

SERFF Tracking Number: META-127942545 State: Arkansas
 Filing Company: Metropolitan Life Insurance Company State Tracking Number:
 Company Tracking Number: B11-158 GJ
 TOI: H111 Individual Health - Disability Income Sub-TOI: H111.003 Long Term - Unrelated to marketing
 with employer or association groups
 Product Name: Individual Disability Income Programs
 Project Name/Number: EMED-13-05/B11-158 GJ

Filing at a Glance

Company: Metropolitan Life Insurance Company

Product Name: Individual Disability Income Programs SERFF Tr Num: META-127942545 State: Arkansas

TOI: H111 Individual Health - Disability Income SERFF Status: Closed-Approved- Closed State Tr Num:

Sub-TOI: H111.003 Long Term - Unrelated to marketing with employer or association groups Co Tr Num: B11-158 GJ State Status: Approved-Closed

Filing Type: Form

Reviewer(s): Rosalind Minor

Authors: Sandra Bennett, Ruth Rivera, Linda Williams

Disposition Date: 01/10/2012

Date Submitted: 01/09/2012

Disposition Status: Approved-Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: EMED-13-05

Project Number: B11-158 GJ

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Deemer Date:

Submitted By: Sandra Bennett

Filing Description:

Individual Disability Income Programs

Form EMED-13-05 Paramedical/Medical Exam Application

Our NAIC No. is 65978

Our FEIN No. is 13-5581829

Status of Filing in Domicile:

Date Approved in Domicile:

Domicile Status Comments:

Market Type: Individual

Individual Market Type:

Filing Status Changed: 01/10/2012

State Status Changed: 01/10/2012

Created By: Linda Williams

Corresponding Filing Tracking Number:

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Dear Sir/Madam:

We enclose for filing final printed copies of the above referenced application form. This form is new and does not replace any form previously filed with your Department. It was initially filed for use with Metropolitan Life Insurance Company's individual and variable life insurance policy forms. We respectfully ask that the Department extend the use of this application for use with all of Metropolitan Life Insurance Company's individual disability income policy forms approved by your Department.

Form Number / Description

EMED-13-05

Paramedical/Medical Exam Application Form. This form will be used when it is necessary to obtain medical information from a paramedical examiner for a proposed insured and will always be used in conjunction with an approved application. The application is a multi-company form and the agent will check off the appropriate company name. Your Department approved this application for use with the individual and variable life insurance portfolio for Metropolitan Life Insurance Company on January 11, 2006.

While this form is in final print format for actual field use, it is subject only to minor modifications in paper size, stock, ink, border, company logo and adaptation to computer printing. This form is being submitted as a duplex form, however, it may appear in the policy single-sided, especially if it is faxed to us. We have bracketed as variable the company names on each form because the form is a multi-company (subsidiary) application. This will allow us to remove a company that ceases to sell new business from the multi-company application without refiling the application. We assure you that the only variability to the list of companies is the ability to remove a company name; no new insurer will be added to the form without refiling the application for all companies.

If you have any questions or comments that you feel could best be handled by contacting me, please feel free to do so via telephone, fax or e-mail (see upper left-hand corner of the first page of this letter).

Very truly yours,

Gayle Jones
Consultant, Group Contracts & Compliance

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Company and Contact

Filing Contact Information

Gayle Jones, Consultant ggjones@metlife.com
 501 Route 22 908-253-2753 [Phone]
 Bridgewater Township, NJ 08807 908-253-2126 [FAX]

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 form.
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Metropolitan Life Insurance Company	\$50.00	01/09/2012	55139705

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	01/10/2012	01/10/2012

SERFF Tracking Number: *META-127942545* *State:* *Arkansas*
Filing Company: *Metropolitan Life Insurance Company* *State Tracking Number:*
Company Tracking Number: *B11-158 GJ*
TOI: *H111 Individual Health - Disability Income* *Sub-TOI:* *H111.003 Long Term - Unrelated to marketing*
Product Name: *Individual Disability Income Programs*
Project Name/Number: *EMED-13-05/B11-158 GJ*

Disposition

Disposition Date: 01/10/2012

Implementation Date:

Status: Approved-Closed

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-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	Yes
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Supporting Document	ARCERTREG19	Approved-Closed	Yes
Supporting Document	NAIC Transmittal Document	Approved-Closed	Yes
Form	Application Form	Approved-Closed	Yes

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Form Schedule

Lead Form Number: EMED-13-05

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 01/10/2012	EMED-13-05	Application/Enrollment Form	Application Form	Initial		63.720	5. EMED-13-05.pdf

**Paramedical/
Medical Exam**

- Metropolitan Life Insurance Company
- MetLife Investors Insurance Company
- New England Life Insurance Company

- Metropolitan Tower Life Insurance Company
- MetLife Investors USA Insurance Company
- General American Life Insurance Company

The Company indicated above is referred to as "the Company."

The questions below are directed to the person to be examined. Record **ONLY** this person's answers in the spaces below.

1. Name of Proposed Insured _____ **LAST** _____ **FIRST** _____ **MIDDLE** _____ Date of Birth **MONTH/DAY/YEAR** _____

2. Tobacco Use – Indicate date last smoked/used:
 Cigarette _____ **Never** Smokeless Tobacco _____ **Never** Cigar/Pipe _____ **Never**
 Nicotine Substitute (i.e., Patch, Gum, etc.) _____ **Never** Amount/Frequency _____ How Long _____ yrs.

3. Please provide name of doctor, practitioner, or health care facility who can give us the most complete and up to date information concerning your present health. If **None**, check .

Physician Name _____ Name of Practice/Clinic _____
 Street _____ City _____ State _____ Zip _____
 Phone Number _____ Fax Number _____ Date Last Consulted **MONTH/DAY/YEAR** _____
 Reason _____
 Findings, treatment given, medication prescribed. If **None**, check . _____

 Reasons, findings, earlier consultations past 5 years _____

4. Height _____ ft. _____ in. Weight _____ lbs. Change in weight in past 12 months? **Yes** **No**
 If **Yes**, Pounds lost _____ Pounds gained _____ Reason _____

5. Have you **EVER** received treatment, attention, or advice from any physician, practitioner or health facility for, or been told by any physician, practitioner or health facility that you had:

a) High blood pressure; chest pain; heart attack; irregular heartbeat; peripheral vascular disease; or any other disease or disorder of the heart or circulatory system (blood vessels)? **Yes** **No**

b) Asthma; bronchitis; pneumonia; emphysema; sleep apnea; shortness of breath; or any other disease or disorder of the lungs or respiratory system? **Yes** **No**

c) Seizures; stroke; paralysis; Alzheimer's disease or other form of dementia; multiple sclerosis; memory loss; Parkinson's disease; progressive neurological disorder; headaches; or any other disease or disorder of the brain or nervous system? **Yes** **No**

d) Ulcers; colitis; hepatitis; cirrhosis; pancreatitis; or any other disease or disorder of: the liver; pancreas; gallbladder; esophagus; stomach; spleen; or intestines? **Yes** **No**

e) Any disease or disorder of: the breasts; reproductive organs; or the genitourinary system, including but not limited to: the kidney; bladder; or prostate; or blood, protein or pus in the urine? **Yes** **No**

f) Diabetes; thyroid disorder; elevated cholesterol or other lipid disorder; or any other endocrine disease or disorder? **Yes** **No**

g) Arthritis; gout; osteoporosis; or other disease or disorder of the: muscles; bones; spine (discs, back, neck); or joints? **Yes** **No**

h) Cancer; tumor; polyp; or cyst? Any disease or disorder of the skin? **Yes** **No**

i) Anemia; leukemia; or any other disease or disorder of the blood or lymph glands? **Yes** **No**

j) Depression; stress; anxiety; or any other psychological or emotional disorder or symptoms? **Yes** **No**

k) Any disease or disorder of the eyes, ears, nose, or throat? **Yes** **No**

Details: List question number. Give: dates; duration/description of condition; diagnosis; treatment; physician, practitioner or health facility names and addresses.



Details (Continued):

- 6. Are you now, or within the past year, taking medication or receiving treatment? (Including over the counter medications, vitamins, herbal supplements, alternative therapies, etc.) Yes No
- 7. Do you have any doctor's visits, medical tests, medical care, or surgery scheduled for the next six months? Yes No
- 8. Other than the above, during the past five years have you had any:
 - a) Checkup; consultations; electrocardiogram; chest x-ray; or other medical test? Yes No
 - b) Illness; injury; or health condition not revealed above; or have been recommended to have any: treatment; hospitalization; surgery; medical test; or medication? Yes No
- 9. Have you:
 - a) ever been diagnosed or treated by a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS)? Yes No
 - b) ever tested positive for the AIDS Human Immunodeficiency Virus (HIV) virus or for antibodies to the AIDS (HIV) virus? Yes No
- 10. a) Have you ever used heroin, cocaine, barbiturates, or other drugs, except as prescribed by a physician or other licensed practitioner? Yes No
 - b) Have you ever received treatment from a physician, practitioner, health facility or counselor regarding the use of alcohol, or the use of drugs; or been advised by a physician, practitioner, health facility or counselor to restrict the use of alcohol or drugs; or received treatment or advice from an organization that assists those who have an alcohol or drug problem? Yes No

11. Do you exercise? Yes No Type _____ How often? _____

12. Are you now pregnant? Yes No If Yes, estimated date of delivery? _____

13. Has a parent or sibling ever had: heart disease; coronary artery disease; vascular disease; stroke/cerebrovascular disease; diabetes; cancer? (If Yes, indicate below.) Yes No

Relationship to Proposed Insured:	Age(s) if living	Age(s) at Death	State of Health (Specific Conditions) or Cause of Death Attach additional sheet(s) if necessary.

- 14. a) Do you currently use any assisted devices such as: a walker; wheelchair; long leg braces; cane; or crutches? Yes No
- b) Do you need any assistance or supervision with any or all of the following activities: eating; bathing; dressing; walking; moving in/out of a chair or bed; toileting; continence or taking medication? Yes No

If Yes, provide details above.

I have read the answers to questions 2-14 before signing. They correctly reflect the answers given by me, and are true and complete to the best of my knowledge and belief. There are no exceptions to any such answers other than as written.

 Signature of Proposed Insured _____ (PARENT OR GUARDIAN IF UNDER 18) Date _____ MONTH/DAY/YEAR

 Witness to Signature _____ City and State _____



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Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification	Approved-Closed	01/10/2012
Comments:	ARCERTREAD		
Attachment:	2. ARCERTREAD.pdf		

		Item Status:	Status Date:
Bypassed - Item:	Application	Approved-Closed	01/10/2012
Bypass Reason:	The requirement listed above is not applicable for this filing submission.		
Comments:			

		Item Status:	Status Date:
Bypassed - Item:	Health - Actuarial Justification	Approved-Closed	01/10/2012
Bypass Reason:	The requirement listed above is not applicable for this filing submission.		
Comments:			

		Item Status:	Status Date:
Bypassed - Item:	Outline of Coverage	Approved-Closed	01/10/2012
Bypass Reason:	The requirement listed above is not applicable for this filing submission.		
Comments:			

		Item Status:	Status Date:
Satisfied - Item:	ARCERTREG19	Approved-Closed	01/10/2012
Comments:	ARCERTREG19		

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Attachment:

3. ARCERTREG19.pdf

Satisfied - Item: NAIC Transmittal Document

Comments:

NAIC Transmittal Document

Attachment:

4. NAIC Transmittal Document.pdf

Item Status:

Approved-Closed

Status

Date:

01/10/2012



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
EMED-13-05	Paramedical Application	63.72

A handwritten signature in black ink, appearing to read "Michael F. Tietz". The signature is written in a cursive style with a large, stylized initial "M".

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

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
B11-158 GJ	

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

4.	Contact Name & Address	Telephone #	Fax #	E-mail Address
	Gayle Jones Metropolitan Life Insurance Co. 501 Route 22 Bridgewater Twncsp, NJ 08807	(908) 253-2753	(908) 253-2528	ggjones@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	B11-158 GJ
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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)	H11I – Individual Health – Disability Income
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10.	Sub-Type of Insurance (Sub-TOI)	H11I.003 Long-Term—Unrelated to marketing with employer or association groups H11I.007 Long-Term—Related to marketing with employer or association groups
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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	January 9, 2012
13.	Filing Fee (If required)	Amount _____ Check Date _____ Retaliatory <input type="checkbox"/> Yes <input type="checkbox"/> No Check Number _____
14.	Date of Domiciliary Approval	Filing Concurrently
15.	Filing Description:	
	Paramedical/Medical Exam Application Form. This form will be used when it is necessary to obtain medical information from a paramedical examiner for a proposed insured and will always be used in conjunction with an approved application.	

16.	Certification (If required)	
	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>	
	Print Name <u>Gayle Jones</u>	Title <u>Contract Consultant</u>
	Signature 	Date: <u>January 9, 2012</u>

17.	Form Filing Attachment	
This filing transmittal is part of company tracking number		B11-158 GJ
This filing corresponds to rate filing company tracking number		

	Document Name	Form Number		Replaced Form Number
	Description			Previous State Filing Number
01	Paramed Application	EMED-13-05	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
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 _____	

LH FFA-1

18.		Rate Filing Attachment		
This filing transmittal is part of company tracking number		N/A		
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