclosed sample check (marked VOID) is drawn, to:
  - (a) accept the deductions initiated by MetLife; and
  - (b) give MetLife my most recent address upon MetLife's request.

Withdrawals will continue until MetLife has had a reasonable opportunity to act upon my written request to end this service. I authorize deductions to be taken on the effective date of the policy and on the \_\_\_\_\_ day of the month, or the next business day. If no day is selected, deductions will be taken on the first business day of the month.

\_\_\_\_\_  
Signature of Account Holder for Monthly Automatic Deductions

\_\_\_\_\_  
Date

If your check is drawn on a credit union, indicate credit union phone number:

( \_\_\_\_\_ ) \_\_\_\_\_

## Application for Individual Disability Income Insurance

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\* Home office copy,  
do not detach

### RECEIPT AND CONDITIONAL PREMIUM RECEIPT for Disability Income Insurance

Received from: \_\_\_\_\_ \$ \_\_\_\_\_ on \_\_\_\_\_  
Name of Proposed Insured (Please print) Disability Income Premium Date

\$ \_\_\_\_\_ on \_\_\_\_\_  
Overhead Expense Premium Date

\$ \_\_\_\_\_ on \_\_\_\_\_  
Buy-Sell Premium Date

\$ \_\_\_\_\_ on \_\_\_\_\_  
Total Date

**THERE IS NO COVERAGE IN EFFECT UNDER THIS RECEIPT UNLESS METLIFE ISSUES A STANDARD POLICY OR ISSUES A NON-STANDARD POLICY, WHICH YOU ACCEPT. PLEASE NOTE THAT ANY DISABILITY THAT IS INCURRED DURING THE RECEIPT PERIOD IS SUBJECT TO THE LIMITATIONS SET FORTH IN THE COVERAGE, TERMS AND LIMITATIONS SECTION BELOW.**

#### **I. DEFINITIONS:**

**Coverage Date** means the later of: (1) the date the application was signed by You; or (2) the date You complete a medical examination if such an examination is required by Us.

**Disabled or Disability** means a disability as defined in any policy issued to You.

**Initial Application Requirements** means: (1) a completed application in which You have answered "No" to Question 7(a) in Part B; (2) if required by Us, a completed medical examination and receipt by Us of any attending physician statement(s), medical records and any other medical documents that We may require; and (3) at least one (1) month's premium must be submitted to Us at the time the application is signed. The full amount of any check, draft or money order paid under this Receipt must be honored on its first presentation for payment.

**MetLife, We, Our or Us** means Metropolitan Life Insurance Company.

**Receipt** means Conditional Premium Receipt.

**Receipt Period** means the period starting on the Coverage Date and ending on the earliest of: (a) the date MetLife issues a Standard Policy; (b) the date a Non-Standard Policy is delivered and accepted by You; or (c) 90 days after the Coverage Date.

**Standard Policy** means a policy issued for the coverage You applied for with Us.

**Non-Standard Policy** means a policy issued for coverage other than as applied for by You.

**You or Your** means the proposed insured.

#### **II. CONDITIONS OF COVERAGE:**

1. If, after MetLife receives (a) the Initial Application Requirements; and (b) evidence of insurability acceptable to Us, We determine that as of the Coverage Date You are insurable based upon Our underwriting criteria, then coverage under this Receipt and the policy issued to You will take effect on the Coverage Date.

**DURING THE RECEIPT PERIOD YOU WILL HAVE LIMITED COVERAGE AS OF THE COVERAGE DATE AS PROVIDED FOR IN THIS RECEIPT, EVEN IF THE POLICY IS ISSUED TO YOU WITH A LATER EFFECTIVE DATE.**

Any changes in Your health after the Coverage Date will not affect Our underwriting decision.

2. If We issue a policy to You, any unpaid balance of the first full premium due, in accordance with the premium payment mode You have selected, must be paid upon delivery of the policy issued to You.

#### **III. COVERAGE, TERMS AND LIMITATIONS:**

This Receipt covers a disability that is incurred during the Receipt Period. If you become disabled under the terms of a Disability Income Insurance Policy, We will pay benefits. **Regardless of the Maximum Benefit Period set forth in the Disability Income Insurance Policy issued to You, the Maximum Benefit Period for all benefits paid as a result of a disability incurred during the Receipt Period is 24 months.**

**Application  
for Individual  
Disability  
Income  
Insurance**

**PAGE 14**

\* Home office copy,  
do not detach

If You become disabled under the terms of a Business Overhead Expense Policy during the Receipt Period, We will reimburse covered expenses resulting from that disability. **All expenses reimbursed as a result of a disability incurred while this Receipt is in effect are limited to the lesser of: (1) for a Standard Policy or a Non-Standard Policy accepted by You, the expenses to be paid for the maximum benefit period; or (2) \$120,000.**

If You become disabled under the terms of a Disability Buy-Sell Insurance Policy during the Receipt Period, We will pay a Buy-Out Benefit. **The Buy-Out Benefit will be limited to the lesser of (1) for a Standard Policy or a Non-Standard Policy accepted by You, the Maximum Buy-Out Benefit; or (2) \$120,000.**

Please note, however, that this Receipt and any policy referenced above which is issued to You or any claim made during the Receipt Period will be subject to certain proof requirements, exclusions, limitations and other provisions that may prevent an insured from receiving any benefits under this Receipt or any policy referenced above, including, but not limited to, provisions under which this Receipt or the policy issued to You can be voided by MetLife. **However, with respect to a disability incurred during the Receipt Period, the Effective Date will be deemed the Coverage Date for purposes of applying the Preexisting Conditions Exclusion in any policy issued to You.**

**IV. NO COVERAGE UNDER THIS RECEIPT:**

If We: (1) issue a Standard Policy or Non-Standard Policy which You decline to accept delivery of; or (2) do not issue a policy within 60 days from the date the application was signed by You, there will be no coverage under this Receipt and any premium paid will be returned to You.

**V. LIMITATION ON AUTHORITY:**

No one but the President, the Secretary or a Vice-President of MetLife may change or waive the terms of this Receipt. No agent, financial services representative or medical examiner has authority to determine insurability or to make or modify any contract of insurance or waive any of Our requirements.

**CAUTION: MetLife relies on Your answers to all questions in Part B of the application in accepting payment and issuing this Receipt. This Receipt will be null and void and the premium paid will be returned if any of these answers are incorrect or incomplete, or if MetLife does not issue a policy within 60 days from the date the application was signed by You.**

I have read this Receipt, and reviewed my answers to all questions in Part B of the application. I represent that the answers to all those questions are true and complete. I understand and agree that if the answers to any of the questions in Part B of the application are not true and complete or if MetLife does not issue a policy within 60 days from the date the application was signed by me, the amount of premium tendered will be returned and this Receipt will be null and void. I understand and agree to all of the terms of this Receipt. I have received a copy of this Receipt.

X \_\_\_\_\_ X \_\_\_\_\_  
Signature of Proposed Insured Date

**No agent or financial services representative is authorized to accept any payment with the application if You answered "Yes" to (or left blank) any of the questions in Part B of Your application.**

Receipt of \$ \_\_\_\_\_ is acknowledged from \_\_\_\_\_ in connection with the application for Disability Income/Business Overhead Expense/Buy-Sell insurance on this date \_\_\_\_\_.

By: \_\_\_\_\_ Metropolitan Life Insurance Company  
Countersignature

Title: \_\_\_\_\_ District/Branch: \_\_\_\_\_

**ALL CHECKS MUST BE MADE PAYABLE TO METROPOLITAN LIFE INSURANCE COMPANY. DO NOT MAKE CHECK PAYABLE TO THE AGENT OR LEAVE THE PAYEE BLANK.**

## Application for Individual Disability Income Insurance

PAGE 15

\* Detach for applicant

### RECEIPT AND CONDITIONAL PREMIUM RECEIPT for Disability Income Insurance

Received from: \_\_\_\_\_ \$ \_\_\_\_\_ on \_\_\_\_\_  
Name of Proposed Insured (Please print) Disability Income Premium Date

\$ \_\_\_\_\_ on \_\_\_\_\_  
Overhead Expense Premium Date

\$ \_\_\_\_\_ on \_\_\_\_\_  
Buy-Sell Premium Date

\$ \_\_\_\_\_ on \_\_\_\_\_  
Total Date

**THERE IS NO COVERAGE IN EFFECT UNDER THIS RECEIPT UNLESS METLIFE ISSUES A STANDARD POLICY OR ISSUES A NON-STANDARD POLICY, WHICH YOU ACCEPT. PLEASE NOTE THAT ANY DISABILITY THAT IS INCURRED DURING THE RECEIPT PERIOD IS SUBJECT TO THE LIMITATIONS SET FORTH IN THE COVERAGE, TERMS AND LIMITATIONS SECTION BELOW.**

#### I. DEFINITIONS:

**Coverage Date** means the later of: (1) the date the application was signed by You; or (2) the date You complete a medical examination if such an examination is required by Us.

**Disabled or Disability** means a disability as defined in any policy issued to You.

**Initial Application Requirements** means: (1) a completed application in which You have answered "No" to Question 7(a) in Part B; (2) if required by Us, a completed medical examination and receipt by Us of any attending physician statement(s), medical records and any other medical documents that We may require; and (3) at least one (1) month's premium must be submitted to Us at the time the application is signed. The full amount of any check, draft or money order paid under this Receipt must be honored on its first presentation for payment.

**MetLife, We, Our or Us** means Metropolitan Life Insurance Company.

**Receipt** means Conditional Premium Receipt.

**Receipt Period** means the period starting on the Coverage Date and ending on the earliest of: (a) the date MetLife issues a Standard Policy; (b) the date a Non-Standard Policy is delivered and accepted by You; or (c) 90 days after the Coverage Date.

**Standard Policy** means a policy issued for the coverage You applied for with Us.

**Non-Standard Policy** means a policy issued for coverage other than as applied for by You.

**You or Your** means the proposed insured.

#### II. CONDITIONS OF COVERAGE:

1. If, after MetLife receives (a) the Initial Application Requirements; and (b) evidence of insurability acceptable to Us, We determine that as of the Coverage Date You are insurable based upon Our underwriting criteria, then coverage under this Receipt and the policy issued to You will take effect on the Coverage Date.

**DURING THE RECEIPT PERIOD YOU WILL HAVE LIMITED COVERAGE AS OF THE COVERAGE DATE AS PROVIDED FOR IN THIS RECEIPT, EVEN IF THE POLICY IS ISSUED TO YOU WITH A LATER EFFECTIVE DATE.**

Any changes in Your health after the Coverage Date will not affect Our underwriting decision.

2. If We issue a policy to You, any unpaid balance of the first full premium due, in accordance with the premium payment mode You have selected, must be paid upon delivery of the policy issued to You.

#### III. COVERAGE, TERMS AND LIMITATIONS:

This Receipt covers a disability that is incurred during the Receipt Period. If you become disabled under the terms of a Disability Income Insurance Policy, We will pay benefits. **Regardless of the Maximum Benefit Period set forth in the Disability Income Insurance Policy issued to You, the Maximum Benefit Period for all benefits paid as a result of a disability incurred during the Receipt Period is 24 months.**

**Application  
for Individual  
Disability  
Income  
Insurance**

**PAGE 16**

\* Detach for applicant

If You become disabled under the terms of a Business Overhead Expense Policy during the Receipt Period, We will reimburse covered expenses resulting from that disability. **All expenses reimbursed as a result of a disability incurred while this Receipt is in effect are limited to the lesser of: (1) for a Standard Policy or a Non-Standard Policy accepted by You, the expenses to be paid for the maximum benefit period; or (2) \$120,000.**

If You become disabled under the terms of a Disability Buy-Sell Insurance Policy during the Receipt Period, We will pay a Buy-Out Benefit. **The Buy-Out Benefit will be limited to the lesser of (1) for a Standard Policy or a Non-Standard Policy accepted by You, the Maximum Buy-Out Benefit; or (2) \$120,000.**

Please note, however, that this Receipt and any policy referenced above which is issued to You or any claim made during the Receipt Period will be subject to certain proof requirements, exclusions, limitations and other provisions that may prevent an insured from receiving any benefits under this Receipt or any policy referenced above, including, but not limited to, provisions under which this Receipt or the policy issued to You can be voided by MetLife. **However, with respect to a disability incurred during the Receipt Period, the Effective Date will be deemed the Coverage Date for purposes of applying the Preexisting Conditions Exclusion in any policy issued to You.**

**IV. NO COVERAGE UNDER THIS RECEIPT:**

If We: (1) issue a Standard Policy or Non-Standard Policy which You decline to accept delivery of; or (2) do not issue a policy within 60 days from the date the application was signed by You, there will be no coverage under this Receipt and any premium paid will be returned to You.

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I have read this Receipt, and reviewed my answers to all questions in Part B of the application. I represent that the answers to all those questions are true and complete. I understand and agree that if the answers to any of the questions in Part B of the application are not true and complete or if MetLife does not issue a policy within 60 days from the date the application was signed by me, the amount of premium tendered will be returned and this Receipt will be null and void. I understand and agree to all of the terms of this Receipt. I have received a copy of this Receipt.

X \_\_\_\_\_ X \_\_\_\_\_  
Signature of Proposed Insured Date

**No agent or financial services representative is authorized to accept any payment with the application if You answered "Yes" to (or left blank) any of the questions in Part B of Your application.**

Receipt of \$ \_\_\_\_\_ is acknowledged from \_\_\_\_\_ in connection with the application for Disability Income/Business Overhead Expense/Buy-Sell insurance on this date \_\_\_\_\_.

By: \_\_\_\_\_ Metropolitan Life Insurance Company  
Countersignature

Title: \_\_\_\_\_ District/Branch: \_\_\_\_\_

**ALL CHECKS MUST BE MADE PAYABLE TO METROPOLITAN LIFE INSURANCE COMPANY. DO NOT MAKE CHECK PAYABLE TO THE AGENT OR LEAVE THE PAYEE BLANK.**

**DISABILITY BUSINESS OVERHEAD  
EXPENSE SUPPLEMENT APPLICATION**

**BUSINESS  
OVERHEAD  
EXPENSE  
SUPPLEMENT  
APPLICATION**

1. Name of Proposed Insured:

\_\_\_\_\_

First

Middle

Last

2. Proposed Insured's Social Security number: \_\_\_\_\_

3. For applicants, other than those who bill directly for time, please describe the personal services that you provide to your business without which its ability to produce revenue would be substantially reduced.

\_\_\_\_\_  
\_\_\_\_\_

4. How many are employed in the business? (Excluding Yourself) \_\_\_\_\_

5. How many of these employees are members of your profession? (Excluding Yourself) \_\_\_\_\_

6. How many of these employees are members of your immediate family? \_\_\_\_\_

7. List your average monthly business overhead expenses during the past 6 months. If you share monthly business expenses with others, list only your share. Exclude salaries, fees, drawing accounts, profits or any other remuneration for: You; any partners; any member of your profession or person performing duties similar to yours; any person to whom you are related by blood or marriage; shareholders:

Rent \$ \_\_\_\_\_

Taxes (not income taxes) and mortgage interest payments \$ \_\_\_\_\_

Other interest on business **indebtedness** \$ \_\_\_\_\_

Utilities:

Electricity \$ \_\_\_\_\_

Telephone \$ \_\_\_\_\_

Maintenance Services \$ \_\_\_\_\_

Property & Liability Insurance \$ \_\_\_\_\_

Depreciation of Business Equipment \$ \_\_\_\_\_

Employee's salaries (excluding items in 7 above) \$ \_\_\_\_\_

Other normal and customary fixed office expenses (specify below): \$ \_\_\_\_\_

Total \$ \_\_\_\_\_

Details of other normal and customary fixed office expenses:

\_\_\_\_\_  
\_\_\_\_\_

8. Business Overhead Insurance being applied for:

Maximum Monthly Benefit for Covered Monthly Expense: \$ \_\_\_\_\_

Elimination Period:  30 days  60 days  90 days

Maximum Benefit Period:  12 months  18 months  24 months

9. Rider:

Guaranteed Insurability Rider:  Yes  No \$ Amount \_\_\_\_\_

This Supplemental Application will become part of my Disability Income Insurance Application and any policy issued. I have read this application and agree that all statements and answers given are true and complete to the best of my knowledge and belief.

X \_\_\_\_\_  
(Signature of Proposed Insured)

X \_\_\_\_\_  
Date (Month/Day/Year)

X \_\_\_\_\_  
(Witness Signature)

X \_\_\_\_\_  
Date (Month/Day/Year)

*SERFF Tracking Number:*      *META-125588806*                      *State:*                      *Arkansas*  
*Filing Company:*              *Metropolitan Life Insurance Company.*              *State Tracking Number:*      *38561*  
*Company Tracking Number:*      *B07-55 RW LW*  
*TOI:*                      *H111 Individual Health - Disability Income*              *Sub-TOI:*                      *H111.003 Long Term - Unrelated to marketing*  
*Product Name:*                      *Individual Disability Income Insurance*  
*Project Name/Number:*              *IDIAPP06-1-AR/B07-55 RW*

## **Rate Information**

Rate data does NOT apply to filing.

SERFF Tracking Number: META-125588806 State: Arkansas  
 Filing Company: Metropolitan Life Insurance Company. State Tracking Number: 38561  
 Company Tracking Number: B07-55 RW LW  
 TOI: H111 Individual Health - Disability Income Sub-TOI: H111.003 Long Term - Unrelated to marketing  
 with employer or association groups  
 Product Name: Individual Disability Income Insurance  
 Project Name/Number: IDIAPP06-1-AR/B07-55 RW

## Supporting Document Schedules

<b>Satisfied -Name:</b>	Certification/Notice	<b>Review Status:</b>	Approved-Closed	04/03/2008
<b>Comments:</b>	Attached are the required Certification/Notice.			
<b>Attachments:</b>	ARCERTREAD.pdf ARCERTREG19.pdf			
<b>Bypassed -Name:</b>	Application	<b>Review Status:</b>	Approved-Closed	04/03/2008
<b>Bypass Reason:</b>	The submitted Applications are attached under the Forms Schedule Tab.			
<b>Comments:</b>				
<b>Bypassed -Name:</b>	Health - Actuarial Justification	<b>Review Status:</b>	Approved-Closed	04/03/2008
<b>Bypass Reason:</b>	Not Applicable.			
<b>Comments:</b>				
<b>Bypassed -Name:</b>	Outline of Coverage	<b>Review Status:</b>	Approved-Closed	04/03/2008
<b>Bypass Reason:</b>	Not Applicable.			
<b>Comments:</b>				
<b>Satisfied -Name:</b>	NAIC Transmittal Form	<b>Review Status:</b>	Approved-Closed	04/03/2008
<b>Comments:</b>	Attached is the NAIC Transmittal Form.			
<b>Attachment:</b>	_RW_ NAIC Transmittal Form _NW_ .pdf			

**Review Status:**

SERFF Tracking Number: META-125588806 State: Arkansas  
Filing Company: Metropolitan Life Insurance Company. State Tracking Number: 38561  
Company Tracking Number: B07-55 RW LW  
TOI: H111 Individual Health - Disability Income Sub-TOI: H111.003 Long Term - Unrelated to marketing  
with employer or association groups  
Product Name: Individual Disability Income Insurance  
Project Name/Number: IDIAPP06-1-AR/B07-55 RW

**Satisfied -Name:** Cover Letter Approved-Closed 04/03/2008

**Comments:**

Attached is the Cover Letter.

**Attachment:**

\_RW\_ Long Form App 2007 Cover Letter.pdf





Metropolitan Life Insurance Company  
NAIC Company Number: 65978  
NAIC Group Number: 241

**ARKANSAS FLESCH CERTIFICATION**

I certify that the form shown below has achieved the Flesch Reading Ease Score shown below and complies with the requirements of Ark. Stat. Ann. Section 66-3251 through 66-3258, cited as the Life and Disability Insurance Policy Language Simplification Act.

Form No.	Form Description	Flesch Score
IDIAPP06-1-AR	Application	50.28
IDIAPP06-2-BOE	Supplemental Application	50.03

Herbert B. Brown Jr.  
Vice President



Metropolitan Life Insurance Company  
NAIC Company Number: 65978  
NAIC Group Number: 241

**ARKANSAS CERTIFICATION**  
**Rule and Regulation 19**  
**Unfair Sex Discrimination in the Sale of Insurance**

I certify that this submission meets the provisions of Rule and Regulation 19, and all applicable requirements of the Arkansas Department of Insurance.

A handwritten signature in black ink, appearing to read "Herbert B. Brown Jr." in a cursive style.

Herbert B. Brown Jr.  
Vice President

**Life, Accident & Health, Annuity, Credit Transmittal Document**

Reset Form

<b>1.</b>	<b>Prepared for the State of</b>	ARKANSAS					
<b>2.</b>	<b>Department Use Only</b>						
	<b>State Tracking ID</b>						
<b>3.</b>	<b>Insurer Name &amp; Address</b>	<b>Domicile</b>	<b>Insurer License Type</b>	<b>NAIC Group #</b>	<b>NAIC #</b>	<b>FEIN #</b>	<b>STATE #</b>
	Metropolitan Life Insurance Co. One MetLife Plaza Long Island City, NY 11101	New York		241	65978	13-5581829	
<b>4.</b>	<b>Contact Name &amp; Address</b>	<b>Telephone #</b>	<b>Fax #</b>		<b>E-mail Address</b>		
	Robert Winograd Metropolitan Life Insurance Co. 501 Route 22 Bridgewater Twncsp, NJ 08807	(908) 253-2288	(908) 253-2126		rwinograd@metlife.com		
<b>5.</b>	<b>Requested Filing Mode</b>	<input checked="" type="checkbox"/> Review & Approval <input type="checkbox"/> File & Use <input type="checkbox"/> Informational <input type="checkbox"/> Combination (please explain): _____ <input type="checkbox"/> Other (please explain): _____					
<b>6.</b>	<b>Company Tracking Number: B07-55 RW</b>						
<b>7.</b>	<input checked="" type="checkbox"/> New Submission <input type="checkbox"/> Resubmission <input type="checkbox"/> Previous file #						
<b>8.</b>	<b>Market</b>	<input checked="" type="checkbox"/> Individual <input type="checkbox"/> Franchise  <input type="checkbox"/> Small <input type="checkbox"/> Large <input type="checkbox"/> Small and Large <input type="checkbox"/> Employer <input type="checkbox"/> Association <input type="checkbox"/> Blanket <input type="checkbox"/> Discretionary <input type="checkbox"/> Trust <input type="checkbox"/> Other: _____					
<b>9.</b>	<b>Type of Insurance</b>	H11I Individual Health – Disability Income					
<b>10.</b>	<b>Product Coding Matrix Matrix Filing Code</b>	H11I.003 - Long Term					

<b>11.</b>	<b>Submitted Documents</b>	<input checked="" type="checkbox"/> <b>FORMS</b> <input type="checkbox"/> Policy <span style="margin-left: 150px;"><input type="checkbox"/> Outline of Coverage</span> <span style="margin-left: 100px;"><input type="checkbox"/> Certificate</span> <input checked="" type="checkbox"/> Application <span style="margin-left: 100px;"><input type="checkbox"/> Rider/Endorsement</span> <span style="margin-left: 100px;"><input type="checkbox"/> Advertising</span> <input type="checkbox"/> Schedule of Benefits <span style="margin-left: 100px;"><input type="checkbox"/> Other</span>  <input type="checkbox"/> <b>RATES</b> <input type="checkbox"/> New Rate <span style="margin-left: 50px;"><input type="checkbox"/> Revised Rate</span>  <input type="checkbox"/> <b>FILING OTHER THAN FORM OR RATES:</b> Please explain: _____  <b>SUPPORTING DOCUMENTATION</b> <input type="checkbox"/> Articles of Incorporation <span style="margin-left: 100px;"><input type="checkbox"/> Third Party Authorization</span> <input type="checkbox"/> Association Bylaws <span style="margin-left: 100px;"><input type="checkbox"/> Trust Agreements</span> <input type="checkbox"/> Statement of Variability <span style="margin-left: 100px;"><input checked="" type="checkbox"/> Certifications</span> <input type="checkbox"/> Actuarial Memorandum <input type="checkbox"/> Other: _____
<b>12.</b>	<b>Filing Submission Date</b>	<b>March 31, 2008</b>
<b>13.</b>	<b>Filing Fee (If required)</b>	Amount <u>          \$40 .00 (EFT SERFF)</u> Check Date _____ Retaliatory <input type="checkbox"/> Yes <input type="checkbox"/> No <span style="margin-left: 50px;">Check Number _____</span>
<b>14.</b>	<b>Date of Domiciliary Approval</b>	<b>New York Approved for out of state use 1/17/08</b>
<b>15.</b>	<b>Filing Description:</b>  <b>PLEASE SEE COVER LETTER</b>	

**View Complete Filing Description**

<b>16.</b>	<b>Certification (If required)</b>	
<p><b>I HEREBY CERTIFY</b> that I have reviewed the applicable filing requirements for this filing, and complies with all applicable statutory provisions for the state of <u>Arkansas</u></p>		
Print Name <u>          Robert Winograd          </u>		Title: <u>          Sr. Contract Analyst          </u>
Original Signature <u>                    </u>		Date <u>          March 31, 2008          </u>

<b>17.</b>	<b>Form Filing Attachment</b>	
<b>This filing transmittal is part of company tracking number</b>		<b>B07-55 RW</b>
<b>This filing corresponds to rate filing company tracking number</b>		

	<b>Document Name</b>	<b>Form Number</b>		<b>Replace Form Number</b>
	<b>Description</b>			<b>Previous State Filing Number</b>
01	<b>Application</b>	<b>IDIAPP06-1-AR</b>	<input checked="" type="checkbox"/> <b>Initial</b> <input type="checkbox"/> <b>Revised</b> <input type="checkbox"/> <b>Other</b>	
02	<b>Application Supplement</b>	<b>IDIAPP06-2-BOE</b>	<input checked="" type="checkbox"/> <b>Initial</b> <input type="checkbox"/> <b>Revised</b> <input type="checkbox"/> <b>Other</b>	
03			<input type="checkbox"/> <b>Initial</b> <input type="checkbox"/> <b>Revised</b> <input type="checkbox"/> <b>Other</b>	
04			<input type="checkbox"/> <b>Initial</b> <input type="checkbox"/> <b>Revised</b> <input type="checkbox"/> <b>Other</b>	
05			<input type="checkbox"/> <b>Initial</b> <input type="checkbox"/> <b>Revised</b> <input type="checkbox"/> <b>Other</b>	
06			<input type="checkbox"/> <b>Initial</b> <input type="checkbox"/> <b>Revised</b> <input type="checkbox"/> <b>Other</b>	
07			<input type="checkbox"/> <b>Initial</b> <input type="checkbox"/> <b>Revised</b> <input type="checkbox"/> <b>Other</b>	
08			<input type="checkbox"/> <b>Initial</b> <input type="checkbox"/> <b>Revised</b> <input type="checkbox"/> <b>Other</b>	
09			<input type="checkbox"/> <b>Initial</b> <input type="checkbox"/> <b>Revised</b> <input type="checkbox"/> <b>Other</b>	
10			<input type="checkbox"/> <b>Initial</b> <input type="checkbox"/> <b>Revised</b> <input type="checkbox"/> <b>Other</b>	
11			<input type="checkbox"/> <b>Initial</b> <input type="checkbox"/> <b>Revised</b> <input type="checkbox"/> <b>Other</b>	
12			<input type="checkbox"/> <b>Initial</b> <input type="checkbox"/> <b>Revised</b> <input type="checkbox"/> <b>Other</b>	

LH FFA-1

18.		Rate Filing Attachment		
This filing transmittal is part of company tracking number				
This filing corresponds to form filing company tracking number				
Overall percentage rate impact for this filing		%		
	Document Name	Affected Form Numbers		Previous State Filing Number
	Description			
01			<input type="checkbox"/> New <input type="checkbox"/> Revised Request + ___% - ___% <input type="checkbox"/> Other _____	
02			<input type="checkbox"/> New <input type="checkbox"/> Revised Request + ___% - ___% <input type="checkbox"/> Other _____	
03			<input type="checkbox"/> New <input type="checkbox"/> Revised Request + ___% - ___% <input type="checkbox"/> Other _____	
04			<input type="checkbox"/> New <input type="checkbox"/> Revised Request + ___% - ___% <input type="checkbox"/> Other _____	
05			<input type="checkbox"/> New <input type="checkbox"/> Revised Request + ___% - ___% <input type="checkbox"/> Other _____	
06			<input type="checkbox"/> New <input type="checkbox"/> Revised Request + ___% - ___% <input type="checkbox"/> Other _____	
07			<input type="checkbox"/> New <input type="checkbox"/> Revised Request + ___% - ___% <input type="checkbox"/> Other _____	
08			<input type="checkbox"/> New <input type="checkbox"/> Revised Request + ___% - ___% <input type="checkbox"/> Other _____	
09			<input type="checkbox"/> New <input type="checkbox"/> Revised Request + ___% - ___% <input type="checkbox"/> Other _____	

LH RFA-1

Metropolitan Life Insurance Company  
501 Route 22, Bridgewater Township, NJ 08807  
Tel 908 253-2288 Fax 908 253-2126  
rwinograd@metlife.com

**MetLife®**

**Robert Winograd**  
Senior Contract Analyst  
Group and SBC Contracts & Compliance Department

March 31, 2008

Arkansas Department of Insurance  
1200 West 3<sup>rd</sup> Street  
Little Rock, Arkansas 72201-1904

**Re:** Individual Disability Income Insurance Long-Form Application IDIAPP06-1-AR  
Individual Disability Income Supplemental Business Overhead Expense Application  
IDIAPP06-2-BOE  
Our NAIC Company No. is 65978  
Our FEIN is 13-5581829

Dear Sir/Madam:

We enclose for filing final printed copies of the long-form individual disability income ("IDI") application and supplemental business overhead expense ("BOE") application described below. These forms are new and do not replace any forms previously approved by your Department.

The long-form application is a redesigned version of application IDI2000-APP, approved by your Department on January 8, 2001. For administrative convenience, the questions needed to underwrite business overhead expense insurance have been removed from the subject long form application and placed in the BOE supplemental application referenced above and described below.

<b>Form Number</b>	<b>Description</b>
IDIAPP06-1-AR	Application for IDI Insurance. This form will be used by a person to apply for any fully underwritten IDI insurance policy approved by your Department.
IDIAPP06-2-BOE	Application Supplement This form will be used with the above application IDIAPP06-1-AR when a business overhead expense policy is being applied for, and therefore contains questions needed to underwrite such coverage.

We enclose the required filing fee.

The enclosed forms do not impact rates.

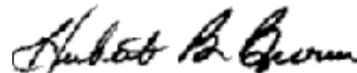
**Filing Correspondence Instructions**

Please address all correspondence regarding this filing to me at the address, telephone, fax or e-mail shown in the upper left hand corner of this letter. Thank you for your consideration.

Very truly yours,



Robert Winograd  
Senior Contract Analyst



Herbert B Brown Jr.  
Vice President

**B07-55 RW**