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

Member of:
- ☐ IBEW Local 9
- ☐ IBEW Local 134
- ☐ Sheet Metal Workers Local 73
- ☐ IBEW Local 109
- ☐ IUOE Local 399
- ☐ BCTGM Local 1
- ☐ IUEC Local 2
- ☐ Teamsters 179 Bus Driver
- ☐ Teamsters 179 Non-Bus Driver
- ☐ ATU 241 PACE MV

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 or Badge Number
Union Initiation Date:	Hourly Wage Rate: $	

Please Select Your Coverage Option(s):		
IBEW Local 9: ☐ Short Term Disability Income Insurance $250 per week ☐ Short Term Disability Income Insurance $500 per week ☐ Long Term Disability Income Insurance	**IBEW Local 109:** ☐ Short Term Disability Income Insurance ☐ Long Term Disability Income Insurance	**IUOE Local 399:** ☐ Short Term Disability Income Insurance ☐ Long Term Disability Income Insurance
	IBEW Local 134: ☐ Short Term Disability Income Insurance ☐ Long Term Disability Income Insurance	**Sheet Metal Workers Local 73:** ☐ Short Term Disability Income Insurance ☐ Long Term Disability Income Insurance
BCTGM Local 1: ☐ Short Term Disability Income Insurance ☐ Long Term Disability Income Insurance	**Teamsters Local 179 Bus Drivers:** ☐ Short Term Disability Income Insurance ☐ Long Term Disability Income Insurance	**Teamsters Local 179 Non-Bus Drivers:** ☐ Short Term Disability Income Insurance ☐ Long Term Disability Income Insurance
IUEC: ☐ Short Term Disability Income Insurance ☐ Long Term Disability Income Insurance	**ATU 241 PACE MV:** ☐ Short Term & Long Term Disability Income Insurance	

If this application is outside of an Open Enrollment Period, a medical questionnaire is required if you were initiated into your Local ninety (90) days or more prior to your enrollment. If a medical questionnaire is required, it must be approved by the insurance company before coverage can be offered.

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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 60 days of any layoff and again within 60 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

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.

Guardian® The Guardian Life Insurance Company of America

EVIDENCE OF INSURABILITY FORM

PLEASE RETURN TO GBA VIA FAX, EMAIL, OR MAIL:

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

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

Planholder Name (Company Name)	Group Plan No.

Complete the following information:

Name (Last, First, Middle Initial)	Sex	Birthdate	Height	Weight	Full time Student
Employee:	☐M ☐F				☐ Yes ☐ No

Employee Home Address:	Preferred Method of Contact:	Employee Telephone Number:

Union Initiation Date: / /	Cell Phone:	E-mail Address:

Employee's Social Security Number:		Employee's Place of Birth (State):
Employee Amount of Insurance Currently Inforce: None		
Employee's Insurance Elected: ☐ STD ☐ LTD (per contract)		

Section I: questions 1-5 must only be answered by the Employee.

1. In the past 10 years, has any proposed insured been treated for or diagnosed as having any of the following: a) any disorder or condition of the heart; liver, kidney(s); lung or respiratory system; b) any disorder or condition of your digestive system including your esophagus, stomach, or intestines; c) any mental, nervous, emotional or neurological disorder or condition; d) auto immune disorder; e) diabetes; f) cancer; or g) a stroke?;	Employee ☐ Yes ☐ No
2. In the past 5 years, has any proposed insured: used any illegal drugs; used prescription medication other than as prescribed; been treated for alcoholism or drug use or dependency; or been advised to seek treatment for alcoholism, drug abuse or drug dependency?	Employee ☐ Yes ☐ No
3. Has any proposed insured ever tested positive for HIV (Human Immunodeficiency Virus) antibodies?	Employee ☐ Yes ☐ No
4. In the past year, has any proposed insured: (a) consulted or been examined by or treated by a physician, practitioner or specialist for any illness or injury, disease or disorder NOT listed in the questions above (including routine physicals only when there is an existing or newly diagnosed medical condition); or (b) sought treatment or a consultation in a hospital or other health care facility for observation, diagnosis, treatment or an operation; undergone any diagnostic testing including but not limited to X ray, blood work, ultrasound, an MRI, a CT scan, or PET scan with abnormal findings; or been prescribed medication(s) – (other than for colds, flu or allergies)?	Employee ☐ Yes ☐ No
5. **Please complete these additional questions:** (a) In the past 5 years, has any proposed insured been treated for any disorder or condition of the back, neck, spine; arthritis; or any muscular skeletal disorder or condition? (b) Are you currently pregnant?	Employee ☐ Yes ☐ No Employee ☐ Yes ☐ No

Please retain a copy for your records

For each "yes" answer to question 1 through 5 give details below. (Continue on reverse side if additional space is needed.)

Question #	Name	Test, Injury, Illness, Disease, Operation or Complication	Date of Onset	Date of Recovery	Full Details (including Doctors' Names and Addresses)

Please retain a copy for your records

Representations of the Proposed Insured(s) and Authorization **Please read and sign below.**

Part I. Representations of the Proposed Insured

Those parties who sign below hereby represent that the statements and answers to the question(s) are, to the best of the knowledge and belief of the party signing below, full, complete, true and correctly recorded. Those parties who sign below understand that they will form the basis of any coverage under the Group Plan for which Evidence of Insurability is required. When used in this Part I, "I" refers to the person applying for insurance signing below.

Also, it is mutually understood and agreed that (1) the Company reserves the right to request, at its expense (except in the case of a late entrant, it is not at the Company's expense), that any proposed insured be examined by an accredited medical examiner selected by the Company; (2) no Group Insurance will be binding or in force until satisfactory evidence of insurability is submitted, approved by the Company and the required premiums are received by the Company; and: (a) I am actively at work on a full-time basis (as defined in the Group Plan) for full pay on the date my Group Insurance becomes effective; otherwise, (b) I become insured on the date I do return to work and satisfy a waiting period (as defined in the Group Plan) of full-time service; (3) coverage for my dependents will not take effect if a dependent other than a newborn is: (a) confined to the hospital or other health care facility; or (b) is unable to perform the normal activities of someone of like age and sex; (4) no person, except the President, a Vice President or a Secretary of the Company, has authority to: (a) determine whether any contract(s) of insurance shall be issued on the basis of the application; (b) waive or modify any of the provisions of the application or any of the Company's requirements; (c) bind the Company by any statement or promise pertaining to any insurance contract(s) issued or to be issued on the basis of the application; or (d) accept any information or representation not contained in the written application; (5) the employer is hereby named the Proposed Insured's representative for the purpose of receiving premiums and remitting them to the Company. In the event the Company receives premiums in excess of the appropriate amount for the coverage provided, the Company will only be liable for the overpaid premiums plus applicable interest.

Any misrepresentation or omission, if found to be material, may adversely affect acceptance of the risk, claims payment or may lead to rescission of any coverage issued based on this Evidence of Insurability Form.

Part II. Authorization to Obtain Information (Medical Records and other information)

I authorize my physician, medical practitioner, hospital, clinic, other health facility, practitioner, mental health professional, pharmacy or pharmacy benefit manager, laboratory, the MIB, Inc., insurance or reinsurance company, group policyholder, benefit plan administrator, employer, other organization, institution or person that has any records or knowledge of the Proposed Insured or his/her health, business associate, other person or organization to release any and all medical and non-medical information in its possession about me, to The Guardian Life Insurance Company of America or its legal representatives. Medical information means all information in the possession of or derived from providers of health care regarding the medical history, pharmaceutical history, and all past and present physical, mental, drug and alcohol condition, or treatment of me. Non-medical information includes employment history, job duties, and any wage or earnings information. I understand that the information released could contain reference to or results of HIV Antibody (AIDS) testing, and may relate to the symptoms, evaluation, diagnosis, examination, treatment or prognosis of any mental or physical condition, including psychiatric, and psychological conditions, and drug or alcohol abuse.

I understand that Guardian will use the information obtained by this authorization to determine eligibility for insurance or eligibility for benefits under an existing plan. I further understand that if I refuse to sign this authorization, the Company may not be able to process my application, or pay a claim in the case of coverage which is already in force. Guardian will not release any information obtained to any person or organization except to reinsurance companies, the MIB, Inc., or other persons or organizations performing business or legal services in connection with my application, claim or as may be lawfully permitted or required, or as I may fully authorize. I understand that any information disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal regulations governing privacy (such as the HIPAA Privacy Rule).

By my signature below, I authorize the Company or its legal representatives to make a brief report of my personal health information to the MIB, Inc.

I know that I may revoke this authorization in writing, at any time, by sending a written request for revocation to the Guardian Corporate Secretary at 7 Hanover Square, New York, NY 10004-2616. I understand that a revocation is not effective to the extent that the Company and/or any of the entities listed above has already relied on this authorization, or to the extent that the Company has a legal right to contest a claim under an insurance policy or to contest the policy itself.

I know that I may request and receive a copy of this authorization.

Please retain a copy for your records

I agree that a photocopy of this authorization will be as valid as the original. I agree that this authorization will be valid for two and one half years from the date shown below.

Any person who with intent to defraud any insurance company or other person files an application for insurance or statements of claim containing any materially, false information, or conceals for purpose of misleading information concerning any fact material hereto, commits a fraudulent insurance act, which is a crime, and may also be subject to civil penalties, or denial of insurance benefits.

The state in which you reside may have a specific state fraud warning. Please refer to the Fraud Warning Statements page below.

The laws of New York require the following statement appear: 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 a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation. (Does not apply to Life Insurance.)

By my signature below,

1. I agree with all of the terms, conditions, statements, and representations stated above in Part I. Representations of the Proposed Insured; and
2. I agree and consent to the Company obtaining and disclosing the information as stated above in Part II. Authorization to Obtain Information (Medical Records and Other Information) and with all other terms and conditions stated therein.

_____ _____

Signature of Employee Date

Please retain a copy for your records

Insurance Information Practices Please read and detach for your records

Thank you for choosing The Guardian Life Insurance Company of America ("Guardian"). This notice is given to you at the time you apply for life or disability insurance to tell you about the kinds of information we may obtain in connection with your application. We will treat all personal information about you as confidential, except as authorized by you, or as required by law. You have a right of access and correction with respect to this information. If you wish a more detailed explanation of our information practices, please send your written request to: The Privacy Office, The Guardian Life Insurance Company of America, 7 Hanover Square, New York, NY 10004-4025.

MIB, Inc. Pre-Notice: Information regarding your insurability will be treated as confidential. Guardian, or its reinsurers may, however, make a brief report thereon to MIB, Inc., a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its Members. If you apply to another MIB, Inc. member company for life, health or disability insurance coverage, or a claim for benefits is submitted to such a company, MIB, Inc., upon request, will supply such company with the information about you in its file.

Upon receipt of a request from you, MIB, Inc. will arrange disclosure of any information it may have in your file. Please contact MIB, Inc., at 866 692-6901 (TTY 866 346-3642). If you question the accuracy of the information in your MIB, Inc. file, you may contact MIB, Inc., and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB, Inc., information office is 50 Braintree Hill Park, Suite 400, Braintree MA 02184-8734.

Guardian, or its reinsurers, may also release information in its file to other insurance companies to whom you may apply for life, health, or disability insurance, or to whom a claim for benefits may be submitted.

Medical Records: We may request information from health care providers or others who have records of your medical history, mental or physical condition, or treatment. Only qualified members of Guardian's staff will have access to your medical file to evaluate your eligibility for insurance or to service your claim for benefits under a policy. Your authorization will govern our request for information and any later disclosure of that information.

Please retain a copy for your records

Fraud Warning Statements

The laws of several states require the following statements to appear on the evidence of insurability form:

Alabama: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

Arizona: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

California: For your protection California law requires the following to appear on this form: The falsity of any statement in the application shall not bar the right to recovery under the policy unless such false statement was made with actual intent to deceive or unless it materially affected either the acceptance of the risk or the hazard assumed by the insurer.

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.

Connecticut, Iowa, Kansas, Nebraska, Oregon, and Vermont: Any person who knowingly, and with intent to defraud any insurance company or other person, files an application of insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto, may be guilty of a fraudulent insurance act, which may be a crime, and may also be subject to civil penalties.

Delaware, Indiana and Oklahoma: WARNING: Any person who knowingly, and with the 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.

District of Columbia: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits, if false information materially related to a claim was provided by the applicant.

Florida: Any person who knowingly and with intent to injure, defraud, or deceive any insurer 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 a 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.

Louisiana and Texas: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit is guilty of a crime and may be subject to fines and confinements in state prison.

New Mexico: Any person who knowingly presents a false or fraudulent claim for payment or a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties or denial of insurance benefits.

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 benefit.

Maryland: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or 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.

Minnesota: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

New Hampshire: Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in N.H. Rev. Stat. Ann. § 638:20.

New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

Ohio: Any person who with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Pennsylvania: 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.

Rhode Island: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Please retain a copy for your records