

State: Arkansas **Filing Company:** Metropolitan Life Insurance Company
TOI/Sub-TOI: H11G Group Health - Disability Income/H11G.001 Business Overhead Expense
Product Name: GCERT2000 Series - Business Overhead Expense
Project Name/Number: GCERT2000 Series/T12-135

Filing at a Glance

Company: Metropolitan Life Insurance Company
Product Name: GCERT2000 Series - Business Overhead Expense
State: Arkansas
TOI: H11G Group Health - Disability Income
Sub-TOI: H11G.001 Business Overhead Expense
Filing Type: Form
Date Submitted: 09/25/2012
SERFF Tr Num: META-128701397
SERFF Status: Closed-Approved-Closed
State Tr Num:
State Status: Approved-Closed
Co Tr Num: T12-135 -

Implementation
Date Requested:
Author(s): Sandra Bennett, Ruth Rivera, Linda Williams
Reviewer(s): Rosalind Minor (primary)
Disposition Date: 09/26/2012
Disposition Status: Approved-Closed
Implementation Date:

State Filing Description:

State: Arkansas **Filing Company:** Metropolitan Life Insurance Company
TOI/Sub-TOI: H11G Group Health - Disability Income/H11G.001 Business Overhead Expense
Product Name: GCERT2000 Series - Business Overhead Expense
Project Name/Number: GCERT2000 Series/T12-135

General Information

Project Name: GCERT2000 Series Status of Filing in Domicile:
Project Number: T12-135 Date Approved in Domicile:
Requested Filing Mode: Review & Approval Domicile Status Comments:
Explanation for Combination/Other: Market Type: Group
Submission Type: New Submission Group Market Size: Small
Group Market Type: Employer Overall Rate Impact:
Filing Status Changed: 09/26/2012 Deemer Date:
State Status Changed: 09/26/2012 Submitted By: Sandra Bennett
Created By: Sandra Bennett
Corresponding Filing Tracking Number:

Filing Description:

Dear Sir/Madam:

We enclose for filing final printed copies of the above referenced group business overhead expense insurance form. This form is new and does not replace any forms previously filed with your Department.

Form Number / Description

GCERT2000 Series

The enclosed form is an additional form for use with the GCERT2000 certificate series. The initial installment of the GCERT2000 certificate series was approved by your department on July 24, 2001.

GCERT2000
di/boe

This is a new form that will pay for business overhead expenses if the insured becomes disabled. This form will be included in the certificate whenever business operating expense benefit is elected by the Policyholder. We have also included the corresponding Explanation of Variable Material.

The insurance described may be contributory or noncontributory. This form is designed to be issued in conjunction with any eligible group with the exception of creditors groups.

This form may be printed in another format such as continuous text or booklet. This form may be used in connection with any policy forms approved for use by your department, including the previously approved GPNP99 group policy form – approved by your department on April 28, 1999; as well as any application/enrollment form approved by your department for use with group insurance, including the GEF02-1 series previously approved by your department on September 12, 2002.

Thank you for your review of this filing. We hope that the Department has enough information to approve the filing. Should you have any additional questions, please feel free to contact me.

State: Arkansas **Filing Company:** Metropolitan Life Insurance Company
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Product Name: GCERT2000 Series - Business Overhead Expense
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Very truly yours,

Carmelean Hyppolite
 Consultant – Group Contracts Development

Company and Contact

Filing Contact Information

Carmelean Hyppolite, Contracts Development
 18210 Crane Nest Drive Tampa, FL 33647
 chyppolite@metlife.com
 813-983-4457 [Phone] 4457 [Ext]
 813-983-4940 [FAX]

Filing Company Information

Metropolitan Life Insurance Company
 MetLife
 1095 Avenue of the Americas
 New York, NY 10036-6796
 (212) 578-2211 ext. [Phone]

CoCode: 65978
 Group Code: 241
 Group Name:
 FEIN Number: 13-5581829

State of Domicile: New York
 Company Type: Life
 State ID Number:

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	09/25/2012	63053686

State: Arkansas Filing Company: Metropolitan Life Insurance Company
TOI/Sub-TOI: H11G Group Health - Disability Income/H11G.001 Business Overhead Expense
Product Name: GCERT2000 Series - Business Overhead Expense
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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	09/26/2012	09/26/2012

SERFF Tracking #:

META-128701397

State Tracking #:**Company Tracking #:**

T12-135 -

State:

Arkansas

Filing Company:

Metropolitan Life Insurance Company

TOI/Sub-TOI:

H11G Group Health - Disability Income/H11G.001 Business Overhead Expense

Product Name:

GCERT2000 Series - Business Overhead Expense

Project Name/Number:

GCERT2000 Series/T12-135

Disposition

Disposition Date: 09/26/2012

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	A&H NAIC Transmittal Document 1-1-2009_AR	Approved-Closed	Yes
Supporting Document	ARCERTREG19	Approved-Closed	Yes
Supporting Document	EOVM for GCERT2000 di_boe_08-7-12	Approved-Closed	Yes
Form	Certificate	Approved-Closed	Yes

State: Arkansas **Filing Company:** Metropolitan Life Insurance Company
TOI/Sub-TOI: H11G Group Health - Disability Income/H11G.001 Business Overhead Expense
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Form Schedule

Lead Form Number: GCERT2000 di/boe

Item No.	Schedule Item Status	Form Number	Form Type	Form Name	Action/ Action Specific Data	Readability Score	Attachments
1	Approved-Closed 09/26/2012	GCERT2000 di/boe	CERA	Certificate	Initial:		GCERT2000 di_boe_08-7-12.pdf

Form Type Legend:

ADV	Advertising	AEF	Application/Enrollment Form
CER	Certificate	CERA	Certificate Amendment, Insert Page, Endorsement or Rider
DDP	Data/Declaration Pages	FND	Funding Agreement (Annuity, Individual and Group)
MTX	Matrix	NOC	Notice of Coverage
OTH	Other	OUT	Outline of Coverage
PJK	Policy Jacket	POL	Policy/Contract/Fraternal Certificate
POLA	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	SCH	Schedule Pages

DISABILITY INCOME INSURANCE: BUSINESS OVERHEAD EXPENSE BENEFIT

- (1) If You become Disabled while insured, Proof must be sent to [Us]. Proof must include evidence that You:
- are actively engaged in business and contributing to the Business Office Overhead Expenses;
- (2) [• are:
- the sole proprietor;
 - the general partner;
 - a member of a limited liability company; or
 - a member of a professional corporation;] and
- are Disabled.

You or Your legal representative must send [Us] satisfactory Proof of the Business Office Overhead Expenses You have incurred, in addition to sending [Us] Proof of Your Disability.

When [We] receive such Proof, [We] will review the claim. If [We] approve the claim, [We] will pay the Monthly Benefit up to the Maximum Benefit Period shown in the Schedule of Benefits, subject to the Date Benefit Payments End section.

To verify that You continue to be Disabled without interruption after [Our] initial approval, [We] may periodically request that You send [Us] Proof that You continue to be Disabled. Such Proof may include physical exams, exams by independent medical examiners, in-home interviews or functional capacity exams, as needed.

While You are Disabled, the Business Office Overhead Expense Benefit described in this certificate will not be affected if:

- Your insurance ends; or
- the Group Policy is amended to change the plan of benefits for Your class.

BENEFIT PAYMENTS

If [We] approve Your claim, benefits will begin to accrue on the day after the day You complete Your Elimination Period. [We] will pay the first Monthly Benefit one month after the date benefits begin to accrue. [We] will make subsequent payments monthly thereafter for a period of [1-60] months. Payment will be based on the number of days You are Disabled during each month and will be pro-rated for any partial month of Disability.

- (3) [While You are receiving Business Office Overhead Expenses Benefits, premium payments for the cost of any insurance provided under this certificate is not required.]

BUSINESS OFFICE OVERHEAD EXPENSE BENEFIT AMOUNT

[We] will pay an amount equal to the covered monthly Business Office Overhead Expenses You actually incur in the operation of Your business, up to a maximum monthly benefit amount equal to **[\$1,000-\$25,000]**. If You share those expenses with someone else, [We] will pay only Your share. [We] will determine Your share based on Your business records for the [6-24] months before You become Disabled. For periods of less than one month, [We] will pro-rate Your benefit based on a 30 day month.

BUSINESS OFFICE OVERHEAD EXPENSE BENEFIT PAYMENT

[We] will pay Business Office Overhead Expense Benefit to You. If You die, [We] will pay the amount of any due and unpaid benefits as described in the General Provisions subsection entitled Disability Income Benefit Payments: Who We Will Pay.

DISABILITY INCOME INSURANCE: BUSINESS OVERHEAD EXPENSE BENEFIT (continued)

DATE BENEFIT PAYMENTS END

Benefit payments will end on the earliest of:

- the date You are no longer Disabled;
- the date You die;
- the date You fail to provide required Proof of continuing Disability;
- (4) [• the date You fail to have a medical exam requested by Us as described in the Physical Exams subsection of the General Provisions section;]
- (5) [• the date [1-60] monthly benefit payments have been made;
- the end of the Maximum Benefit Period;
- the date you reach age [65-85].]

DEFINITIONS

For purposes of this Disability Income Insurance: Business Office Overhead Expense Benefits section, the following definitions apply:

(6)(7) **Business Office Overhead Expenses** means the fixed expenses You incur that are [normal and customary in the operation of Your business in the operation of Your office.] [Such expenses **include:**

- Rent, electricity, heat, gas, telephone, telephone answering, laundry and janitorial services, postage and stationery, and water for Your office;
- Employees' salaries, payments for group insurance and pension plans; salaries include payroll taxes;
- Monthly pro-rata portion of annual contributions and membership fees and dues;
- Accountants' services;
- Mortgage interest and principal on debt owed for business premises owned and used by You in Your profession;
- Interest and principal on debt owed incurred for business equipment used in Your office;
- Tax payments for real and personal property used in Your business;
- Rental of business equipment (except automobiles or motor vehicles);
- Interest payments or lease payments on equipment, if such equipment is used exclusively in Your office. Principal payments on equipment loans are limited to the lesser of: (a) the amount of the Your indebtedness at the time Monthly Benefits become payable, divided by the number of months in the remaining term of indebtedness; or (b) [10%-50%] of the total Monthly Benefit.
- The depreciation of office furniture and equipment.
- Insurance premiums for: (a) tax deductible business insurance, including professional liability, malpractice and property and casualty insurance; (b) Worker's Compensation; and (c) employee group benefit plans.
- Interest payments on business debts.
- The cost of maintenance of existing office equipment.
- The expense for a license related to Your normal profession, subscriptions, membership dues, accountant's services, and such other fixed expenses which are normal and customary in the conduct and operation of the office; and
- Other such expenses necessary to operate Your office.]

If Your Office is jointly occupied, monthly Business Office Overhead Expenses will mean Your portion of such expenses. [We] will determine Your portion of Business Office Overhead Expenses based on Your business records for the [6-24] months before the start of Your Disability.

(8) [Business Office Overhead Expenses do not include salary, fees, drawing account or any other remuneration for:

- You;
- any partner, shareholder or member of Your profession;

DISABILITY INCOME INSURANCE: BUSINESS OVERHEAD EXPENSE BENEFIT (continued)

- any person sharing business expenses with You;
- any person employed to perform Your duties;
- any person hired after Your Disability began; or
- any person to whom You are related by blood or marriage.

Business Office Overhead Expenses also do not include:

- income taxes;
- cost of goods;
- cost of implements You use in the performance of Your job;
- payments on mortgage principal, or the principal of any other indebtedness;
- monthly expenses for which You were not normally and customarily liable for on a periodic basis prior to the start of Disability;
- personal expenses for You, including but not limited to any of the following: (a) Your salary, fees, income taxes, drawing account or any other remuneration; or (b) charitable contributions.
- salaries of individuals hired after Your Disability began;
- salaries of or fees paid to other individuals in Your same occupation for professional services.
- any expenses that would otherwise constitute Business Office Overhead Expenses that are reimbursed under another business overhead expense type policy.]

Renewal Date means the date [1-5 years] after the date Your insurance is effective.

Policy Effective Date means the effective date of the Group Policy.

RECOVERY FROM A DISABILITY

- (9) If You return to Active Work, [We will consider You to have recovered from Your Disability.]
- (10) [The provisions of this subsection will not apply if Your insurance has ended and You are eligible for coverage under another group long term disability plan.]

If You Return to Active Work Before Completing Your Elimination Period

If You return to Active Work before completing Your Elimination Period for a period of [1-365] days or less, and then become Disabled again due to the same or related Sickness or accidental injury, [We] will not require You to complete a new Elimination Period. [We] will count those days towards the completion of Your Elimination Period.

If You return to Active Work for a period of more than [1-365] days, and then become Disabled again, You will have to complete a new Elimination Period.

For purposes of this provision, the term Active Work only includes those days You actually work.

If You Return to Active Work After Completing Your Elimination Period

If You return to Active Work after completing Your Elimination Period for a period of [1-365] days or less, and then become Disabled again due to the same or related Sickness or accidental injury, [We] will not require You to complete a new Elimination Period. For the purpose of determining Your benefits, [We] will consider such Disability to be a part of the original Disability and apply the same terms, provisions and conditions that were used for the original Disability.

If You return to Active Work for a period of more than [1-365] days and then become Disabled again, You will have to complete a new Elimination Period.

For purposes of this provision, the term Active Work includes all of the continuous days which follow Your return to work for which You are not Disabled.]

DISABILITY INCOME INSURANCE: BUSINESS OVERHEAD EXPENSE BENEFIT (continued)

(11) [OPTIONAL PROVISION: CARRYOVER BENEFIT]

If Your actual Business Office Overhead Expenses exceed Your Monthly Benefit, the monthly excess may be carried forward for use in future months during the same Disability, subject to the Lifetime Maximum Limit.]

(12) [OPTIONAL PROVISION: GUARANTEED PURCHASE OPTION]

(13) You may elect a [25%-100%] increase in Your initial Monthly Benefit without evidence of insurability on [each of the second, fourth, sixth, and eighth anniversaries of the Renewal Date.] If You are Disabled on any such anniversary date, this option will be available to You at the end of a period of continuous Disability.

You will be notified of the Guaranteed Purchase Option within [30-90] days prior to the second policy anniversary. You must exercise this option for the first time prior to Your attainment of age [40-60].

(14) If You accept the increase, [We] will increase Your Monthly Benefit and You will be notified how much You will be required to contribute to premium. [If You do not elect the increase prior to the second anniversary, the Guaranteed Purchase Option will terminate and You will not have the increase option available to You for the subsequent anniversaries. Once You have elected this option, such increases will take effect automatically on the anniversaries described above that occur after the first such increase.]

You may not increase Your Monthly Benefit to an amount that exceeds the maximum Monthly Benefit available under the Group Policy.

The increased Guaranteed Purchase benefit amount will not apply to any continuous period of Disability that starts before any of the above mentioned anniversary dates.

Provided You make any contribution to premium, the increase will take effect on the date of Your request, if You are Actively at Work. If You are not Actively at Work, the increase will take effect on the date You return to Active Work.

(15) [BUSINESS ESTATE SETTLEMENT BENEFIT]

If You die while receiving the Monthly Benefit, We will pay a benefit for covered expenses incurred in closing Your office. The maximum benefit payable is [1-6] times the Monthly Benefit. We will pay this benefit as described in the General Provisions subsection entitled Disability Income Benefit Payments: Who We Will Pay.]

FILING A CLAIM

(16) The [Policyholder] should have a supply of claim forms. Obtain a claim form from the [Policyholder] and fill it out carefully. Return the completed claim form with the required Proof to the [Policyholder]. The [Policyholder] will certify Your insurance under the Group Policy and send the certified claim form and Proof to [Us].

When [We] receive the claim form and Proof, [We] will review the claim and, if [We] approve it, [We] will pay benefits subject to the terms and provisions of this certificate and the Group Policy.

CLAIMS FOR INSURANCE BENEFITS

When a claimant files an initial claim for Business Office Overhead Expense Insurance benefits described in this certificate, both the notice of claim and the required Proof should be sent to [Us] within 90 days of the end of the Elimination Period.

Notice of claim and Proof may also be given to [Us] by following the steps set forth below:

DISABILITY INCOME INSURANCE: BUSINESS OVERHEAD EXPENSE BENEFIT (continued)

Step 1

A claimant may give [Us] notice by calling Us at the toll free number shown in the Certificate Face Page within 20 days of the date of a loss.

Step 2

[We] will send a claim form to the claimant and explain how to complete it. The claimant should receive the claim form within 15 days of giving [Us] notice of claim.

Step 3

When the claimant receives the claim form, the claimant should fill it out as instructed and return it with the required Proof described in the claim form.

If the claimant does not receive a claim form within 15 days after giving [Us] notice of claim, Proof may be sent using any form sufficient to provide [Us] with the required Proof.

Step 4

The claimant must give [Us] Proof not later than 90 days after the end of the Elimination Period.

If notice of claim or Proof is not given within the time limits described in this section, the delay will not cause a claim to be denied or reduced if such notice and Proof are given as soon as is reasonably possible.

(17) [Items to be Submitted for a Disability Income Insurance Claim]

When submitting Proof on an initial or continuing claim for Business Office Overhead Expense Insurance, the following items may be required:

- documentation which must include, but is not limited to, the following information:
 - the date Your Disability started;
 - the cause of Your Disability;
 - the prognosis of Your Disability;
 - the continuity of Your Disability.
- Written authorization for Us to obtain and release medical, employment and financial information and any other items [We] may reasonably require to document Your Disability or to determine Your receipt of or eligibility for Other Income;
- any and all medical information, including but not limited to:
 - x-ray films; and
 - photocopies of medical records, including:
 - histories,
 - physical, mental or diagnostic examinations; and
 - treatment notes; and
- the names and addresses of all:
 - physicians and medical practitioners who have provided You with diagnosis, treatment or consultation;
 - hospitals or other medical facilities which have provided You with diagnosis, treatment or consultation; and
 - pharmacies which have filled Your prescriptions within the past three years.

DISABILITY INCOME INSURANCE: BUSINESS OVERHEAD EXPENSE BENEFIT (continued)

- Proof that You have incurred Business Office Overhead Expenses prior to the date You became Disabled. Such Proof of expenses may include the following:
 - Tax documents;
 - Copies of bills (addressed to Your attention or to the attention of Your business);
 - Business Ownership documents;
 - Proof of joint occupancy; or
 - Documents which indicate person(s) who are authorized to pay expenses.]

(18) **[Time Limit on Legal Actions.** A legal action on a claim may only be brought against Us during a certain period. This period begins 60 days after the date Proof is filed and ends 3 years after the date such Proof is required.]

State: Arkansas **Filing Company:** Metropolitan Life Insurance Company
TOI/Sub-TOI: H11G Group Health - Disability Income/H11G.001 Business Overhead Expense
Product Name: GCERT2000 Series - Business Overhead Expense
Project Name/Number: GCERT2000 Series/T12-135

Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification	Approved-Closed	09/26/2012
Comments:	ARCERTREAD		
Attachment(s):	ARCERTREAD.pdf		

		Item Status:	Status Date:
Bypassed - Item:	Application	Approved-Closed	09/26/2012
Bypass Reason:	The requirement listed above is not applicable for this filing submission.		
Comments:			

		Item Status:	Status Date:
Satisfied - Item:	A&H NAIC Transmittal Document 1-1-2009_AR	Approved-Closed	09/26/2012
Comments:	A&H NAIC Transmittal Document 1-1-2009_AR		
Attachment(s):	A&H NAIC Transmittal Document 1-1-2009_AR.pdf		

		Item Status:	Status Date:
Satisfied - Item:	ARCERTREG19	Approved-Closed	09/26/2012
Comments:	ARCERTREG19		
Attachment(s):	ARCERTREG19.pdf		

		Item Status:	Status Date:
Satisfied - Item:	EOVM for GCERT2000 di_boe_08-7-12	Approved-Closed	09/26/2012
Comments:	EOVM for GCERT2000 di_boe_08-7-12		
Attachment(s):	EOVM for GCERT2000 di_boe_08-7-12.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
GCERT2000 series	Certificate	49

Howard Koransky
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 Ins Co. 1095 Avenue of the Americas – MSC 39087 NY, NY 10036	NY		241	65978	13-5581829	

4.	Contact Name & Address	Telephone #	Fax #	E-mail Address
	Carmealeu Hyppolite 18210 Crane Nest Dr, Bldg 7 Tampa, FL. 33647	813-983-4457	813-983-4940	chypolite@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	T12-135
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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
		Group	<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:

9.	Type of Insurance (TOI)	H11G Group Health – Disability Income
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10.	Sub-Type of Insurance (Sub-TOI)	H11G.001 Business Overhead Expense
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11.	Submitted Documents	<input checked="" type="checkbox"/> FORMS <input type="checkbox"/> Policy <input type="checkbox"/> Outline of Coverage <input checked="" type="checkbox"/> Certificate <input 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 checked="" 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	September 25, 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		
15.	Filing Description:		
<p>Please see enclosed letter.</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 AR.</p>			
Print Name Carmelean Hyppolite		Title Carl Hyppolite	
Signature 		Date: September 25, 2012	

17.	Form Filing Attachment	
This filing transmittal is part of company tracking number		T12-135
This filing corresponds to rate filing company tracking number		

	Document Name	Form Number		Replaced Form Number
	Description			Previous State Filing Number
01	Certificate Group Disability Insurance	GCERT2000 di/boe	<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	

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	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 _____	

LH RFA-1



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, reading "Howard Koransky". The signature is written in a cursive style with a long, sweeping tail that extends to the right.

Howard Koransky
Vice President



Metropolitan Life Insurance Company

EXPLANATION OF VARIABLE MATERIAL

CERTIFICATE FORM GCERT2000 di/boe

There are two types of variable material set forth in brackets within this form. These types are

1. Illustrative variable material; and
2. Specific variable material.

Illustrative Variable Material

Illustrative variable material consists of entries that include ranges of numbers. When illustrative material shows a range, actual entries will always fall within that range. All illustrated ranges have been bracketed and bolded.

Unless indicated elsewhere in this Explanation of Variable Material, time periods expressed in terms of a specific measure may be expressed using other comparable measures. For example an item stated in years may also be expressed in terms of months, weeks or days. One year may appear as 12 months, 52 weeks or 365 days. When a time period is expressed as a range comparable measures could be used to indicate a point anywhere on the continuum of the range. For example, a filed range of “**1-2** years” if stated in terms of months could be expressed as 12,13,14,15 ... 23 or 24 months.

Specific Variable Material

Specific variable material is also bracketed and marked as numerical items within the margins of the form. Specific items marked will be changed only as indicated in the explanations set forth in this Explanation of Variable Material.

- (1) “Us”, “We” and “Our” may be replaced with “Policyholder” or a Third Party Administrator or another entity that may administer claims. If revised here, it will be revised throughout.
- (2) Any or all of the bulleted items may be omitted.
- (3) We may replace this with:

“If Your Disability begins prior to age **[55-65]** and You are Disabled for at least **[1-12]** consecutive months, while You are receiving Business Office Overhead Expenses Benefits, premium payments for the cost of any insurance provided under this certificate is not required.”

OR

“While You are receiving Business Office Overhead Expenses Benefits, premium payments for the cost of any insurance provided under this certificate is required.”

- (4) This may be omitted or be replaced with “• the date You:
 - fail to have;
 - postpone more than twice;
 - or refuse to participate, without good cause,

in an examination requested by Us as described in the Physical Exams subsection of the GENERAL PROVISIONS section;”

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- (5) Any or all of the bulleted items may be omitted. We may add the following additional item: "the date You refuse to work on either a Part-Time or Full-Time basis, if it is determined by a Physician that You are able to work on such Part-Time or Full-Time basis."
- (6) We may replace "normal and customary in the operation of Your business in the operation of Your office." with "normal and customary in the conduct and operation of Your business office." We may also add this to the end of the sentence, ", and generally accepted as tax deductible by the Internal Revenue Service."
- (7) Any of the bulleted items may be omitted in whole or in part or moved to the section headed "Business Office Overhead Expenses also do not include:"
- (8) Any of the bulleted items may be omitted in whole or in part or moved to the list of bulleted items that are included as Business Office Overhead Expenses.
- (9) We may replace this phrase with: "for more than [1-130 days],[We] will consider You to have recovered from Your Disability."
- (10) Either or both of these sections "If You Return to Active Work Before Completing Your Elimination Period" or "If You Return to Active Work After Completing Your Elimination Period" may be omitted.
- (11) This item will appear as shown or be omitted.
- (12) This item will appear as shown or be omitted.
- (13) The election periods "second, fourth, sixth, and eighth anniversaries of the Renewal Date" may vary to reflect other election periods, such as "each Year at the annual enrollment period." or "second, third, fourth and fifth anniversaries of the Renewal Date."
- (14) Either or both sentences may be omitted. The phrase "prior to the second anniversary" may be revised to read "prior to the first time the election is available" or to reflect the first election period that is permitted.
- (15) This item will appear as shown or be omitted.
- (16) "Policyholder" may be replaced with "We", or "MetLife" or may be replaced with a Third Party Administrator or another entity that may administer claims. If revised here, it will be revised throughout.
- (17) Item may appear as shown or may vary by omitting any of the items of required Proof as stated in the subsection entitled "Items to be Submitted for a Disability Income Insurance Claim."

If the Policyholder's plan includes in the definition of Disability the requirement that the insured be approved for Federal Social Security, the following may be added to the items that must be submitted for a Disability Income claim:

"For Proof to establish Your Disability on the basis of the award of Federal Social Security disability benefits, You must also submit documentation satisfactory to Us of the following items:

- the date You applied for Federal Social Security benefits; and
- the complete Notice of Award of Social Security disability benefits, including the date of such Award and the date of disability indicated in such Award."

Depending on the level at which You are awarded Federal Social Security disability benefits, You must also submit documentation satisfactory to Us of one of the following:

If awarded Federal Social Security disability benefits at either the initial or reconsideration level:

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- A letter or some other written confirmation from the Federal Social Security Administration containing a text description of the diagnosis for the condition for which You were approved for Federal Social Security disability benefits.

If awarded Federal Social Security disability benefits at the Administrative Law Judge level:

- The Administrative Law Judge favorable decision.”

- (18) Item will appear as shown or may be omitted. Also, if the Policyholder’s plan includes in the definition of Disability the requirement that the insured be approved for Federal Social Security, this item may be changed to read as follows:

“Time Limit on Legal Actions. A legal action on a claim may only be brought against Us during a certain period. This period begins 60 days after the date Proof is filed and ends 3 years after the date such Proof is required. However, if on the date We uphold an adverse determination concerning Your claim for Business Office Overhead Expense Benefits under this certificate pursuant to the definition of Disability, You have not yet received notice of a final determination of Your claim for Federal Social Security disability benefits, a lawsuit may not be started with respect to Your claim for Business Office Overhead Expense Benefits under this certificate until a reasonable period of time expires following the earlier of:

- the date We receive a copy of the final denial of Your request for Federal Social Security disability benefits by an Administrative Law Judge; or
- the expiration of a period of **24-36** consecutive months from the date You completed the Elimination Period under this certificate.”