IUOE LOCAL 399 VOLUNTARY DISABILITY INCOME INSURANCE ENROLLMENT FORM

Group Benefit Associates
1701 E. Lake Avenue
Suite 400
Glenview, IL 60025

Telephone: 800-450-1271
Fax: 773-427-6875
Email: CustomerService@groupba.com
www.groupba.com

Personal Information		
Last Name, First Name, MI:		Social Security Number:
Street Address:		
City:	State:	Zip:
Home Phone:	Cell Phone:	
Email:		
Date of Birth:	Gender: MALE FEMALE	Union Number:
Union Initiation Date:	Hourly Wage Rate: $	

Please Select Your Coverage Option(s):

IUOE Local 399:

- ☐ Both Short and Long Term Disability Income Insurance
- ☐ Short Term Disability Income Insurance ONLY
- ☐ Long Term Disability Income Insurance ONLY

If you were initiated into your Local ninety (90) days or more prior to your enrollment, a medical questionnaire is required. Your enrollment must be approved by the insurance company before coverage can be offered.

Both sides of form must be filled out completely in order to process the enrollment.

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Please Select a Payment Method:		
☐ Checking Account	Name on account as it appears on check:	
	Bank Name:	
	Routing Number (9 digits):	
	Account Number:	
☐ Visa ☐ MasterCard ***We do not accept Amex or Discover*	Name as it appears on card:	
	Credit Card Number:	
	Expiration (MM/YY):	
	Card Security Code (last 3 digits on back of card):	

As a plan participant, I agree to notify Group Benefit Associates:

- Within 30 days of any layoff and again within 30 days of my subsequent return to work
- Immediately when my payment method changes for the purpose of premium collection
- Immediately when my wage rate changes
- Within 1 year of my date of disability if I become disabled
- Within 30 days if I withdraw from the Union

I understand that failure to notify Group Benefit Associates in a timely manner of any of the above listed changes can affect my participation in the plan or the benefits I am eligible to receive under the plan. I am hereby enrolling in the Voluntary Group Disability Income Insurance Plan offered by Babbitt Municipalities, Inc. d.b.a. Group Benefit Associates.

Your initial premium due will be collected within 5 business days of receipt of your enrollment. Subsequent premiums will be collected on the 15th of the month prior to the start of the next month. There will be NO invoicing of premium.

You are authorizing Babbitt Municipalities d.b.a. Group Benefit Associates to collect your premium directly from your checking account or credit card. Please note that your monthly premium may change when the policy renews on its annual anniversary date, you make changes to the coverage including modifications to your insured wage rate, or your age bracket changes.

All cancellation requests must be received in writing.

Signature Date

Both sides of form must be filled out completely in order to process the enrollment.

INSTRUCTIONS

FOR THE **STATEMENT OF HEALTH** FORM AND THE **AUTHORIZATION** FORM THAT FOLLOW THIS SECTION

Please complete all sections in their entirety and forward to Group Benefit Associates. Group Benefit Associates will forward your application to MetLife for consideration. You may mail, fax or email to:

Group Benefit Associates

1701 E. Lake Avenue

Suite 400

Glenview, IL 60025

Email: CustomerService@groupba.com

Fax: 773-427-6875

Telephone: 800-450-1271

Note: Additional medical information may be required after MetLife's initial review of a completed Statement of Health form. The additional information requested may be a physical examination, paramedical exam, or an Attending Physician Report. Correspondence will be sent within ten days by MetLife or our approved vendor. Incomplete forms will be returned to you for completion.
Some services in connection with your Statement of Health form may be performed by our affiliate, MetLife Global Operations Support Center Private Limited. This service arrangement in no way alters Metropolitan Life Insurance Company's obligations to you. Services will not be performed by our affiliate if prohibited by state or local law or by mutual agreement with the Group Customer.

STATEMENT OF HEALTH FORM

MetLife
Metropolitan Life Insurance Company, New York, NY

GROUP CUSTOMER INFORMATION

Name of Group Customer/Employer/Association	Group Customer #	Class	Reporting Location #
International Union of Operating Engineers Local 399	**5929767**	**N/A**	**N/A**

Street Address	City	State	Zip Code
c/o GBA, 1701 E. Lake Avenue, Suite 400	Glenview	IL	60025

INSURANCE INFORMATION

Enrollment year:

Please select which coverage(s) you are requesting:

Disability Income Insurance
- ☐ Short Term Disability Benefits
- ☐ Long Term Disability Benefits

EMPLOYEE INFORMATION

Name of Employee (First, Middle, Last)		Social Security # of Employee
☒ Employee	Date of Hire (MM/DD/YYYY)	Employee's Basic Annual Earnings $

YOUR INFORMATION

Name (First, Middle, Last)			Relationship to Employee ☒ Self	☐ Male ☐ Female
Street Address		City	State	Zip Code
Date of Birth (MM/DD/YYYY)	Daytime Phone #	Home Phone #	Email Address	

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ADM

Please complete all sections of this form. Incomplete forms will be returned to you.

HEALTH INFORMATION

SECTION 1

Please complete all questions below. Omitted information will cause delays. In this section, "you" and "your" refers to the person for whom insurance is being requested. Health Information is required for the Proposed Insured only. For questions 5 through 11u, for "yes" answers, please provide full details in Section 2.

Your name _____ Employee's Name _____

Employee's Social Security/Identification # _____

	Yes	No
1. Your height ___ feet ___ inches Your weight ____ pounds		
2. Are you now on a diet prescribed by a physician or other health care provider? If "yes" indicate type _____	☐	☐
3. Are you now pregnant? If "yes," what is your due date (month/day/year)? _____	☐	☐
If "yes", provide Physician's name _____ Telephone: (____) ____ – _____		
4. Are you now, or have you in the past 2 years, used tobacco in any form?	☐	☐
5. In the past 5 years, have you received medical treatment or counseling by a physician or other health care provider for, or been advised by a physician or other health care provider to discontinue, the use of alcohol or prescribed or non-prescribed drugs?	☐	☐
6. In the past 5 years, have you been convicted of driving while intoxicated or under the influence of alcohol and/or any drug? If "yes", specify "date(s) of conviction(s) (month/day/year) _____	☐	☐
7. Have you had any application for life, accidental death and dismemberment or disability insurance ☐ declined ☐ postponed ☐ withdrawn ☐ rated ☐ modified or ☐ issued other than as applied for? Indicate reason _____	☐	☐
8. Are you now receiving or applying for any disability benefits, including workers' compensation?	☐	☐
9. Have you been **Hospitalized** as defined below (not including well-baby delivery) in the past 90 days? **Hospitalized** means admission for inpatient care in a hospital; receipt of care in a hospice facility, intermediate care facility, or long term care facility; or receipt of the following treatment wherever performed: chemotherapy, radiation therapy, or dialysis.	☐	☐
10. Have you ever been diagnosed or treated by a physician or other health care provider for Acquired Immunodeficiency Syndrome (AIDS), AIDS Related Complex (ARC) or the Human Immunodeficiency Virus (HIV) infection?	☐	☐
11. Have you ever been diagnosed, treated or given medical advice by a physician or other health care provider for:		
a. cardiac or cardiovascular disorder? Indicate type _____	☐	☐
b. stroke or circulatory disorder? Indicate type _____	☐	☐
c. high blood pressure?	☐	☐
d. cancer, Hodgkin's disease, lymphoma or tumors? Indicate type _____	☐	☐
e. anemia, leukemia or other blood disorder? Indicate type _____	☐	☐
f. diabetes? Your age at diagnosis? ____ ☐ Check if insulin treated	☐	☐
g. asthma, COPD, emphysema or other lung disease? Indicate type _____	☐	☐
h. ulcers, stomach, hepatitis or other liver disorder? Indicate type _____	☐	☐
i. colitis, Crohn's, diverticulitis or other intestinal disorder? Indicate type _____	☐	☐
j. memory loss? Indicate type _____	☐	☐
k. epilepsy, paralysis, seizures, dizziness or other neurological disorder? Specify date of last seizure (month/year) ____ Indicate type _____	☐	☐
l. Epstein-Barr, chronic fatigue syndrome or fibromyalgia? Indicate type _____	☐	☐
m. multiple sclerosis, ALS or muscular dystrophy? Indicate type _____	☐	☐
n. lupus, scleroderma, auto immune disease or connective tissue disorder?	☐	☐
o. arthritis? ☐ osteoarthritis ☐ rheumatoid ☐ other/type _____	☐	☐
p. back, neck, knee, spinal, joint or other musculoskeletal disorder? Indicate type _____	☐	☐
q. carpal tunnel syndrome?	☐	☐
r. kidney, urinary tract or prostate disorder? Indicate type _____	☐	☐
s. thyroid or other gland disorder? Indicate type _____	☐	☐
t. mental, anxiety, depression, attempted suicide or nervous disorder? Indicate type _____	☐	☐
u. sleep apnea? Indicate type _____	☐	☐

After completing the Personal Physician and Prescription Information on the next page, please provide full details in Section 2 for "yes" answers to questions 5 through 11u.

Personal Physician Information

Personal Physician's Name: _____

Address (Street, City, State, Zip Code): _____ Telephone: (___) ___-____

Date of last visit (MM/DD/YYYY): __/__/____ Reason for visit: _____

Prescription Information

Are you currently taking any prescribed medications? ☐ Yes ☐ No If yes, list the medications.

Medication: _____ Condition/Diagnosis: _____

Prescribing Physician's Name: _____ Telephone: (___) ___-____

Address (Street, City, State, Zip Code): _____

Medication: _____ Condition/Diagnosis: _____

Prescribing Physician's Name: _____ Telephone: (___) ___-____

Address (Street, City, State, Zip Code): _____

☐ Check here if you are attaching another sheet for any additional medications.

SECTION 2

Please provide full details below for each "Yes" answer to questions 5 through 11u in Section 1. If you need more space to provide full details, attach a separate sheet with the information and sign and date it. Delays in processing your application may occur if complete details are not provided. MetLife may contact you for additional or missing information. ☐ Check here if you are attaching another sheet.

Your name _____ Employee's Name _____

Your Date of Birth __/__/____

Question Number	Condition/Diagnosis	Please list any medication prescribed that you did not already identify in the Prescription Information above.
Date of Diagnosis (Month/Year)	**Date of Last Treatment (Month/Year)**	**Type of Treatment**

Treating Health Professional

Physician's Name: _____

Date of last visit: _____ Reason for visit: _____

Address _____
Street City State Zip Code

Telephone: (___) ___-____

Question Number	Condition/Diagnosis	Please list any medication prescribed that you did not already identify in the Prescription Information above.
Date of Diagnosis (Month/Year)	**Date of Last Treatment (Month/Year)**	**Type of Treatment**

Treating Health Professional

Physician's Name: _____

Date of last visit: _____ Reason for visit: _____

Address _____
Street City State Zip Code

Telephone: (___) ___-____

Question Number	Condition/Diagnosis	Please list any medication prescribed that you did not already identify in the Prescription Information above.
Date of Diagnosis (Month/Year)	Date of Last Treatment (Month/Year)	Type of Treatment

Treating Health Professional

Physician's Name: _____

Date of last visit: _____ Reason for visit: _____

Address _____

Street City State Zip Code

Telephone: (___) ___-_____

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HEA

FRAUD WARNINGS

Before signing this Statement of Health form, please read the warning for the state where you reside and for the state where the contract under which you are applying for coverage was issued.

Alabama, Arkansas, District of Columbia, Louisiana, Massachusetts, 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.

Kentucky: 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 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 purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

Maryland: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or 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 (only applies to Accident and Health Benefits): 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 such 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 in an application 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.

Pennsylvania and 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.

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Please complete all sections of this form. Incomplete forms will be returned to you.

DECLARATIONS AND SIGNATURES

By signing below, I acknowledge:

1. I have read this Statement of Health form and declare that all information I have given, including any health information, is true and complete to the best of my knowledge and belief. I understand that this information will be used by MetLife to determine my insurability.
2. I have read the applicable Fraud Warning(s) provided in this Statement of Health form.

Sign Here

Signature of Proposed Insured	Print Name	Date Signed (MM/DD/YYYY)

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DEC

Please complete all sections of this form. Incomplete forms will be returned to you.

AUTHORIZATION

This Authorization is in connection with an enrollment in group insurance and information required for underwriting and claim purposes for the proposed insured(s) ("employee", spouse, and /or any other person(s) named below). Underwriting means classification of individuals for determination of insurability and / or rates, based upon physician health reports, prescription drug history, laboratory test results, and other factors. Notwithstanding any prior restriction placed on information, records or data by a proposed insured, each proposed insured hereby authorizes:

- Any medical practitioner, facility or related entity; any insurer; MIB Group, Inc ("MIB"); any employer; any group policyholder, contract holder or benefit plan administrator; any pharmacy or pharmacy related service organization; any consumer reporting agency; or any government agency to give Metropolitan Life Insurance Company ("MetLife") or any third party acting on MetLife's behalf in this regard:
  - personal information and data about the proposed insured including employment and occupational information;
  - medical information, records and data about the proposed insured including information, records and data about drugs prescribed, medical test results and sexually transmitted diseases;
  - information, records and data about the proposed insured related to alcohol and drug abuse and treatment, including information and data records and data related to alcohol and drug abuse protected by Federal Regulations 42 CFR part 2;
  - information, records and data about the proposed insured relating to Acquired Immunodeficiency Syndrome (AIDS) or AIDS related conditions including, where permitted by applicable law, Human Immunodeficiency Virus (HIV) test results;
  - information, records and data about the proposed insured relating to mental illness, except psychotherapy notes; and
  - motor vehicle reports.

Note to All Heath Care Providers: The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. 'Genetic information' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Expiration, Revocation and Refusal to Sign: This authorization will expire 24 months from the date on this form or sooner if prescribed by law. The proposed insured may revoke this authorization at any time. To revoke the authorization, the proposed insured must write to MetLife at P.O. Box 14069, Lexington, KY 40512-4069, and inform MetLife that this Authorization is revoked. Any action taken before MetLife receives the proposed insured's revocation will be valid. Revocation may be the basis for denying coverage or benefits. If the proposed insured does not sign this Authorization, that person's enrollment for group insurance cannot be processed.

By signing below, each proposed insured acknowledges his or her understanding that:

- All or part of the information, records and data that MetLife receives pursuant to this authorization may be disclosed to MIB. Such information may also be disclosed to and used by any reinsurer, employee, affiliate or independent contractor who performs a business service for MetLife on the insurance applied for or on existing insurance with MetLife, or disclosed as otherwise required or permitted by applicable laws.
- Medical information, records and data that may have been subject to federal and state laws or regulations, including federal rules issued by Health and Human Services, setting forth standards for the use, maintenance and disclosure of such information by health care providers and health plans and records and data related to alcohol and drug abuse protected by Federal Regulations 42 CFR part 2, once disclosed to MetLife or upon redisclosure by MetLife, may no longer be covered by those laws or regulations.
- Information relating to HIV test results will only be disclosed as permitted by applicable law.
- Information obtained pursuant to this authorization about a proposed insured may be used, to the extent permitted by applicable law, to determine the insurability of other family members.
- A photocopy of this form is as valid as the original form. Each proposed insured has a right to receive a copy of this form.
- I authorize MetLife, or its reinsurers, to make a brief report of my personal health information to MIB.

Sign Here

Signature of Proposed Insured		Date Signed (MM/DD/YYYY)
Print Name	State of Birth	Country of Birth