

*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 | e-mail: ins@wmc.org