

SERFF Tracking Number: META-127673553 State: Arkansas
Filing Company: Metropolitan Life Insurance Company State Tracking Number: 50096
Company Tracking Number: W11-65 BW (MET IB)
TOI: LTC06 Long Term Care - Other Sub-TOI: LTC06.000 Long Term Care - Other
Product Name: Individual Long-Term Care
Project Name/Number: C11-IB-MET IB/W11-65 BW (MET IB)

Filing at a Glance

Company: Metropolitan Life Insurance Company

Product Name: Individual Long-Term Care SERFF Tr Num: META-127673553 State: Arkansas
TOI: LTC06 Long Term Care - Other SERFF Status: Closed-Approved State Tr Num: 50096
Sub-TOI: LTC06.000 Long Term Care - Other Co Tr Num: W11-65 BW (MET IB) State Status: Approved-Closed
Filing Type: Form Reviewer(s): Donna Lambert
Authors: Cherise Crittenden, Disposition Date: 10/25/2011
Andrea DeAlmeida
Date Submitted: 10/24/2011 Disposition Status: Approved
Implementation Date Requested: On Approval Implementation Date: 11/25/2011
State Filing Description:

General Information

Project Name: C11-IB-MET IB Status of Filing in Domicile:
Project Number: W11-65 BW (MET IB) Date Approved in Domicile:
Requested Filing Mode: Review & Approval Domicile Status Comments:
Explanation for Combination/Other: Market Type: Individual
Submission Type: New Submission Individual Market Type:
Overall Rate Impact: Filing Status Changed: 10/25/2011
State Status Changed: 10/25/2011
Deemer Date: Created By: Cherise Crittenden
Submitted By: Cherise Crittenden Corresponding Filing Tracking Number:
Filing Description:
This is a filing of individual long-term care insurance coverage change application forms. Please see our filing letter for details.

Company and Contact

Filing Contact Information

Thomas F. O'Connor, Sr, Analyst-Contracts tocnnor1@metlife.com
Dev.
57 GREENS FARMS ROAD 203-221-3834 [Phone]
WESTPORT, CT 06880 203-221-3348 [FAX]

Filing Company Information

SERFF Tracking Number: META-127673553 State: Arkansas
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 Product Name: Individual Long-Term Care
 Project Name/Number: C11-IB-MET IB/W11-65 BW (MET IB)
 Metropolitan Life Insurance Company CoCode: 65978 State of Domicile: New York
 MetLife Group Code: 241 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: \$50.00
 Retaliatory? No
 Fee Explanation: \$50.00 per application x 2 = \$100.00
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Metropolitan Life Insurance Company	\$100.00	10/24/2011	53116989

SERFF Tracking Number: META-127673553 State: Arkansas
Filing Company: Metropolitan Life Insurance Company State Tracking Number: 50096
Company Tracking Number: W11-65 BW (MET IB)
TOI: LTC06 Long Term Care - Other Sub-TOI: LTC06.000 Long Term Care - Other
Product Name: Individual Long-Term Care
Project Name/Number: C11-IB-MET IB/W11-65 BW (MET IB)

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved	Donna Lambert	10/25/2011	10/25/2011

SERFF Tracking Number: *META-127673553* *State:* *Arkansas*
Filing Company: *Metropolitan Life Insurance Company* *State Tracking Number:* *50096*
Company Tracking Number: *W11-65 BW (MET IB)*
TOI: *LTC06 Long Term Care - Other* *Sub-TOI:* *LTC06.000 Long Term Care - Other*
Product Name: *Individual Long-Term Care*
Project Name/Number: *C11-IB-MET IB/W11-65 BW (MET IB)*

Disposition

Disposition Date: 10/25/2011

Implementation Date: 11/25/2011

Status: Approved

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: META-127673553 State: Arkansas
 Filing Company: Metropolitan Life Insurance Company State Tracking Number: 50096
 Company Tracking Number: W11-65 BW (MET IB)
 TOI: LTC06 Long Term Care - Other Sub-TOI: LTC06.000 Long Term Care - Other
 Product Name: Individual Long-Term Care
 Project Name/Number: C11-IB-MET IB/W11-65 BW (MET IB)

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved	Yes
Supporting Document	Application	Approved	Yes
Supporting Document	Health - Actuarial Justification	Approved	Yes
Supporting Document	Outline of Coverage	Approved	Yes
Supporting Document	Ceritfication	Approved	Yes
Supporting Document	Filing Letter	Approved	Yes
Supporting Document	NAIC Transmittal form	Approved	Yes
Form	Application	Approved	Yes
Form	Application	Approved	Yes

SERFF Tracking Number: META-127673553 State: Arkansas
 Filing Company: Metropolitan Life Insurance Company State Tracking Number: 50096
 Company Tracking Number: W11-65 BW (MET IB)
 TOI: LTC06 Long Term Care - Other Sub-TOI: LTC06.000 Long Term Care - Other
 Product Name: Individual Long-Term Care
 Project Name/Number: C11-IB-MET IB/W11-65 BW (MET IB)

Form Schedule

Lead Form Number: CC11-IB

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved 10/25/2011	CC11-IB	Application/ Enrollment Form	Application	Initial		52.000	CC11 IB FRD-filing.pdf
Approved 10/25/2011	CC11-IB- TIAA	Application/ Enrollment Form	Application	Initial		52.000	CC11 IB TIAA ASM FRD- filing.pdf



MetLife[®]

Individual Long-Term Care Insurance (LTCI) Coverage Change Packet

Table of Contents

Application _____

- Part A Person Applying for Coverage
- Part B Insurability Questions
- Part C Coverage Change Selections
- Part D Health Questions
- Part E Agreement and Acknowledgement

Required Forms and Notices _____

- AUTH Medical Authorization
- AAUTH Agent/Producer Authorization
- AR Agent/Producer's Report

Questions? Call [888-565-3761]

Please submit the entire application to MetLife at:

**[MetLife Long-Term Care]
[P.O. Box 64911, St. Paul, MN 55164-0911]**

[IMPORTANT INSTRUCTIONS FOR AGENTS/PRODUCERS

This application must be completed if a person is requesting a coverage change to a MetLife Long-Term Care Insurance Policy.

A pharmacy screen, phone or in-person (in their place of residence) health interview and medical records will be required at the underwriter's discretion based on age and/or medical conditions.

To save time during the interview, please ask your client to have the following available:

- Current medication bottles
- Names, addresses and phone numbers of physicians
- Dates of any surgeries or hospitalizations

If your client is changing policies (i.e., Value to Ideal), a new Outline of Coverage must be provided.

Do not submit any payment with this coverage change application.]

[COVERAGE CHANGE PACKET SUBMISSION CHECKLIST

To avoid a delay in processing, confirm the following:

- All Health Information is complete.
- The Medical Authorization is signed by the applicant.
- Correct distribution channel is selected and all information is completed accurately in Agent/Producer's Report.
- All appropriate licensing, appointments, LTC CE's and/or Partnership certifications (if applicable) have been completed prior to submission of the application.
- Application being submitted is based on policy issue state.
- All signatures are complete.]

Agent/Producer Distribution Channel: MetLife NEF MLR General Agent/Producer Other _____ (Firm Name)

Do not submit any payment with this coverage change application.

PART A PERSON APPLYING FOR COVERAGE CHANGE (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/Civil Union Partner
 Domestic Partner
10. Do you have a Spouse or Civil Union Partner or Domestic Partner or household member who has an Individual LTC Insurance policy issued by MetLife? YES NO
IF YES please identify and provide requested information.
Name _____
[Social Security Number] _____
11. Policy number of coverage you wish to increase

PART B INSURABILITY QUESTIONS (Please answer these questions BEFORE you continue with this application.)

If you have any doubt about your answers, 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); Huntington's chorea; or insulin dependent diabetes?	<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 B, questions 1-5, PLEASE DO NOT CONTINUE.
We regret that you are not eligible to increase or add to your Long-Term Care Insurance coverage at this time.
If you answered "NO" to all of PART B, questions 1-5, please CONTINUE.**

To make a change to your current coverage:

STEP 1

- **Please contact your Agent/Producer or call the phone number listed on the cover of this application to speak with a customer service member to discuss the options available to you. Coverage change options are limited to the amounts and features available at the time of your request.**

STEP 2

- **Based on your discussion with your Agent/Producer or your phone call with the customer service member, please fill in the information below.**

Increase my coverage as follows: _____

Please Note:

[If your policy includes a Survivor feature and/or Shared Care Rider, please review your policy for information on any applicable requirements for maintaining identical coverage.]

If you currently have a Partnership policy, please check the minimum requirements for Partnership qualification.

I understand that if my application contains a request for a coverage change that is not currently available for my policy, including any misquoted amount or feature, my application for increased coverage will be denied.

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: A pharmacy screen, phone or in-person (in your place of residence) health interview and medical records will be required at the underwriter's discretion based on your age and/or medical conditions.]

[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 above or on the previous page [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 _____				



MetLife®

Long-Term Care Insurance (LTCI) Coverage Change Packet

Table of Contents

Application _____

- Part A Insurability Questions
- Part B Person Applying for Coverage
- Part C Coverage Change Selections
- Part D Health Questions
- Part E Agreement and Acknowledgement

Required Forms and Notices _____

- AUTH Medical Authorization

**Questions? Call [1-888-748-4824]
[Individuals with a TTY may call 1-800-638-1004]**

Please submit the entire application to MetLife at:
**[Metropolitan Life Insurance Company]
[P.O. Box 937, Westport, CT 06881-0937]**

[COVERAGE CHANGE 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 identification number (Social Security or Employee I.D. or Membership 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 G, Agreement and Acknowledgement.
- Complete the Medical Authorization.
- Contingent on any required 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); Huntington’s chorea; or insulin dependent diabetes?	<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 you are not eligible to increase or add to your Long-Term Care Insurance coverage at this time. If you answered “NO” to all of PART A, questions [1-5], please CONTINUE.

PART B - PERSON APPLYING FOR COVERAGE CHANGE

(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/Civil Union Partner
 Domestic Partner

10. Do you have a Spouse or Civil Union Partner or Domestic Partner or household member who has an Individual LTC Insurance policy issued by MetLife? YES NO

IF YES please identify and provide requested information.
Name _____
[Social Security Number] _____

11. Policy number of coverage you wish to increase

PART C - COVERAGE CHANGE SELECTIONS**To make a change to your current coverage:****STEP 1**

- Please call the phone number listed on the cover of this application to speak with a customer service member to discuss the options available to you. Coverage change options are limited to the amounts and features available at the time of your request.

STEP 2

- Based on your phone call with the customer service member, please fill in the information below.

Increase my coverage as follows: _____

Please Note:

[If your policy includes a Survivor feature and/or Shared Care Rider, please review your policy for information on any applicable requirements for maintaining identical coverage.]

If you currently have a Partnership policy, please check the minimum requirements for Partnership qualification.

I understand that if my application contains a request for a coverage change that is not currently available for my policy, including any misquoted amount or feature, my application for increased coverage will be denied.

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: A pharmacy screen, phone or in-person (in your place of residence) health interview and medical records will be required at the underwriter’s discretion based on your age and/or medical conditions.]

[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 above or on the previous page [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 _____				

<i>SERFF Tracking Number:</i>	<i>META-127673553</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Metropolitan Life Insurance Company</i>	<i>State Tracking Number:</i>	<i>50096</i>
<i>Company Tracking Number:</i>	<i>W11-65 BW (MET IB)</i>		
<i>TOI:</i>	<i>LTC06 Long Term Care - Other</i>	<i>Sub-TOI:</i>	<i>LTC06.000 Long Term Care - Other</i>
<i>Product Name:</i>	<i>Individual Long-Term Care</i>		
<i>Project Name/Number:</i>	<i>C11-IB-MET IB/W11-65 BW (MET IB)</i>		

Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification	Approved	10/25/2011
Comments:	Attached is the Flesch Certification		
Attachment:	ARCERTREAD.pdf		
		Item Status:	Status Date:
Bypassed - Item:	Application	Approved	10/25/2011
Bypass Reason:	N/A		
Comments:			
		Item Status:	Status Date:
Bypassed - Item:	Health - Actuarial Justification	Approved	10/25/2011
Bypass Reason:	N/A		
Comments:			
		Item Status:	Status Date:
Bypassed - Item:	Outline of Coverage	Approved	10/25/2011
Bypass Reason:	N/A		
Comments:			
		Item Status:	Status Date:
Satisfied - Item:	Ceritification	Approved	10/25/2011
Comments:	Attached is the Ceritification		
Attachment:			

SERFF Tracking Number: META-127673553 State: Arkansas
 Filing Company: Metropolitan Life Insurance Company State Tracking Number: 50096
 Company Tracking Number: W11-65 BW (MET IB)
 TOI: LTC06 Long Term Care - Other Sub-TOI: LTC06.000 Long Term Care - Other
 Product Name: Individual Long-Term Care
 Project Name/Number: C11-IB-MET IB/W11-65 BW (MET IB)
 ARCERTREG19.pdf

		Item Status:	Status
			Date:
Satisfied - Item:	Filing Letter	Approved	10/25/2011
Comments:	Attached is the Filing Letter		
Attachment:	Filing Letter - Met Ind.pdf		

		Item Status:	Status
			Date:
Satisfied - Item:	NAIC Transmittal form	Approved	10/25/2011
Comments:	Attached is the NAIC Transmittal form		
Attachment:	NAIC Transmittal - Met Ind.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
CC11-IB	Application Form for Coverage Changes	52.00
CC11-IB-TIAA	Application Form for Coverage Changes	52.00

Michael F. Tietz
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 "Michael F. Tietz".

Michael F. Tietz
Vice President

Metropolitan Life Insurance Company
Institutional Contracts – **MSC #39.087**
1095 Avenue of the Americas
New York, NY 10036-6796
Tel 212 578-2944 Fax 212 578-6247
Croth@metlife.com



Carolyn J. Roth
Director
Institutional Business Contracts

October 24, 2011

Arkansas Department of Insurance
1200 West 3rd Street
Little Rock, Arkansas 72201-1904

Re: Metropolitan Life Insurance Company
Individual Long-Term Care Insurance Coverage Change Application
NAIC Company No.: 65978
FEIN: 13-5581829

Dear Sir/Madam:

The following individual long-term care insurance forms are submitted for your review and approval for use in your state. These forms are new, and do not replace any forms previously filed with your Department. Please note that the submitted forms are intended to be used to administer coverage changes for closed blocks of business.

Form Number	Description
CC11-IB	Application form for coverage change requests by individuals currently covered under individual long-term care insurance policies issued and insured by MetLife.
CC11-IB-TIAA	Application form for coverage change requests by individuals covered under individual long-term care insurance policies originally issued by Teachers Insurance and Annuity Association ("TIAA") or TIAA-CREFF Life Insurance Company ("T-C Life"), whose policies were subsequently assumed by MetLife (and are therefore now insured by MetLife) pursuant to assumption reinsurance agreements entered into on May 1, 2004.

Readability Score

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

Form Number	Score
CC11-IB	52
CC11-IB-TIAA	52

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 Thomas F. O'Connor via telephone (203-221-3834), or e-mail (toconnor1@metlife.com).

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

Sincerely,



Carolyn Roth
Director



Michael F. Tietz
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 Insurance Products 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
	Thomas F. O'Connor Metropolitan Life Insurance Co. 57 Greens Farms Road Westport, Connecticut 06880	(203) 221-3834	(203) 221-3348	Toconnor1@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	W11-65 BW (Met IB)
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7.	<input checked="" type="checkbox"/> New Submission <input type="checkbox"/> Resubmission	Previous file # _____
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8.	Market	<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: _____
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9.	Type of Insurance (TOI)	LTC06
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10.	Sub-Type of Insurance (Sub-TOI)	LTC06.000
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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 type="checkbox"/> Other 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	October 24, 2011	
13	Filing Fee (If required)	Amount <u>\$100.00</u>	Check Date <u>EFT Submission</u>
		Retaliatory <input type="checkbox"/> Yes <input type="checkbox"/> No	Check Number _____
14.	Date of Domiciliary Approval	Not Applicable	
15.	Filing Description:		
<p>This is a filing of individual long-term care insurance coverage change applications. Please see our filing letter for details.</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>Michael F. Tietz</u>		Title <u>Vice President</u>	
 Signature _____		Date: <u>October 24, 2011</u>	

17.	Form Filing Attachment	
This filing transmittal is part of company tracking number		W11-65 BW (Met IB)
This filing corresponds to rate filing company tracking number		

	Document Name	Form Number		Replaced Form Number
	Description			Previous State Filing Number
01	Application for coverage change – individual long-term care insurance	CC11-IB	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
	Application			
02	Application for coverage change – individual long-term care insurance	CC11-IB-TIAA	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
	Application			
03			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
04			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
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 _____	

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 indication (when applicable)				
Overall percentage rate impact for this filing		%		
	Document Name Description	Affected Form Numbers		Previous State Filing Number
01			<input type="checkbox"/> New <input type="checkbox"/> Revised Request + 45% - ____% <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