

SERFF Tracking Number: META-127673906 State: Arkansas
Filing Company: Metropolitan Life Insurance Company State Tracking Number: 50097
Company Tracking Number: W11-65 BW (MET GP)
TOI: LTC06 Long Term Care - Other Sub-TOI: LTC06.000 Long Term Care - Other
Product Name: Group Long-Term Care
Project Name/Number: C11-IB-MET GP/W11-65 BW (MET GP)

Filing at a Glance

Company: Metropolitan Life Insurance Company

Product Name: Group Long-Term Care SERFF Tr Num: META-127673906 State: Arkansas
TOI: LTC06 Long Term Care - Other SERFF Status: Closed-Approved State Tr Num: 50097
Sub-TOI: LTC06.000 Long Term Care - Other Co Tr Num: W11-65 BW (MET GP) 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 GP Status of Filing in Domicile:
Project Number: W11-65 BW (MET GP) Date Approved in Domicile:
Requested Filing Mode: Other Domicile Status Comments:
Explanation for Combination/Other: Application Market Type: Group
Submission Type: New Submission Group Market Size: Large
Group Market Type: Employer, Association, Trust 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 group 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]

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Filing Company Information

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
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Metropolitan Life Insurance Company	\$50.00	10/24/2011	53117030

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Correspondence Summary

Dispositions

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

SERFF Tracking Number: *META-127673906* *State:* *Arkansas*
Filing Company: *Metropolitan Life Insurance Company* *State Tracking Number:* *50097*
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Disposition

Disposition Date: 10/25/2011

Implementation Date: 11/25/2011

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	Approved	Yes
Supporting Document	Application	Approved	Yes
Supporting Document	Health - Actuarial Justification	Approved	Yes
Supporting Document	Outline of Coverage	Approved	Yes
Supporting Document	Certification	Approved	Yes
Supporting Document	Filing Letter	Approved	Yes
Supporting Document	NAIC Transmittal Form	Approved	Yes
Form	Application	Approved	Yes

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Form Schedule

Lead Form Number: CC11-G

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



MetLife[®]

Group 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 [1-800-438-6388]
[Individuals with a TTY may call 1-800-638-1004]**

Please submit the entire application to MetLife at:
**[MetLife LTCI]
[P.O. Box 14633, Lexington, KY 40512-4633]**

[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 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 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

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: _____

I understand that if my application contains a request for a coverage change that is not currently available for my certificate, including any misquoted amount or feature, my application 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 _____				

PART E - AGREEMENT AND ACKNOWLEDGEMENT

I understand that all statements made on this application are representations and not warranties. I understand that the coverage change I am applying for, will not take effect unless on the date the 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 the date on which any coverage change is scheduled to go into effect.

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: Before signing this application, please read the warning for the state where you reside and for the state where the insurance policy under which you are applying for coverage was issued.

Arkansas, District of Columbia, Louisiana, New Mexico, Ohio, Rhode Island and West Virginia: 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.

Colorado: It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

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

Georgia: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information, or conceals, for the purpose of misleading, information concerning any fact material thereto, may be committing a fraudulent insurance act, which may subject such person to criminal and civil penalties, as determined by a court of competent jurisdiction.

Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

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

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

New Jersey: Any person who files an application containing any false or misleading information is subject to criminal and civil penalties.

New York: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to civil penalty not to exceed five thousand dollars and the stated value of the claim for each violation.

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

Oregon and Vermont: Any person who knowingly presents a false statement of claim for insurance may be guilty of a criminal offense and subject to penalties under state law.

Puerto Rico: Any person who knowingly and with the intention to defraud includes false information in an application for insurance or files, assists or abets in the filing of a fraudulent claim to obtain payment of a loss or other benefit, or files more than one claim for the same loss or damage, commits a felony and if found guilty shall be punished for each violation with a fine of no less than five thousand dollars (\$5,000), not to exceed ten thousand dollars (\$10,000); or imprisoned for a fixed term of three (3) years, or both. If aggravating circumstances exist, the fixed jail term may be increased to a maximum of five (5) years; and if mitigating circumstances are present, the jail term may be reduced to a minimum of two (2) years.

All other states: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.】

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 and that I am eligible to request a change in coverage.

X _____
Signature of Applicant

Date

<i>SERFF Tracking Number:</i>	<i>META-127673906</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Metropolitan Life Insurance Company</i>	<i>State Tracking Number:</i>	<i>50097</i>
<i>Company Tracking Number:</i>	<i>W11-65 BW (MET GP)</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>Group Long-Term Care</i>		
<i>Project Name/Number:</i>	<i>C11-IB-MET GP/W11-65 BW (MET GP)</i>		

Supporting Document Schedules

	Item Status:	Status Date:
Satisfied - Item: Flesch Certification Comments: Attached is the Flesch Certification Attachment: ARCERTREAD.pdf	Approved	10/25/2011

	Item Status:	Status Date:
Bypassed - Item: Application Bypass Reason: N/A Comments:	Approved	10/25/2011

	Item Status:	Status Date:
Bypassed - Item: Health - Actuarial Justification Bypass Reason: N/A Comments:	Approved	10/25/2011

	Item Status:	Status Date:
Bypassed - Item: Outline of Coverage Bypass Reason: N/A Comments:	Approved	10/25/2011

	Item Status:	Status Date:
Satisfied - Item: Certification Comments: Attached is the Certification Attachment:	Approved	10/25/2011

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 ARCERTREG19.pdf

		Item Status:	Status
			Date:
Satisfied - Item:	Filing Letter	Approved	10/25/2011
Comments:	Attached is the Filing Letter		
Attachment:	Filing Letter - Met Grp.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 Grp.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 ("MetLife")
Group Long-Term Care Insurance Coverage Change Application
NAIC Company No.: 65978
FEIN: 13-5581829

Dear Sir/Madam:

The following group long-term care insurance form is submitted for your review and approval for use in your state. This form is new and does not replace any forms previously filed with your Department.

Please note that MetLife is no longer marketing group long-term care insurance to new group policyholders; however there are currently group long-term care insurance policies that are still open to new entrants. We anticipate that MetLife will no longer be accepting new entrants under any group long-term care policies by the end of 2012. This form is intended to be used to administer coverage changes for certificateholders of those groups that are still open as well as those that are closed to new entrants.

Form Number	Description
CC11-G	Application form for coverage change requests by individuals currently covered under group long-term care insurance policies for whom coverage is insured by MetLife.

Readability Score

The form has been tested for readability and achieved the following Flesch Reading Ease score, as certified by the MetLife officer signing below:

Form Number	Score
CC11-G	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)

Filer insert his or her information.

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 GP)
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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 checked="" type="checkbox"/> Association <input type="checkbox"/> Blanket <input type="checkbox"/> Discretionary <input checked="" 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>\$50.00</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 group long-term care insurance coverage change application forms.</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 GP)
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 – group long-term care insurance	CC11-G	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
	Application			
02			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
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 _____	

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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 _____	

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