

SERFF Tracking Number: META-126644599 State: Arkansas
Filing Company: Metropolitan Life Insurance Company State Tracking Number: 45766
Company Tracking Number: W09-14 KC (LW)
TOI: LTC03G Group Long Term Care Sub-TOI: LTC03G.001 Qualified
Product Name: Group Long Term Care Insurance
Project Name/Number: GAPP-F/W09-14 KC

Filing at a Glance

Company: Metropolitan Life Insurance Company

Product Name: Group Long Term Care Insurance SERFF Tr Num: META-126644599 State: Arkansas

TOI: LTC03G Group Long Term Care

SERFF Status: Closed-Approved State Tr Num: 45766

Sub-TOI: LTC03G.001 Qualified

Co Tr Num: W09-14 KC (LW) State Status: Closed

Filing Type: Form

Reviewer(s): Marie Bennett, Harris Shearer

Authors: Sandra Bennett, Ruth Rivera, Linda Williams

Disposition Date: 05/28/2010

Date Submitted: 05/25/2010

Disposition Status: Approved

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: GAPP-F

Status of Filing in Domicile:

Project Number: W09-14 KC

Date Approved in Domicile:

Requested Filing Mode: Review & Approval

Domicile Status Comments:

Explanation for Combination/Other:

Market Type: Group

Submission Type: New Submission

Group Market Size: Large

Overall Rate Impact:

Group Market Type: Employer

Filing Status Changed: 05/28/2010

Explanation for Other Group Market Type:

State Status Changed: 05/28/2010

Deemer Date:

Created By: Linda Williams

Submitted By: Linda Williams

Corresponding Filing Tracking Number:

Filing Description:

Re: Group Long-Term Care Insurance Enrollment Forms Filing

Our NAIC Company No. is 65978

Our FEIN is 13-5581829

Dear Sir/Madam:

We are filing, for your review and approval, new enrollment forms for the following previously approved group long-term care insurance policy forms:

<i>SERFF Tracking Number:</i>	<i>META-126644599</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Metropolitan Life Insurance Company</i>	<i>State Tracking Number:</i>	<i>45766</i>
<i>Company Tracking Number:</i>	<i>W09-14 KC (LW)</i>		
<i>TOI:</i>	<i>LTC03G Group Long Term Care</i>	<i>Sub-TOI:</i>	<i>LTC03G.001 Qualified</i>
<i>Product Name:</i>	<i>Group Long Term Care Insurance</i>		
<i>Project Name/Number:</i>	<i>GAPP-F/W09-14 KC</i>		

- G.LTC197, approved by your Department on September 28, 1998;
- GPNP99-LTC, approved by your Department on February 22, 2000;
- G.LTC297 and G.LTC397, approved by your Department on September 28, 1998; and
- G.LTC199 approved by your Department on January 24, 2000.

These forms are new and do not replace any forms previously filed with your Department.

Form Number Description

GAPP-F Full underwriting enrollment form. The fraud warning may appear as shown or may vary as follows. Fraud warnings may be added or taken out according to the population demographics of the policyholder's plan. The language used may be changed to comply with the fraud warning requirements of any jurisdiction where this form may be used.

GAPP-GI Guaranteed issue enrollment form. The fraud warning may appear as shown or may vary as follows. Fraud warnings may be added or taken out according to the population demographics of the policyholder's plan. The language used may be changed to comply with the fraud warning requirements of any jurisdiction where this form may be used.

GAPP-SI Simplified issue enrollment form. The fraud warning may appear as shown or may vary as follows. Fraud warnings may be added or taken out according to the population demographics of the policyholder's plan. The language used may be changed to comply with the fraud warning requirements of any jurisdiction where this form may be used.

G-REINST Reinstatement application. The fraud warning may appear as shown or may vary as follows. Fraud warnings may be added or taken out according to the population demographics of the policyholder's plan. The language used may be changed to comply with the fraud warning requirements of any jurisdiction where this form may be used.

Readability Score

The forms have been tested for readability and they achieved the following Flesch Reading Ease scores, as certified by the MetLife officer signing below:

Form Number Score

GAPP-F 70.41
GAPP-GI 69.56

SERFF Tracking Number: *META-126644599* *State:* *Arkansas*
Filing Company: *Metropolitan Life Insurance Company* *State Tracking Number:* *45766*
Company Tracking Number: *W09-14 KC (LW)*
TOI: *LTC03G Group Long Term Care* *Sub-TOI:* *LTC03G.001 Qualified*
Product Name: *Group Long Term Care Insurance*
Project Name/Number: *GAPP-F/W09-14 KC*
GAPP-SI 67.76
G-REINST 67.75

Variable Material

The variable material contained in each of the filed forms is indicated by brackets.

Filing Fees

We enclose the required filing fee.

Filing Correspondence Instructions

Please address all correspondence regarding this filing as follows:

Metropolitan Life Insurance Company
Institutional Contracts – MSC #39.087
1095 Avenue of the Americas
New York, NY 10036-6796

If you have any questions or comments that you feel could best be handled by contacting MetLife, please feel free to contact Kris Ann Cappelluti via telephone (212-578-3029), fax (212-578-2126) or e-mail (kcappelluti@metlife.com).

Thank you for your attention to our filing. We look forward to hearing from you.

Sincerely,

Kris Ann E. Cappelluti
Senior Contract Analyst

Herbert B. Brown, Jr.
Vice-President

Company and Contact

Filing Contact Information

William D. Wilson, Staff Analyst

SERFF Tracking Number: META-126644599 State: Arkansas
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501 Route 22 908-253-2290 [Phone]
 Bridgewater, NJ 08807

Filing Company Information

Metropolitan Life Insurance Company	CoCode: 65978	State of Domicile: New York
MetLife	Group Code: -99	Company Type: Life
1095 Avenue of the Americas	Group Name:	State ID Number:
New York, NY 10036-6796	FEIN Number: 13-5581829	
(212) 578-2211 ext. [Phone]		

Filing Fees

Fee Required?	Yes
Fee Amount:	\$200.00
Retaliatory?	No
Fee Explanation:	\$50.00 Per Form submitted for Approval. (4) Forms are submitted.
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Metropolitan Life Insurance Company	\$200.00	05/25/2010	36802189

SERFF Tracking Number: META-126644599

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TOI: LTC03G Group Long Term Care

Sub-TOI: LTC03G.001 Qualified

Product Name: Group Long Term Care Insurance

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved	Marie Bennett	05/28/2010	05/28/2010

SERFF Tracking Number: META-126644599

State: Arkansas

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Disposition

Disposition Date: 05/28/2010

Implementation Date:

Status: Approved

Comment:

Rate data does NOT apply to filing.

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		Yes
Supporting Document	Health - Actuarial Justification		Yes
Supporting Document	Outline of Coverage		Yes
Supporting Document	NAIC Transmittal Document		Yes
Form	Group Enrollment Form		Yes
Form	Group Enrollment Form		Yes
Form	Group Enrollment Form		Yes
Form	Reinstatement Application		Yes

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Form Schedule

Lead Form Number: GAPP-F

Schedule Item Status	Form Number	Form Type Form Name	Action	Action Specific Data	Readability	Attachment
	GAPP-F	Application/Group Enrollment Form Enrollment Form	Initial		70.410	GAPP-F.pdf
	GAPP-GI	Application/Group Enrollment Form Enrollment Form	Initial		69.560	GAPP-GI.pdf
	GAPP-SI	Application/Group Enrollment Form Enrollment Form	Initial		67.760	GAPP-SI.pdf
	G-REINST	Application/Reinstatement Form Enrollment Application Form	Initial		67.750	G-REINST.pdf

[APPLICATION PACKET SUBMISSION INSTRUCTIONS

To avoid a delay in processing your application:

- Print all answers in blue or black ink.
- Answer all questions completely.
- If your spouse is applying for coverage, you and your spouse must complete separate Enrollment/Application Packets.
- Additional medical information can be submitted on a separate sheet of paper. Be sure to include your name and Social Security number/MetLife Issued ID number on all sheets. Information provided on additional sheets will become a part of the application and will be considered by MetLife in determining your eligibility for insurance.
- For Automatic Checking Account Deduction of premium, include a voided check and complete and sign Part F (page 6).
- Complete the Medical Authorization (page 8).
- Complete the Personal Worksheet (pages 9-10).
- Employees who enroll during the initial enrollment period or within the first XX days of employment their eligibility date, may enroll in the plan by completing the yellow Employee Long-Term Care Insurance Enrollment Form Packet, unless you have been directed to this application based on coverage you have selected on the yellow form.
- Please complete and sign Part F, Payment Selections.
- Please complete and sign Part G, Agreement and Acknowledgement.
- Contingent on applicable state approval, this application is subject to change.]

PART [A] - INSURABILITY QUESTIONS

(Please answer these questions BEFORE you continue with this application.)

If you have any doubt about your answers, please ask your doctor.	YES	NO
[1.]Have you ever had, do you currently have, have you been medically diagnosed as having, or have you been treated for: Stroke; Transient Ischemic Attack (TIA) within the past [2 years] , multiple TIAs; Alzheimer’s disease; dementia/organic brain syndrome, memory loss and/or persistent forgetfulness that is progressive or treated with prescription medication; mental retardation; schizophrenia; Parkinson’s disease/syndrome; Multiple Sclerosis; Muscular Dystrophy; Amyotrophic Lateral Sclerosis (ALS); or Huntington’s chorea?	<input type="checkbox"/>	<input type="checkbox"/>
[2.]Have you been medically diagnosed as having or have you been treated for AIDS (Acquired Immune Deficiency Syndrome)/AIDS related conditions; or have you tested positive for antibodies to the AIDS virus?	<input type="checkbox"/>	<input type="checkbox"/>
[3.]Do you require supervision or human assistance with: bathing; dressing; eating; walking; getting in/out of bed or a chair; use of toilet; or bowel/bladder control?	<input type="checkbox"/>	<input type="checkbox"/>
[4.]Do you use or have you been advised to use any of the following medical equipment: wheelchair; motorized scooter; walker; stair lift; quad cane; dialysis; or oxygen (except for sleep apnea)?	<input type="checkbox"/>	<input type="checkbox"/>
[5.]Do you currently reside in, or have you been advised to enter or use: a nursing home; an assisted living facility; residential care facility; adult day care; any other type of long-term care facility; or home health care services?	<input type="checkbox"/>	<input type="checkbox"/>



[If you answered YES to any of PART [A], questions [1-5], PLEASE DO NOT CONTINUE. We regret that we cannot offer you Long-Term Care Insurance. If you answered “NO” to all of PART [A], questions [1-5], please CONTINUE.]

PART [B] - PERSON APPLYING FOR COVERAGE

(You must complete ALL information below.)

[1.] Mr. Mrs. Ms. Dr. (check one)

[2.] First Name _____ Middle Initial _____
Last Name _____

[3.] Address _____
City _____
State _____ Zip _____

[4.] Preferred Contact Phone Number () _____
Additional Phone Number () _____
Best time to call Morning Afternoon Evening

[5.] E-mail address _____

[6.] Gender Male Female

[7.] Date of Birth _____ (mm/dd/yyyy)
[Place of Birth _____ (State & Country)]

[8.] [Social Security Number] _____

[9.] Marital Status Single/Widowed/Divorced
 Married
 Domestic Partnership*
 Civil Union]

[10.] In relation to the [Employee/Member or Retiree], I am the
 [Employee/Member] [Retiree]
 [Retiree's Spouse] [Employee's/Member's] Spouse
 [Domestic Partner*] [Civil Union Partner*]
 Surviving Spouse Parent (includes in-laws)
 Adult Child Grandparent (includes in-laws)]

[11.] Is your Spouse/[Domestic Partner*/Civil Union Partner*] applying for LTC Insurance coverage issued by MetLife?
 YES NO
IF YES please provide requested information.
Name _____
[Social Security Number] _____

If you are the [Employee/Member] [or Retiree]

[12.] Date of Hire _____ (mm/dd/yyyy)

[13.] [[Employee/Member] I.D. /MetLife Issued I.D.]
(if applicable) _____]

[14.] If you are NOT the [Employee/Member] or [Retiree], please provide the [Employee/Member's] or [Retiree's]
Name _____
[Social Security Number] _____

[15.] This is a request for Initial Coverage Coverage Change

[Please Note: MetLife ID numbers are only issued to [employees/members] [and retirees].]

[*Where permissible by law. An affidavit may be required for Domestic Partnerships.]

[PART C - COVERAGE SELECTIONS**You can choose EITHER a pre-packaged plan OR customize your own plan. Do NOT choose both.**

Choose a Pre-packaged Plan	
1. Choose a Pre-packaged Plan	
<input type="checkbox"/> Plan A Comprehensive	Daily Benefit Amount \$XXX Total Lifetime Benefit X Years Optional Inflation Increase
<input type="checkbox"/> Plan B Comprehensive	Daily Benefit Amount \$XXX Total Lifetime Benefit X years Optional Inflation Increase
<input type="checkbox"/> Plan C Comprehensive	Daily Benefit Amount \$XXX Total Lifetime Benefit X years Optional Inflation Increase
2. Choose your Inflation Protection Feature*:	
<input type="checkbox"/> Optional Inflation Increase	
<input type="checkbox"/> 3% Automatic Compound Inflation Protection	
<input type="checkbox"/> 5% Automatic Compound Inflation Protection	
3. Would you like the Nonforfeiture feature**?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	

OR

Customize a Plan	
1. Choose a Plan Type	
<input type="checkbox"/> Comprehensive <input type="checkbox"/> Facilities Only	
2. Choose your Nursing Home Daily Benefit Amount:	
<input type="checkbox"/> \$XX	<input type="checkbox"/> \$XX <input type="checkbox"/> \$XX <input type="checkbox"/> \$XX
<input type="checkbox"/> \$XX	<input type="checkbox"/> \$XX <input type="checkbox"/> \$XX <input type="checkbox"/> \$XX
<input type="checkbox"/> \$XX	<input type="checkbox"/> \$XX <input type="checkbox"/> \$XX <input type="checkbox"/> \$XX
3. Choose your Total Lifetime Benefit duration:	
<input type="checkbox"/> X,XXX days (X years) <input type="checkbox"/> X,XXX days (X years)	
<input type="checkbox"/> X,XXX days (X years)	
4. Choose your Inflation Protection Feature*:	
<input type="checkbox"/> Optional Inflation Increase	
<input type="checkbox"/> 3% Automatic Compound Inflation Protection	
<input type="checkbox"/> 5% Automatic Compound Inflation Protection	
5. Would you like the Nonforfeiture feature**?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	

* If you choose Plan A, B, or C or have customized a plan and do not select any inflation protection, you will automatically receive the Optional Inflation Increase.

** If you choose Plan A, B, or C or have customized a plan and do not select the Nonforfeiture feature, you will automatically receive Contingent Benefit Upon Lapse.]

PART [D] - HEALTH QUESTIONS

(Provide additional information in the DETAILS section on [page 5], if needed.)

Primary Care Physician (with most of your records)

Physician _____ Phone Number () _____ Date Last Seen _____
 Address _____ City _____ State _____ Zip _____

All Physician Specialists (excluding podiatrists, dentists) seen within the past [5] years

Physician _____ Phone Number () _____ Date Last Seen _____
 Address _____ City _____ State _____ Zip _____

Physician _____ Phone Number () _____ Date Last Seen _____
 Address _____ City _____ State _____ Zip _____

You are required to answer all the questions in this section. Missing information will result in underwriting delays. We will review all the information we receive regarding your health status and make a decision whether to approve your request for coverage. **If you have any doubt about your answers in Part [D], please ask your doctor.**

[Underwriting requirements: Adult children ages 18 and older and all other eligibles ages 56 and older will require either a phone health interview or face-to-face interview in their place of residence. Medical records are required for adult children ages 18 and older and for all other eligibles ages 66 and older. Additionally, we may require medical records or conduct a phone or face-to-face health interview regardless of age, to clarify health status.]

[1.] Have you ever had, do you currently have, have you been medically diagnosed as having, or have you been treated for:

	YES	NO
Cancer (excluding basal or squamous cell of the skin)	<input type="checkbox"/>	<input type="checkbox"/>
Heart disease/condition(s)	<input type="checkbox"/>	<input type="checkbox"/>
Atrial fibrillation	<input type="checkbox"/>	<input type="checkbox"/>
Heart attack/angina	<input type="checkbox"/>	<input type="checkbox"/>
Heart surgery/angioplasty	<input type="checkbox"/>	<input type="checkbox"/>
Cardiomyopathy	<input type="checkbox"/>	<input type="checkbox"/>
Congestive heart failure	<input type="checkbox"/>	<input type="checkbox"/>
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>
TIA	<input type="checkbox"/>	<input type="checkbox"/>
Respiratory/lung condition(s)	<input type="checkbox"/>	<input type="checkbox"/>
Kidney/bladder condition(s)	<input type="checkbox"/>	<input type="checkbox"/>
Blood disorder(s)	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes/Endocrine condition(s)	<input type="checkbox"/>	<input type="checkbox"/>
Neurological condition(s)	<input type="checkbox"/>	<input type="checkbox"/>
Seizures/brain condition(s)/head injury	<input type="checkbox"/>	<input type="checkbox"/>
Spine/back condition(s)	<input type="checkbox"/>	<input type="checkbox"/>
Psychiatric condition(s)	<input type="checkbox"/>	<input type="checkbox"/>
Depression/anxiety/bipolar	<input type="checkbox"/>	<input type="checkbox"/>
Blindness	<input type="checkbox"/>	<input type="checkbox"/>

	YES	NO
Joint replacement/fractures/falls	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Connective tissue disorder	<input type="checkbox"/>	<input type="checkbox"/>
Lupus/Scleroderma/CREST	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>
Paralysis/amputation/weakness	<input type="checkbox"/>	<input type="checkbox"/>
Bladder/bowel incontinence	<input type="checkbox"/>	<input type="checkbox"/>
Numbness of extremities	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness/fainting	<input type="checkbox"/>	<input type="checkbox"/>
Muscle disorder(s)	<input type="checkbox"/>	<input type="checkbox"/>
Fibromyalgia	<input type="checkbox"/>	<input type="checkbox"/>
Chronic fatigue syndrome	<input type="checkbox"/>	<input type="checkbox"/>
Tremor/imbalance/gait disturbance	<input type="checkbox"/>	<input type="checkbox"/>
Polymyalgia rheumatica	<input type="checkbox"/>	<input type="checkbox"/>
Organ transplant completed or medically advised	<input type="checkbox"/>	<input type="checkbox"/>
Memory loss/forgetfulness	<input type="checkbox"/>	<input type="checkbox"/>
Ulcerative colitis/Crohn's	<input type="checkbox"/>	<input type="checkbox"/>
Liver condition(s)	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis/cirrhosis	<input type="checkbox"/>	<input type="checkbox"/>

PART [D] - HEALTH QUESTIONS - continued

(Provide additional information in the DETAILS section on [page 5], if needed.)

					YES	NO
[2.] Do you have any other medical condition(s), past or planned major surgery, planned medical testing, or any condition(s) for which you are seeking or plan to seek or have been advised to seek medical advice?					<input type="checkbox"/>	<input type="checkbox"/>
[3.] Within the past [12] months, have you used any medical equipment (e.g. cane, brace, crutches, nebulizer, Continuous Positive Airway Pressure (CPAP))?					<input type="checkbox"/>	<input type="checkbox"/>
[4.] Do you need or receive help with any of the following activities because you are unable to perform them yourself: shopping, paying bills, meal preparation, transportation, laundry, or taking your medication?					<input type="checkbox"/>	<input type="checkbox"/>
[5.] Have you ever resided in, or used: a nursing home; an assisted living facility; residential care facility; adult day care; any other type of long-term care facility; or home health care services?					<input type="checkbox"/>	<input type="checkbox"/>
[6.] Have you ever had an application for Life, Health, Disability, or Long-Term Care Insurance declined, postponed, modified or rated less than standard?					<input type="checkbox"/>	<input type="checkbox"/>
[7.] Are you receiving or have you applied for or are you planning to apply for any disability payments or workers' compensation?					<input type="checkbox"/>	<input type="checkbox"/>
[8.] Did you answer YES to any question [1-7]? IF YES provide details for each question below.					<input type="checkbox"/>	<input type="checkbox"/>
Question Number	Diagnosis/Condition/Detail	Onset Date	Treatment Date(s)	Name of Treating Health Professional(s)		
[9.] Have you taken any medications (excluding vitamins) or supplements within the past [12] months? If YES provide details below for each medication taken.					<input type="checkbox"/>	<input type="checkbox"/>
Medication	Dosage/Frequency	Reason For Taking	Name of Prescribing Health Professional			
[10.] Have you used tobacco products (cigarettes, cigars, pipe, chewing tobacco) within the past [2] years? IF YES indicate date of last use. mm/dd/yyyy					<input type="checkbox"/>	<input type="checkbox"/>
[11.] Do you consume alcoholic beverages? How often? _____ How much? _____					<input type="checkbox"/>	<input type="checkbox"/>
[12.] Have you ever been medically treated, hospitalized or counseled for the use of alcohol or controlled substances? IF YES indicate date of last treatment. _____ mm/dd/yyyy					<input type="checkbox"/>	<input type="checkbox"/>
[13.] Height _____ Weight _____						
[14.] Have you had a weight gain or loss of [10] pounds or more within the past [12] months? If YES please specify: Pounds lost _____ Pounds gained _____					<input type="checkbox"/>	<input type="checkbox"/>
[15.] Are you employed or do you participate in other activities (social or physical) outside your home on a regular basis? IF YES, please describe.					<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> I am employed: Job/Title _____ Hours/Week _____		<input type="checkbox"/> I participate in other activities: Other Activities _____ Hours/Week _____				

PART [F] - PAYMENT SELECTIONS

[(Choose only ONE of the payment methods below.)]

[[Employees [and their spouses] MUST select payroll deduction.]

[Payroll/Pension] Deduction

Only available for [full time] [employees/members/retirees] [and their [spouses/domestic partners][civil union partners]]. Deduction will be from the [payroll/pension] of the [employee/member/retiree]. [[Employee/Member/Retiree] must sign this authorization even if application is for [spouse/domestic partner][civil union partner].] **If you do not sign the [Payroll/Pension] Deduction Authorization below we will default your premium mode to quarterly direct bill.**

Authorization: I authorize the required premium for the coverage level selected to be deducted from my [pay/pension].



Signature of [Employee/Member/Retiree] for [Payroll/Pension] Deduction Authorization
(if any portion of the premium is to be [payroll/pension deducted])

Date

Monthly [Automatic Checking Account] Deduction

Electronic Payment Agreement Authorization

Your monthly premium will be deducted automatically from the bank or credit union checking account you request. **Enclose a voided blank check for the account you wish to use. Do NOT send deposit slips. We will default your premium mode to quarterly direct bill if a voided check is not provided.** If using a credit union account, please provide credit union phone number.

Credit Union Phone Number () _____

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. Deductions will continue until MetLife has had a reasonable opportunity to act upon my written request to end this service.

By signing below, I represent that I am an authorized account holder of this checking account and I authorize deductions to be taken 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

Date

- [Annual Direct Bill] [Semi-Annual Direct Bill] [Quarterly Direct Bill] Monthly Direct Bill]

If you would like your bill sent to an address other than the address listed in [Part A], please indicate below.

Name _____ Phone Number () _____

Address _____

City _____ State _____ Zip _____]

PART [G] - AGREEMENT AND ACKNOWLEDGEMENT

Protection Against Unintended Lapse

I understand that I have the right to designate at least one person other than myself to receive notice of lapse or termination of this Long-Term Care Insurance coverage for non-payment of premium. I understand that notice will not be given until [31] days after a premium is due and unpaid. Please select one of the options below:

I elect NOT to designate a person to receive this notice.

I designate the following person to receive notice prior to cancellation of my coverage for nonpayment of premium:

Name _____ Phone Number (____) _____

Address _____

City _____ State _____ Zip _____

Relationship _____

[[You must check the rejection of 5% Automatic Inflation Protection box below if you [chose [Plan A, B or C] or have customized a plan and] did not choose the 5% Automatic Compound Inflation Protection feature.]

Rejection of 5% Automatic Compound Inflation Protection feature [(if applicable)]

I have reviewed the Outline of Coverage for the coverage applied for, and the graphs that compare coverage with and without the 5% Automatic Compound Inflation Protection feature. Specifically, I have reviewed the options offered, and I reject the 5% Automatic Compound Inflation Protection feature.]

Only check below if you [chose [Plan A, B, or C] or have customized a plan and] did not choose the nonforfeiture feature.

Rejection of Nonforfeiture Coverage [(if applicable)]

I have reviewed the Outline of Coverage and the Nonforfeiture Coverage as described therein. Specifically, I have reviewed the plan with the Nonforfeiture Coverage and I reject the Nonforfeiture Coverage.]

Your signature below confirms the following:

I understand that all statements made on this application are representations and not warranties. I represent that I am eligible to request enrollment for the Long-Term Care Insurance Plan. I understand that: (1) the coverage; or (2) any coverage change I am applying for, will not take effect unless on the date the coverage or coverage change would otherwise be effective: (a) the condition of my health is the same as given in this application; and (b) I have not received any medical advice or treatment from a physician or other health care provider since the date of this application. I agree that I will inform MetLife, in writing, if there is a change in my health or if I have received any medical advice or treatment as described above, between the date of this application and (1) the effective date of coverage; or (2) the date on which any coverage change is scheduled to go into effect.

Your signature below confirms your request for coverage; confirms your election concerning a Lapse Designee; [and if you rejected 5% Automatic Compound Inflation Protection feature, confirms your review of the information above concerning 5% Automatic Compound Inflation Protection feature and your rejection of 5% Automatic Compound Inflation Protection feature.]

Your signature below also confirms that you have received all of the following items: Privacy Notice, Potential Rate Increase Disclosure form, Outline of Coverage and the Shopper's Guide to Long-Term Care Insurance.

Caution: If your answers or statements on this application are misstated or untrue, MetLife may have the right to deny benefits or rescind your coverage.

[Fraud Warning: 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 and confinement in prison.]

I have read the above answers and statements on this application. By signing below, I declare, to the best of my knowledge and belief, that all information supplied in this application is true and complete.



Signature of Proposed Covered Person

Date

[ENROLLMENT FORM PACKET SUBMISSION INSTRUCTIONS]

This is a special form to be used by employees only during the initial enrollment period or within the first 90 days of employment. If you are enrolling outside of this period, you will need to complete the white application packet. To avoid a delay in processing your enrollment form:

- Print all answers in blue or black ink.
- Answer all questions completely.
- If your spouse is applying for coverage, you and your spouse must complete separate Enrollment/Application Packets.
- For Automatic Checking Account Deduction of premium, include a voided check and complete and sign Part D (page 3).
- Please complete and sign Part D, Payment Selections.
- Please complete and sign Part E, Agreement and Acknowledgement.
- Complete the Personal Worksheet (pages 5-6).
- Contingent on applicable state approval, this enrollment form is subject to change.]

PART [A] - PERSON ENROLLING

(You must complete ALL information below.)

<p>[1.] <input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms. <input type="checkbox"/> Dr. (check one)</p> <p>[2.] First Name _____ Middle Initial _____ Last Name _____</p> <p>[3.] Address _____ City _____ State _____ Zip _____</p> <p>[4.] Preferred Contact Phone Number () _____ Additional Phone Number () _____ Best time to call <input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Evening</p> <p>[5.] E-mail address _____</p> <p>[6.] Gender <input type="checkbox"/> Male <input type="checkbox"/> Female</p> <p>[7.] Date of Birth _____ (mm/dd/yyyy) [Place of Birth _____ (State & Country)]</p>	<p>[8.] [Social Security Number] _____</p> <p>[9.] Marital Status <input type="checkbox"/> Single/Widowed/Divorced <input type="checkbox"/> Married <input type="checkbox"/> Domestic Partnership* <input type="checkbox"/> Civil Union*</p> <p>[10.] [Is your Spouse[/Domestic Partner*/Civil Union Partner*] applying for LTC Insurance coverage issued by MetLife?] <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES please provide requested information. Name _____ [Social Security Number] _____</p> <p>[11.] Name of your Employer _____</p> <p>[12.] Date of Hire _____ (mm/dd/yyyy)</p> <p>[13.] [[Employee/Member] I.D./[MetLife Issued I.D.] (if applicable) _____]</p> <p>[14.] [Are you actively at work** [30 hours] per week or more?] <input type="checkbox"/> YES <input type="checkbox"/> NO</p>
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[Please Note: MetLife ID numbers are only issued to active [employees/members] [and retirees].]

[* Where permissible by law. An affidavit may be required for Domestic Partnerships.]

[** Actively at Work means that you are working at your usual place of employment, or other location to which your employer requires you to travel, and are performing all of the usual and customary duties of your occupation on a regular full-time basis, on the date your coverage becomes effective.]

[PART B - COVERAGE SELECTIONS]

You can choose EITHER a pre-packaged plan OR customize your own plan. Do NOT choose both.

Choose a Pre-packaged Plan	
1. Choose a Pre-packaged Plan	
<input type="checkbox"/> Plan A Comprehensive	Daily Benefit Amount \$XXX Total Lifetime Benefit X Years Optional Inflation Increase
<input type="checkbox"/> Plan B Comprehensive	Daily Benefit Amount \$XXX Total Lifetime Benefit X years Optional Inflation Increase
<input type="checkbox"/> Plan C Comprehensive	Daily Benefit Amount \$XXX Total Lifetime Benefit X years Optional Inflation Increase
2. Choose your Inflation Protection Feature*:	
<input type="checkbox"/> Optional Inflation Increase	
<input type="checkbox"/> 3% Automatic Compound Inflation Protection	
<input type="checkbox"/> 5% Automatic Compound Inflation Protection	
3. Would you like the Nonforfeiture feature**?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	

OR

Customize a Plan	
1. Choose a Plan Type	
<input type="checkbox"/> Comprehensive <input type="checkbox"/> Facilities Only	
2. Choose your Nursing Home Daily Benefit Amount:	
<input type="checkbox"/> \$XX <input type="checkbox"/> \$XX <input type="checkbox"/> \$XX <input type="checkbox"/> \$XX	
<input type="checkbox"/> \$XX <input type="checkbox"/> \$XX <input type="checkbox"/> \$XX <input type="checkbox"/> \$XX	
<input type="checkbox"/> \$XX <input type="checkbox"/> \$XX <input type="checkbox"/> \$XX <input type="checkbox"/> \$XX [†]	
3. Choose your Total Lifetime Benefit duration:	
<input type="checkbox"/> X,XXX days (X years) <input type="checkbox"/> X,XXX days (X years)	
<input type="checkbox"/> X,XXX days (X years) [†]	
4. Choose your Inflation Protection Feature*:	
<input type="checkbox"/> Optional Inflation Increase	
<input type="checkbox"/> 3% Automatic Compound Inflation Protection	
<input type="checkbox"/> 5% Automatic Compound Inflation Protection	
5. Would you like the Nonforfeiture feature**?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	

* If you choose Plan A, B, or C or have customized a plan and do not select any inflation protection, you will automatically receive the Optional Inflation Increase.

** If you choose Plan A, B, or C or have customized a plan and do not select the Nonforfeiture feature, you will automatically receive Contingent Benefit Upon Lapse.

[†] These higher coverage amounts require additional underwriting. You must complete the white application packet to apply for this benefit.

Based on your answers to questions in Part D of the white application, we will determine if you qualify for the Plan choices you selected. If you are accepted for LTCI coverage, but do not qualify for the particular Plan choices you selected, you will receive the highest level of coverage for which you qualify based on your answers to the questions in Part D.]

PART [C] - REPLACEMENT QUESTIONS

(You MUST answer all questions or we will not be able to process this enrollment form.)

Please Note: You are responsible for canceling any existing coverage you may have. State regulations require that we ask the following questions if you are applying for insurance.		YES	NO
1. Do you have another long-term care insurance policy or certificate in-force (including a health care service contract or a health maintenance organization contract)? IF YES coverage types/amounts? _____		<input type="checkbox"/>	<input type="checkbox"/>
2. Did you have another long-term care insurance policy or certificate in-force during the last twelve (12) months? IF YES with which insurance company? _____ If that policy or certificate lapsed, when did it lapse? _____ mm/dd/yyyy Is the policy in-force under a nonforfeiture benefit provision?		<input type="checkbox"/>	<input type="checkbox"/>
3. Are you covered under Medicaid? ("Medicaid" is different from "Medicare.")		<input type="checkbox"/>	<input type="checkbox"/>
4. Do you intend to replace any of your long-term care, medical or health insurance coverages with this coverage? IF YES, Insurance Company Name: _____ Policy #: _____ Insurance Company Address: _____		<input type="checkbox"/>	<input type="checkbox"/>

PART [D] - PAYMENT SELECTIONS

[[Choose only ONE of the payment methods below.]]

[[Employees [and their spouses] MUST select payroll deduction.]]

[Payroll/Pension] Deduction

Only available for [full-time] [employees/members/retirees] [and their spouses[/domestic partners][/civil union partners]]. Deduction will be from the [payroll/pension] of the [employee/member/retiree]. [[Employee/Member/Retiree] must sign this authorization even if application is for spouse[/domestic partner][/civil union partner].] **If you do not sign the [Payroll/Pension] Deduction Authorization below we will default your premium mode to quarterly direct bill.**

Authorization: I authorize the required premium for the coverage level selected to be deducted from my [pay/pension].



Signature of [Employee/Member/Retiree] for [Payroll/Pension] Deduction Authorization
(if any portion of the premium is to be [payroll/pension deducted])

Date

Monthly [Automatic Checking Account] Deduction

Electronic Payment Agreement Authorization

Your monthly premium will be deducted automatically from the bank or credit union checking account you request. **Enclose a voided blank check for the account you wish to use. Do not send deposit slips. We will default your premium mode to quarterly direct bill if a voided check is not provided.** If using a credit union account, please provide credit union phone number.

Credit Union Phone Number () _____

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. Deductions will continue until MetLife has had a reasonable opportunity to act upon my written request to end this service.

By signing below, I represent that I am an authorized account holder of this checking account and I authorize deductions to be taken 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

Date

- [Annual Direct Bill] [Semi-Annual Direct Bill] [Quarterly Direct Bill] [Monthly Direct Bill]

If you would like your bill sent to an address other than the address listed in [Part A], please indicate below.

Name _____ Phone Number () _____

Address _____

City _____ State _____ Zip _____]

PART [E] - AGREEMENT AND ACKNOWLEDGEMENT

Protection Against Unintended Lapse

I understand that I have the right to designate at least one person other than myself to receive notice of lapse or termination of this Long-Term Care Insurance coverage for non-payment of premium. I understand that notice will not be given until [31] days after a premium is due and unpaid. Please select one of the options below:

- I elect NOT to designate a person to receive this notice.
- I designate the following person to receive notice prior to cancellation of my coverage for nonpayment of premium:

Name _____ Phone Number () _____

Address _____

City _____ State _____ Zip _____

Relationship _____

[[You must check the rejection of 5% Automatic Inflation Protection box below if you [chose [Plan A, B or C] or have customized a plan and] did not choose the 5% Automatic Compound Inflation Protection feature.]

- Rejection of 5% Automatic Compound Inflation Protection feature [(if applicable)]**
I have reviewed the Outline of Coverage for feature applied for, and the graphs that compare coverage with and without the 5% Automatic Compound Inflation Protection feature. Specifically, I have reviewed the options offered, and I reject the 5% Automatic Compound Inflation Protection feature.]

Only check below if you [chose [Plan A, B, or C] or have customized a plan and] did not choose the nonforfeiture feature.

- Rejection of Nonforfeiture Coverage [(if applicable)]**
I have reviewed the Outline of Coverage and the Nonforfeiture Coverage as described therein. Specifically, I have reviewed the plan with the Nonforfeiture Coverage and I reject the Nonforfeiture Coverage.]

I represent that I am eligible to request enrollment for the Long-Term Care Insurance Plan.

Your signature below confirms your request for coverage; confirms your election concerning a Lapse Designee; [and if you rejected 5% Automatic Compound Inflation Protection feature, confirms your review of the information above concerning 5% Automatic Compound Inflation Protection feature and your rejection of 5% Automatic Compound Inflation Protection feature.]

Your signature below also confirms that you have received all of the following items: Privacy Notice, Potential Rate Increase Disclosure form, Outline of Coverage and the Shopper's Guide to Long-Term Care Insurance.

Caution: If your answers or statements on this enrollment form are misstated or untrue MetLife may have the right to deny benefits or rescind your coverage.

[Fraud Warning: 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 and confinement in prison.]

I understand that I must be actively at work on the effective date for this coverage to become effective. If I am not actively at work on the effective date, my coverage will become effective on the first of the month coincident with or following the date I return to work.

I have read the above answers and statements on this application. By signing below, I declare, to the best of my knowledge and belief, that all information supplied in this application is true and complete.

PART [A] - INSURABILITY QUESTIONS

(Please answer these questions BEFORE you continue with this application.)

If you have any doubt about your answers, please ask your doctor.	YES	NO
[1.] Have you ever had, do you currently have, have you been medically diagnosed as having, or have you been treated for: Stroke; Transient Ischemic Attacks (TIA's) within the past [5 years] , multiple TIA's; Alzheimer's disease; dementia/organic brain syndrome, memory loss and/or persistent forgetfulness that is progressive or treated with prescription medication; mental retardation; schizophrenia; Parkinson's disease/syndrome; Multiple Sclerosis; Muscular Dystrophy; Amyotrophic Lateral Sclerosis (ALS); or Huntington's chorea?	<input type="checkbox"/>	<input type="checkbox"/>
[2.] Have you been medically diagnosed as having or have you been treated for AIDS (Acquired Immune Deficiency Syndrome)/AIDS related conditions; or have you tested positive for antibodies to the AIDS virus?	<input type="checkbox"/>	<input type="checkbox"/>
[3.] Do you require supervision or human assistance with: bathing; dressing; eating; walking; getting in/out of bed or a chair; use of toilet; or bowel/bladder control?	<input type="checkbox"/>	<input type="checkbox"/>
[4.] Do you use or have you been advised to use any of the following medical equipment: wheelchair; motorized scooter; walker; stair lift; quad cane; dialysis; or oxygen (except for sleep apnea)?	<input type="checkbox"/>	<input type="checkbox"/>
[5.] Do you currently reside in, or have you been advised to enter or use: a nursing home; an assisted living facility; residential care facility; adult day care; any other type of long-term care facility; or home health care services?	<input type="checkbox"/>	<input type="checkbox"/>



[If you answered YES to any of PART [A], questions [1-5], PLEASE DO NOT CONTINUE. We regret that we cannot offer you Long-Term Care Insurance. If you answered "NO" to all of PART [A], questions [1-5], please CONTINUE.]

PART [B] - PERSON APPLYING FOR COVERAGE

(You must complete ALL information below.)

[1.] <input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms. <input type="checkbox"/> Dr. (check one)	[6.] Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
[2.] First Name _____ Middle Initial _____ Last Name _____	[7.] Date of Birth _____ (mm/dd/yyyy) [Place of Birth _____ (State & Country)]
[3.] Address _____ City _____ State _____ Zip _____	[8.] [Social Security Number] _____
[4.] Preferred Contact Phone Number () _____ Additional Phone Number () _____ Best time to call <input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Evening	[9.] Marital Status <input type="checkbox"/> Single/Widowed/Divorced <input type="checkbox"/> Married <input type="checkbox"/> Domestic Partnership* <input type="checkbox"/> Civil Union*]
[5.] E-mail address _____	[10.] Date of Hire _____ (mm/dd/yyyy)
	[11.] [[Employee/Member] I.D. [MetLife Issued I.D.] (if applicable) _____]
	[12.] [Are you actively at work** [30 hours] per week or more? <input type="checkbox"/> Yes <input type="checkbox"/> No]

[Please Note: MetLife ID numbers are only issued to [employees/members] [and retirees].]

[* Where permissible by law. An affidavit may be required for Domestic Partnerships.]

[** Actively at Work means that you are working at your usual place of employment, or other location to which your employer requires you to travel, and are performing all of the usual and customary duties of your occupation on a regular full-time basis, on the date your coverage becomes effective.]

[PART C - COVERAGE SELECTIONS

Please choose EITHER a pre-packaged plan OR customize your own plan. Do NOT choose both.

Choose a Pre-Packaged Plan

Plan A

Comprehensive
Daily Benefit Amount \$XXX
Total Lifetime Benefit X Years
Optional Inflation Increase

Plan B

Comprehensive
Daily Benefit Amount \$XXX
Total Lifetime Benefit X Years
Optional Inflation Increase

Plan C

Comprehensive
Daily Benefit Amount \$XXX
Total Lifetime Benefit X Years
Optional Inflation Increase

Choose your Inflation Protection Feature*:

- Optional Inflation Increase
- 3% Automatic Compound Inflation Protection
- 5% Automatic Compound Inflation Protection

Would you like the Nonforfeiture feature?**

- Yes No

Skip to Part E

OR

Customize a Plan

1. Choose a Plan Type:

- Comprehensive Facilities Only

2. Choose your Nursing Home Daily Benefit Amount:

- \$XX \$XX \$XX \$XX \$XX
- \$XX \$XX \$XX \$XX \$XX[†]

3. Choose your Total Lifetime Benefit Duration:

- X,XXX days (X years) X,XXX days (X years) X,XXX days (X years)[†]

4. Choose your Inflation Protection Feature*:

- Optional Inflation Increase
- 3% Automatic Compound Inflation Protection
- 5% Automatic Compound Inflation Protection

5. Would you like the Nonforfeiture feature?**

- Yes No

Skip to Part E

[†]Higher Coverage Amounts That Require Additional Medical Information

These higher coverage amounts require additional underwriting. You must complete Part D to apply for this benefit.

Skip to Part D

Based on your answers to questions in Part D, we will determine if you qualify for the Plan choices you selected. If you are accepted for LTCI coverage, but do not qualify for the particular Plan choices you selected, you will receive the highest level of coverage for which you qualify based on your answers to the questions in Part D.

* If you choose Plan A, B, or C or have customized a plan and do not select any inflation protection, you will automatically receive the Optional Inflation Increase.
** If you choose Plan A, B, or C or have customized a plan and do not select the Nonforfeiture feature, you will automatically receive Contingent Benefit Upon Lapse.]

Please complete PART [D] ONLY if required, based on your coverage selections in PART [C]. Otherwise, please skip to Part [E].

PART [D] - HEALTH QUESTIONS

(Provide additional information in the DETAILS section on [page 5], if needed.)

Primary Care Physician (with most of your records)

Physician _____ Phone Number () _____ Date Last Seen _____
 Address _____ City _____ State _____ Zip _____

All Physician Specialists (excluding podiatrists, dentists) seen within the past [5] years

Physician _____ Phone Number () _____ Date Last Seen _____
 Address _____ City _____ State _____ Zip _____
 Physician _____ Phone Number () _____ Date Last Seen _____
 Address _____ City _____ State _____ Zip _____

You are required to answer all the questions in this section. Missing information will result in underwriting delays. We will review all the information we receive regarding your health status and make a decision whether to approve your request for coverage. If you have any doubt about your answers in Part [D], please ask your doctor.

[Underwriting requirements: Adult children ages 18 and older and all other eligibles ages 56 and older will require either a phone health interview or face-to-face interview in their place of residence. Medical records are required for adult children ages 18 and older and for all other eligibles ages 66 and older. Additionally, we may require medical records or conduct a phone or face-to-face health interview regardless of age, to clarify health status.]

[1.]Have you ever had, do you currently have, have you been medically diagnosed as having, or have you been treated for:

	YES	NO		YES	NO
Cancer (excluding basal or squamous cell of the skin)	<input type="checkbox"/>	<input type="checkbox"/>	Joint replacement/fractures/falls	<input type="checkbox"/>	<input type="checkbox"/>
Heart disease/condition(s)	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Atrial fibrillation	<input type="checkbox"/>	<input type="checkbox"/>	Connective tissue disorder	<input type="checkbox"/>	<input type="checkbox"/>
Heart attack/angina	<input type="checkbox"/>	<input type="checkbox"/>	Lupus/Scleroderma/CREST	<input type="checkbox"/>	<input type="checkbox"/>
Heart surgery/angioplasty	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>
Cardiomyopathy	<input type="checkbox"/>	<input type="checkbox"/>	Paralysis/amputation/weakness	<input type="checkbox"/>	<input type="checkbox"/>
Congestive heart failure	<input type="checkbox"/>	<input type="checkbox"/>	Bladder/bowel incontinence	<input type="checkbox"/>	<input type="checkbox"/>
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	Numbness of extremities	<input type="checkbox"/>	<input type="checkbox"/>
TIA	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness/fainting	<input type="checkbox"/>	<input type="checkbox"/>
Respiratory/lung condition(s)	<input type="checkbox"/>	<input type="checkbox"/>	Muscle disorder(s)	<input type="checkbox"/>	<input type="checkbox"/>
Kidney/bladder condition(s)	<input type="checkbox"/>	<input type="checkbox"/>	Fibromyalgia	<input type="checkbox"/>	<input type="checkbox"/>
Blood disorder(s)	<input type="checkbox"/>	<input type="checkbox"/>	Chronic fatigue syndrome	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes/Endocrine condition(s)	<input type="checkbox"/>	<input type="checkbox"/>	Tremor/imbalance/gait disturbance	<input type="checkbox"/>	<input type="checkbox"/>
Neurological condition(s)	<input type="checkbox"/>	<input type="checkbox"/>	Polymyalgia rheumatica	<input type="checkbox"/>	<input type="checkbox"/>
Seizures/brain condition(s)/head injury	<input type="checkbox"/>	<input type="checkbox"/>	Organ transplant completed or medically advised	<input type="checkbox"/>	<input type="checkbox"/>
Spine/back condition(s)	<input type="checkbox"/>	<input type="checkbox"/>	Memory loss/forgetfulness	<input type="checkbox"/>	<input type="checkbox"/>
Psychiatric condition(s)	<input type="checkbox"/>	<input type="checkbox"/>	Ulcerative colitis/Crohn's	<input type="checkbox"/>	<input type="checkbox"/>
Depression/anxiety/bipolar	<input type="checkbox"/>	<input type="checkbox"/>	Liver condition(s)	<input type="checkbox"/>	<input type="checkbox"/>
Blindness	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis/cirrhosis	<input type="checkbox"/>	<input type="checkbox"/>

PART [D] - HEALTH QUESTIONS - continued

(Provide additional information in the DETAILS section on [page 5], if needed.)

					YES	NO
[2.] Do you have any other medical condition(s), past or planned major surgery, planned medical testing, or any condition(s) for which you are seeking or plan to seek or have been advised to seek medical advice?					<input type="checkbox"/>	<input type="checkbox"/>
[3.] Within the past [12] months, have you used any medical equipment (e.g. cane, brace, crutches, nebulizer, Continuous Positive Airway Pressure (CPAP))?					<input type="checkbox"/>	<input type="checkbox"/>
[4.] Do you need or receive help with any of the following activities because you are unable to perform them yourself: shopping, paying bills, meal preparation, transportation, laundry, or taking your medication?					<input type="checkbox"/>	<input type="checkbox"/>
[5.] Have you ever resided in, or used: a nursing home; an assisted living facility; residential care facility; adult day care; any other type of long-term care facility; or home health care services?					<input type="checkbox"/>	<input type="checkbox"/>
[6.] Have you ever had an application for Life, Health, Disability, or Long-Term Care Insurance declined, postponed, modified or rated less than standard?					<input type="checkbox"/>	<input type="checkbox"/>
[7.] Are you receiving or have you applied for or are you planning to apply for any disability payments or workers' compensation?					<input type="checkbox"/>	<input type="checkbox"/>
[8.] Did you answer YES to any question [1-7]? IF YES provide details for each question below.					<input type="checkbox"/>	<input type="checkbox"/>
Question Number	Diagnosis/Condition/Detail	Onset Date	Treatment Date(s)	Name of Treating Health Professional(s)		
[9.] Have you taken any medications (excluding vitamins) or supplements within the past [12] months? IF YES provide details below for each medication taken.					<input type="checkbox"/>	<input type="checkbox"/>
Medication	Dosage/Frequency	Reason For Taking	Name of Prescribing Health Professional			
[10.] Have you used tobacco products (cigarettes, cigars, pipe, chewing tobacco) within the past [2] years? IF YES indicate date of last use. mm/dd/yyyy					<input type="checkbox"/>	<input type="checkbox"/>
[11.] Do you consume alcoholic beverages? How often? _____ How much? _____					<input type="checkbox"/>	<input type="checkbox"/>
[12.] Have you ever been medically treated, hospitalized or counseled for the use of alcohol or controlled substances? IF YES indicate date of last treatment. _____ mm/dd/yyyy					<input type="checkbox"/>	<input type="checkbox"/>
[13.] Height _____ Weight _____						
[14.] Have you had a weight gain or loss of [10] pounds or more within the past [12] months? IF YES please specify: Pounds lost _____ Pounds gained _____					<input type="checkbox"/>	<input type="checkbox"/>
[15.] Are you employed or do you participate in other activities (social or physical) outside your home on a regular basis? If YES, please describe.					<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> I am employed: Job/Title _____ Hours/Week _____		<input type="checkbox"/> I participate in other activities: Other Activities _____ Hours/Week _____				

PART [F] - PAYMENT SELECTIONS

[(Choose only ONE of the payment methods below.)]

[[Employees [and their spouses] MUST select payroll deduction.]

[Payroll/Pension] Deduction

Only available for [full-time] [employees/members/retirees] [and their spouses[/domestic partners][/civil union partners]]. Deduction will be from the [payroll/pension] of the [employee/member/retiree]. [[Employee/Member/Retiree] must sign this authorization even if application is for spouse[/domestic partner][/civil union partner].] **If you do not sign the [Payroll/Pension] Deduction Authorization below we will default your premium mode to quarterly direct bill.**

Authorization: I authorize the required premium for the coverage level selected to be deducted from my [pay/pension].



Signature of [Employee/Member/Retiree] for [Payroll/Pension] Deduction Authorization
(if any portion of the premium is to be [payroll/pension deducted])

Date

Monthly [Automatic Checking Account] Deduction

Electronic Payment Agreement Authorization

Your monthly premium will be deducted automatically from the bank or credit union checking account you request. **Enclose a voided blank check for the account you wish to use. Do NOT send deposit slips. We will default your premium mode to quarterly direct bill if a voided check is not provided.** If using a credit union account, please provide credit union phone number.

Credit Union Phone Number () _____

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. Deductions will continue until MetLife has had a reasonable opportunity to act upon my written request to end this service.

By signing below, I represent that I am an authorized account holder of this checking account and I authorize deductions to be taken 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

Date

- [Annual Direct Bill] [Semi-Annual Direct Bill] [Quarterly Direct Bill] [Monthly Direct Bill]

If you would like your bill sent to an address other than the address listed in [Part A], please indicate below.

Name _____ Phone Number () _____

Address _____

City _____ State _____ Zip _____]

PART [G] - AGREEMENT AND ACKNOWLEDGEMENT

Protection Against Unintended Lapse

I understand that I have the right to designate at least one person other than myself to receive notice of lapse or termination of this Long-Term Care Insurance coverage for non-payment of premium. I understand that notice will not be given until [31] days after a premium is due and unpaid. Please select one of the options below:

I elect NOT to designate a person to receive this notice.

I designate the following person to receive notice prior to cancellation of my coverage for nonpayment of premium:

Name _____ Phone Number (____) _____

Address _____

City _____ State _____ Zip _____

Relationship _____

[[You must check the rejection of 5% Automatic Inflation Protection box below if you [chose [Plan A, B or C] or have customized a plan and] did not choose the 5% Automatic Compound Inflation Protection feature.]

Rejection of 5% Automatic Compound Inflation Protection feature [(if applicable)]

I have reviewed the Outline of Coverage for the coverage applied for, and the graphs that compare coverage with and without the 5% Automatic Compound Inflation Protection feature. Specifically, I have reviewed the options offered, and I reject the 5% Automatic Compound Inflation Protection feature.]

Only check below if you [chose [Plan A, B, or C] or have customized a plan and] did not choose the nonforfeiture feature.

Rejection of Nonforfeiture Coverage [(if applicable)]

I have reviewed the Outline of Coverage and the Nonforfeiture Coverage as described therein. Specifically, I have reviewed the plan with the Nonforfeiture Coverage and I reject the Nonforfeiture Coverage.]

Your signature below confirms the following:

I understand that all statements made on this application are representations and not warranties. I represent that I am eligible to request enrollment for the Long-Term Care Insurance Plan. I understand that: (1) the coverage; or (2) any coverage change I am applying for, will not take effect unless on the date the coverage or coverage change would otherwise be effective: (a) the condition of my health is the same as given in this application; and (b) I have not received any medical advice or treatment from a physician or other health care provider since the date of this application. I agree that I will inform MetLife, in writing, if there is a change in my health or if I have received any medical advice or treatment as described above, between the date of this application and (1) the effective date of coverage; or (2) the date on which any coverage change is scheduled to go into effect.

Your signature below confirms your request for coverage; confirms your election concerning a Lapse Designee; [and if you rejected 5% Automatic Compound Inflation Protection feature, confirms your review of the information above concerning 5% Automatic Compound Inflation Protection feature and your rejection of 5% Automatic Compound Inflation Protection feature.]

Your signature below also confirms that you have received all of the following items: Privacy Notice, Potential Rate Increase Disclosure form, Outline of Coverage and the Shopper's Guide to Long-Term Care Insurance.

Caution: If your answers or statements on this application are misstated or untrue MetLife may have the right to deny benefits or rescind your coverage.

[Fraud Warning: 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 and confinement in prison.]

I understand that I must be actively at work on the effective date for this coverage to become effective. If I am not actively at work on the effective date, my coverage will become effective on the first of the month coincident with or following the date I return to work.

I have read the above answers and statements on this application. By signing below, I declare, to the best of my knowledge and belief, that all information supplied in this application is true and complete.



Signature of Proposed Covered Person

Date

[REINSTATEMENT PACKET SUBMISSION INSTRUCTIONS]

To avoid a delay in processing your application:

- Print all answers in blue or black ink.
- Answer all questions completely.
- Additional medical information can be submitted on a separate sheet of paper. Be sure to include your name and Social Security number/MetLife Issued ID number on all sheets. Information provided on additional sheets will become a part of the application and will be considered by MetLife in determining your eligibility for insurance.
- Please complete and sign Part D, Agreement and Acknowledgement.
- Complete the Medical Authorization (page 6).
- If your request is approved, you will receive the coverage previously in-force.]

PART [A] - INSURABILITY QUESTIONS (Please answer these questions BEFORE you continue with this application.)

If you have any doubt about your answers, please ask your doctor.	YES	NO
[1.] Have you ever had, do you currently have, have you been medically diagnosed as having, or have you been treated for: Stroke; Transient Ischemic Attack (TIA) within the past [2 years] , multiple TIA's; Alzheimer's disease; dementia/organic brain syndrome, memory loss and/or persistent forgetfulness that is progressive or treated with prescription medication; mental retardation; schizophrenia; Parkinson's disease/syndrome; Multiple Sclerosis; Muscular Dystrophy; Amyotrophic Lateral Sclerosis (ALS); or Huntington's chorea?	<input type="checkbox"/>	<input type="checkbox"/>
[2.] Have you been medically diagnosed as having or have you been treated for AIDS (Acquired Immune Deficiency Syndrome)/AIDS related conditions; or have you tested positive for antibodies to the AIDS virus?	<input type="checkbox"/>	<input type="checkbox"/>
[3.] Do you require supervision or human assistance with: bathing; dressing; eating; walking; getting in/out of bed or a chair; use of toilet; or bowel/bladder control?	<input type="checkbox"/>	<input type="checkbox"/>
[4.] Do you use or have you been advised to use any of the following medical equipment: wheelchair; motorized scooter; walker; stair lift; quad cane; dialysis; or oxygen (except for sleep apnea)?	<input type="checkbox"/>	<input type="checkbox"/>
[5.] Do you currently reside in, or have you been advised to enter or use: a nursing home; an assisted living facility; residential care facility; adult day care; any other type of long-term care facility; or home health care services?	<input type="checkbox"/>	<input type="checkbox"/>



[If you answered YES to any of PART [A], questions [1-5], PLEASE DO NOT CONTINUE. We regret that we cannot offer you Long-Term Care Insurance. If you answered "NO" to all of PART [A], questions [1-5], please CONTINUE.]

PART [B] - PERSON APPLYING FOR COVERAGE (You must complete ALL information below.)

[1.] <input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms. <input type="checkbox"/> Dr. (check one)	[5.] E-mail address _____
[2.] First Name _____ Middle Initial _____ Last Name _____	[6.] Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
[3.] Address _____ City _____ State _____ Zip _____	[7.] Date of Birth _____ (mm/dd/yyyy) [Place of Birth _____ (State & Country)]
[4.] Preferred Contact Phone Number (____) _____ Additional Phone Number (____) _____ Best time to call <input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Evening	[8.] [Social Security Number] _____
	[9.] Marital Status <input type="checkbox"/> Single/Widowed/Divorced <input type="checkbox"/> Married <input type="checkbox"/> [Domestic Partnership*] <input type="checkbox"/> [Civil Union*]
	[10.] Date of Hire _____ (mm/dd/yyyy)
	[11.] [[Employee/Member] I.D./[MetLife Issued I.D.] _____

[Please Note: MetLife ID numbers are only issued to [employees/members] [and retirees].]

[*Where permissible by law. An affidavit may be required for Domestic Partnerships.]

PART [C] - HEALTH QUESTIONS

(Provide additional information in the DETAILS section on [page 4], if needed.)

Primary Care Physician (with most of your records)

Physician _____ Phone Number () _____ Date Last Seen _____
 Address _____ City _____ State _____ Zip _____

All Physician Specialists (excluding podiatrists, dentists) seen within the past [5] years

Physician _____ Phone Number () _____ Date Last Seen _____
 Address _____ City _____ State _____ Zip _____

Physician _____ Phone Number () _____ Date Last Seen _____
 Address _____ City _____ State _____ Zip _____

You are required to answer all the questions in this section. Missing information will result in underwriting delays. We will review all the information we receive regarding your health status and make a decision whether to approve your request for reinstatement. If you have any doubt about your answers in Part [D], please ask your doctor.

[Underwriting requirements: Adult children ages 18 and older and all other eligibles ages 56 and older will require either a phone health interview or face-to-face interview in their place of residence. Medical records are required for adult children ages 18 and older and for all other eligibles ages 66 and older. Additionally, we may require medical records or conduct a phone or face-to-face health interview regardless of age, to clarify health status.]

[1.] Have you ever had, do you currently have, have you been medically diagnosed as having, or have you been treated for:

	YES	NO		YES	NO
[Cancer (excluding basal or squamous cell of the skin)	<input type="checkbox"/>	<input type="checkbox"/>	Joint replacement/fractures/falls	<input type="checkbox"/>	<input type="checkbox"/>
Heart disease/condition(s)	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Atrial fibrillation	<input type="checkbox"/>	<input type="checkbox"/>	Connective tissue disorder	<input type="checkbox"/>	<input type="checkbox"/>
Heart attack/angina	<input type="checkbox"/>	<input type="checkbox"/>	Lupus/Scleroderma/CREST	<input type="checkbox"/>	<input type="checkbox"/>
Heart surgery/angioplasty	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>
Cardiomyopathy	<input type="checkbox"/>	<input type="checkbox"/>	Paralysis/amputation/weakness	<input type="checkbox"/>	<input type="checkbox"/>
Congestive heart failure	<input type="checkbox"/>	<input type="checkbox"/>	Bladder/bowel incontinence	<input type="checkbox"/>	<input type="checkbox"/>
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	Numbness of extremities	<input type="checkbox"/>	<input type="checkbox"/>
TIA	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness/fainting	<input type="checkbox"/>	<input type="checkbox"/>
Respiratory/lung condition(s)	<input type="checkbox"/>	<input type="checkbox"/>	Muscle disorder(s)	<input type="checkbox"/>	<input type="checkbox"/>
Kidney/bladder condition(s)	<input type="checkbox"/>	<input type="checkbox"/>	Fibromyalgia	<input type="checkbox"/>	<input type="checkbox"/>
Blood disorder(s)	<input type="checkbox"/>	<input type="checkbox"/>	Chronic fatigue syndrome	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes/Endocrine condition(s)	<input type="checkbox"/>	<input type="checkbox"/>	Tremor/imbalance/gait disturbance	<input type="checkbox"/>	<input type="checkbox"/>
Neurological condition(s)	<input type="checkbox"/>	<input type="checkbox"/>	Polymyalgia rheumatica	<input type="checkbox"/>	<input type="checkbox"/>
Seizures/brain condition(s)/head injury	<input type="checkbox"/>	<input type="checkbox"/>	Organ transplant completed or medically advised	<input type="checkbox"/>	<input type="checkbox"/>
Spine/back condition(s)	<input type="checkbox"/>	<input type="checkbox"/>	Memory loss/forgetfulness	<input type="checkbox"/>	<input type="checkbox"/>
Psychiatric condition(s)	<input type="checkbox"/>	<input type="checkbox"/>	Ulcerative colitis/Crohn's	<input type="checkbox"/>	<input type="checkbox"/>
Depression/anxiety/bipolar	<input type="checkbox"/>	<input type="checkbox"/>	Liver condition(s)	<input type="checkbox"/>	<input type="checkbox"/>
Blindness	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis/cirrhosis	<input type="checkbox"/>	<input type="checkbox"/>

PART [C] - HEALTH QUESTIONS - *continued*

(Provide additional information in the DETAILS section on [page 4], if needed.)

					YES	NO
[2.] Do you have any other medical condition(s), past or planned major surgery, planned medical testing, or any condition(s) for which you are seeking or plan to seek or have been advised to seek medical advice?					<input type="checkbox"/>	<input type="checkbox"/>
[3.] Within the past [12] months, have you used any medical equipment (e.g. cane, brace, crutches, nebulizer, Continuous Positive Airway Pressure (CPAP))?					<input type="checkbox"/>	<input type="checkbox"/>
[4.] Do you need or receive help with any of the following activities because you are unable to perform them yourself: shopping, paying bills, meal preparation, transportation, laundry, or taking your medication?					<input type="checkbox"/>	<input type="checkbox"/>
[5.] Have you ever resided in, or used: a nursing home; an assisted living facility; residential care facility; adult day care; any other type of long-term care facility; or home health care services?					<input type="checkbox"/>	<input type="checkbox"/>
[6.] Have you ever had an application for Life, Health, Disability, or Long-Term Care Insurance declined, postponed, modified or rated less than standard?					<input type="checkbox"/>	<input type="checkbox"/>
[7.] Are you receiving or have you applied for or are you planning to apply for any disability payments or workers' compensation?					<input type="checkbox"/>	<input type="checkbox"/>
[8.] Did you answer YES to any question [1-7]? IF YES provide details for each question below.					<input type="checkbox"/>	<input type="checkbox"/>
Question Number	Diagnosis/Condition/Detail	Onset Date	Treatment Date(s)	Name of Treating Health Professional(s)		
[9.] Have you taken any medications (excluding vitamins) or supplements within the past [12] months? IF YES provide details below for each medication taken.					<input type="checkbox"/>	<input type="checkbox"/>
Medication	Dosage/Frequency	Reason For Taking	Name of Prescribing Health Professional			
[10.] Have you used tobacco products (cigarettes, cigars, pipe, chewing tobacco) within the past [2] years? IF YES indicate date of last use. mm/dd/yyyy					<input type="checkbox"/>	<input type="checkbox"/>
[11.] Do you consume alcoholic beverages? How often? _____ How much? _____					<input type="checkbox"/>	<input type="checkbox"/>
[12.] Have you ever been medically treated, hospitalized or counseled for the use of alcohol or controlled substances? IF YES indicate date of last treatment. _____ mm/dd/yyyy					<input type="checkbox"/>	<input type="checkbox"/>
[13.] Height _____ Weight _____						
[14.] Have you had a weight gain or loss of [10] pounds or more within the past [12] months? If YES please specify: Pounds lost _____ Pounds gained _____					<input type="checkbox"/>	<input type="checkbox"/>
[15.] Are you employed or do you participate in other activities (social or physical) outside your home on a regular basis? IF YES, please describe.					<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> I am employed:		<input type="checkbox"/> I participate in other activities:				
Job/Title _____		Other Activities _____				
Hours/Week _____		Hours/Week _____				

SERFF Tracking Number: META-126644599 State: Arkansas
 Filing Company: Metropolitan Life Insurance Company State Tracking Number: 45766
 Company Tracking Number: W09-14 KC (LW)
 TOI: LTC03G Group Long Term Care Sub-TOI: LTC03G.001 Qualified
 Product Name: Group Long Term Care Insurance
 Project Name/Number: GAPP-F/W09-14 KC

Supporting Document Schedules

	Item Status:	Status Date:
<p>Satisfied - Item: Flesch Certification Comments: Attached is the Flesch Certification and Rule & Regulation 19 Certification. Attachments: ARCERTREAD.pdf ARCERTREG19.pdf</p>		
<p>Bypassed - Item: Application Bypass Reason: Not Applicable for this type of filing submission. Comments:</p>		
<p>Bypassed - Item: Health - Actuarial Justification Bypass Reason: Not Applicable for this type of filing submission. Comments:</p>		
<p>Bypassed - Item: Outline of Coverage Bypass Reason: Not Applicable for this type of filing submission. Comments:</p>		
<p>Satisfied - Item: NAIC Transmittal Document Comments: Attached is the NAIC Transmittal Document.</p>		

SERFF Tracking Number: META-126644599

State: Arkansas

Filing Company: Metropolitan Life Insurance Company

State Tracking Number: 45766

Company Tracking Number: W09-14 KC (LW)

TOI: LTC03G Group Long Term Care

Sub-TOI: LTC03G.001 Qualified

Product Name: Group Long Term Care Insurance

Project Name/Number: GAPP-F/W09-14 KC

Attachment:

L-A&H NAIC Transmittal Document 1-1-2009.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
GAPP-F	Enrollment Form	70.41
GAPP-GI	Enrollment Form	69.56
GAPP-SI	Enrollment Form	67.76
G-REINST	Reinstatement Application	67.75

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.", written in a cursive style.

Herbert B. Brown Jr.
Vice President

Life, Accident & Health, Annuity, Credit Transmittal Document

1.	Prepared for the State of	Arkansas
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2.	Department Use Only
	State Tracking ID

3.	Insurer Name & Address	Domicile	Insurer License Type	NAIC Group #	NAIC #	FEIN #	State #
	Metropolitan Life Insurance Company Institutional Contracts 1095 Avenue of the Americas New York, NY 10036-6796	NY		241	65978	13-5581829	

4.	Contact Name & Address	Telephone #	Fax #	E-mail Address
	Kris Ann Cappelluti MetLife Institutional Contracts MSC #39.087 1095 Avenue of the Americas New York, NY 10036-6796	(212) 578-3029	(212) 578-6247	kcappelluti@metlife.com

5.	Requested Filing Mode	<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): _____
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6.	Company Tracking Number	W09-14 KC
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7.	<input checked="" type="checkbox"/> New Submission <input type="checkbox"/> Resubmission	Previous file # _____
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8.	Market	<input type="checkbox"/> Individual <input type="checkbox"/> Franchise <input type="checkbox"/> Small <input checked="" type="checkbox"/> Large <input type="checkbox"/> Small and Large <input checked="" type="checkbox"/> Employer <input type="checkbox"/> Association <input type="checkbox"/> Blanket <input type="checkbox"/> Discretionary <input type="checkbox"/> Trust <input type="checkbox"/> Other: _____
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9.	Type of Insurance (TOI)	LTC03G – Group Long-Term Care Insurance
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10.	Sub-Type of Insurance (Sub-TOI)	LTC03G.001 – Qualified
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11.	Submitted Documents	<input type="checkbox"/> FORMS <input type="checkbox"/> Policy <input type="checkbox"/> Outline of Coverage <input type="checkbox"/> Certificate <input checked="" type="checkbox"/> Application/Enrollment <input type="checkbox"/> Rider/Endorsement <input type="checkbox"/> Advertising <input type="checkbox"/> Schedule of Benefits <input checked="" type="checkbox"/> Rate Disclosure & Personal Worksheet Rates <input type="checkbox"/> New Rate <input type="checkbox"/> Revised Rate <input type="checkbox"/> FILING OTHER THAN FORM OR RATE: Please explain: _____ SUPPORTING DOCUMENTATION <input type="checkbox"/> Articles of Incorporation <input type="checkbox"/> Third Party Authorization <input type="checkbox"/> Association Bylaws <input type="checkbox"/> Trust Agreements <input type="checkbox"/> Statement of Variability <input type="checkbox"/> Certifications <input type="checkbox"/> Actuarial Memorandum <input type="checkbox"/> Other: _____
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12.	Filing Submission Date	May 25, 2010	
13.	Filing Fee (If required)	Amount <u> \$200.00 </u>	Check Date <u> (SERFF EFT) </u>
		Retaliatory <input type="checkbox"/> Yes <input type="checkbox"/> No	Check Number <u> </u>
14.	Date of Domiciliary Approval		
15.	Filing Description:		
	<p>This is a filing of group long-term care enrollment forms. Please see our filing letter for details concerning this filing.</p>		

16.	Certification (If required)		
	<p>I HEREBY CERTIFY that I have reviewed the applicable filing requirements for this filing, and the filing complies with all applicable statutory and regulatory provisions for the state of <u> Arkansas </u>.</p>		
	Print Name <u> Herbert B. Brown, Jr. </u>	Title <u> Vice President </u>	
			
	Signature <u> </u>	Date: <u> May 25, 2010 </u>	

17.	Form Filing Attachment	
This filing transmittal is part of company tracking number		W09-14 KC
This filing corresponds to rate filing company tracking number		

	Document Name	Form Number		Replaced Form Number
	Description			Previous State Filing Number
01	Group Enrollment Form	GAPP-F	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
	Enrollment Form			
02	Group Enrollment Form	GAPP-GI	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
	Enrollment Form			
03	Group Enrollment Form	GAPP-SI	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
	Enrollment Form			
04	Reinstatement Application	G-REINST	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
	Application			
05			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
06			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
07			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
08			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
09			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
10			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	

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 indication (when applicable)				
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 _____	
10			<input type="checkbox"/> New <input type="checkbox"/> Revised Request +____% -____% <input type="checkbox"/> Other _____	

LH RFA-1