Employee Benefits

From Wisconsin Manufacturers & Commerce

WMC/MetLife Life & Disability Benefits

New Business Checklist

Group Name:____

Proposed Effective Date:____________________

Please submit the following at least 10 working days prior to the requested effective date:

_____ WMC Employer Application

_____ Copy of Sold Proposal

_____ Check for 1st month's premium made payable to WMC Service Corporation

_____ Sold Employee Census (preferably in an excel file format)
Census data should include:

- Employee's last and first name
- Social Security #
- Gender
- Date of Birth
- Date of Hire
- Annual Salary, where applicable (include commissions & regular bonuses, exclude overtime and other pay)
- Class/Dept. # or location indicator, where applicable
- Appropriate coverage data/indicators (i.e. dep. Life, buy-up, supplemental or voluntary coverage)

_____ Employee Enrollment Forms (new contributory plans)

_____ Employee Evidence of Insurability Forms (where applicable)

_____ If replacement coverage, a copy of incumbent carrier's most recent monthly billing statement (employees not listed on this bill may be subject to pre-existing condition limitations)

Under no circumstances should the employer cancel existing coverage without prior written approval.

Contact WMC for additional Information
Phone: (608) 258-3400 Fax: (608) 258-3413 e-mail: ins@wmc.org