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 109 ☐ IBEW (all other locals) ☐ Sheet Metal Workers
☐ IUEC ☐ IUOE Local 399 ☐ BCTGM Local 1
☐ Teamsters 179 Bus Driver ☐ Teamsters 179 Non-Bus Driver

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):		
IUOE Local 399: ☐ Short Term Disability Income Insurance ☐ Long Term Disability Income Insurance	**IBEW Local 109:** ☐ Short Term Disability Income Insurance	**IBEW (all other locals):** ☐ Short Term Disability Income Insurance ☐ Long Term Disability Income Insurance
	IUEC: ☐ Short Term Disability Income Insurance ☐ Long Term Disability Income Insurance	**Sheet Metal Workers:** ☐ 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

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.

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.