VOLUNTARY DISABILITY INCOME INSURANCE ENROLLMENT FORM

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

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

Member of: [X] IBEW Local 9

Personal Information		
Last Name, First Name, MI:		Social Security Number:
Street Address:		
City:	State:	Zip:
Home Phone:	Cell Phone:	
Email:		
Date of Birth:	Initiation Date into Union:	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 **IBEW Local 134:** ☐ Short Term Disability Income Insurance ☐ Long Term Disability Income Insurance	**IUOE Local 399:** ☐ 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

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.

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.

Signature Date

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

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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.

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):	

Signature Date

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

Employer Group Benefits Coverage Information

Thank you for choosing The Hartford. All sections of this form must be completed and received by The Hartford within 30 days of the signature date.

Section 1: Employer Details *(to be completed by Employer)* **PLEASE PRINT CLEARLY**

Employer Name: IBEW Local 9	Policy Number: GLT873273
Employer Mailing Address (Street, City, State, Zip Code): c/o GBA,	
Division/Location/Subsidiary with Mailing Address *(if applicable):*	
Benefits Contact Name (First, Last):	
Benefits Contact Email Address: CustomerService@groupba.com	Benefits Contact Phone: 800-450-1271

Section 2: Employee Details **PLEASE PRINT CLEARLY**

Employee Name (First, MI, Last):	Date of Hire (mm/dd/yyyy):
Hourly Wage Rate: $	Coverage Effective Date* (mm/dd/yyyy): TBD

Disability Insurance Coverage Requested

- Check Yes if employee is requesting Short Term and/or Long Term Disability coverage that is subject to EOI

Short Term Disability	☐ Yes, EOI is required
Long Term Disability	☐ Yes, EOI is required

EVIDENCE OF INSURABILITY

HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY

Applicant Information

	First Name	Last Name	Social Security #	Gender	Height (ft./in.)	Weight (lbs.)*	Date of Birth (mm/dd/yyyy)
Employee				☐ Male ☐ Female			

* If currently pregnant, please provide pre-pregnancy weight

Employee	Street Address		Day Time Phone	
	City		Evening Phone	
	State, Zip Code		Email Address	

Medical Information

Each Applicant must answer each of the following questions to the best of their knowledge and belief.

	Employee
Within the past 5 years, have you been diagnosed with or treated by a licensed medical physician for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) caused by the Human Immunodeficiency Virus (HIV) infection or other sickness or condition derived from such infection?	☐ Yes ☐ No
Are you currently pregnant?	☐ Yes ☐ No
Within the past 5 years, with the exception of a past pregnancy, have you lost time from work for more than 10 consecutive work days due to a disability, injury, or sickness?	☐ Yes ☐ No
Within the past 5 years, have you used any controlled substances, with the exception of those taken as prescribed by your physician, been diagnosed or treated for drug or alcohol abuse (excluding support groups), or been convicted of operating a motor vehicle while under the influence of drugs or alcohol?	☐ Yes ☐ No

Within the past 5 years, have you been diagnosed with or treated by a licensed member of the medical profession for:

	Employee		Employee
Heart Disease (Do not check "Yes" if you only have High Blood Pressure or a Heart Murmur)	☐ Yes ☐ No	Disease, injury or surgery of Joint, Ligaments, Knee, Back, or Neck (including Arthritis)	☐ Yes ☐ No
Heart-Related Surgery or Heart Attack	☐ Yes ☐ No	Muscular Dystrophy	☐ Yes ☐ No
High Blood Pressure If you checked "Yes" to High Blood Pressure, have you had a change in medication within the last 6 months?	☐ Yes ☐ No ☐ Yes ☐ No	Hepatitis (Do not check "Yes" for Hepatitis A) or Cirrhosis	☐ Yes ☐ No
Blocked Arteries (Arteriosclerosis, Atherosclerosis, Aneurysm, or Deep Vein Blood Clot)	☐ Yes ☐ No	Amyotrophic Lateral Sclerosis (ALS) or Multiple Sclerosis (MS)	☐ Yes ☐ No

Medical Information (continued)

	Employee		Employee
Stroke or transient ischemic attack (TIA)	☐ Yes ☐ No	Alzheimer's or Parkinson's Disease	☐ Yes ☐ No
Chronic Obstructive Pulmonary Disease (COPD) or Emphysema	☐ Yes ☐ No	Paralysis	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Major Organ Transplant	☐ Yes ☐ No
Depression	☐ Yes ☐ No	Chronic Fatigue Syndrome or Fibromyalgia	☐ Yes ☐ No
Sleep Apnea	☐ Yes ☐ No	Narcolepsy	☐ Yes ☐ No
Cancer (Do not check "Yes" for Basal Cell Carcinoma only) If "Yes", Date of Diagnosis:	☐ Yes ☐ No	Ulcerative Colitis or Crohn's Disease	☐ Yes ☐ No
Psychotic, Psychiatric, Personality, or Bi-Polar Disorder	☐ Yes ☐ No	Kidney Failure or Dialysis	☐ Yes ☐ No

Notice

To the best of your knowledge, you are required to notify Hartford Life and Accident Insurance Company in writing of any changes in your medical condition between the date you sign this form and the date the coverage is approved.

In order to complete the evaluation of this application, Hartford Life and Accident Insurance Company may contact you, through the mail or over the telephone:

1. to clarify any information contained on this form;
2. to obtain any information missing from this form;
3. to ask additional questions of you or your physician about the information that you have provided; or
4. to request a paramedical exam.

We may also use information about you obtained from other sources, including our claim files, evidence of insurability applications you have previously submitted to us, copies of medical records which you have authorized us to review, and information obtained from MIB, Inc. Only information that is relevant to determining Evidence of Insurability for the coverage which you are currently requesting will be considered.

Authorization

I, an undersigned applicant, authorize Hartford Life and Accident Insurance Company, together with its affiliates, ("Company") to contact me, during the evaluation of this application, through the mail, secure e-mail, or over the telephone, at the address or telephone number identified in this application, or otherwise provided by me:

1. to clarify any information contained on this form;
2. to obtain any information missing from this form; or
3. to request a paramedical exam.

In the event that I cannot be reached via telephone, I authorize a representative of the Company to leave a voice message identifying his or her name, the Company name, and a return phone number, indicating that he or she is calling to obtain information necessary to complete my recent application for insurance. The message will also contain an underwriting ID number and the hours during which I may reach a representative of the Company by telephone.

☐ Yes, you may leave a message as indicated above. ☐ No, please do not leave a message.

In addition to the information that I have provided on this application, I authorize the Company to use information about me obtained from Company claim files, insurance applications and medical information I or my physician(s) have previously submitted to the Company. I further authorize my employer, any health or benefits plan, physician, medical professional, hospital, clinic, laboratory, MIB Group, Inc. (MIB, Inc), pharmacy or pharmacy benefits manager that possesses my protected personal health information ("PHI"), including copies of records concerning physical or mental illness, diagnosis, prognosis, prescription information, care or treatment provided to me (but excluding HIV and genetic testing), to furnish such protected health information to the Company or its representative. The Company may only use information disclosed under this authorization that is relevant

to underwrite this or any other insurance application to the Company during the period that the Authorization is valid (as described below), at any time to aid in the detection of fraud, and for internal research purposes.

I authorize the Company to disclose the "PHI" in its files to its reinsurer(s) and affiliates, other insurance companies and their affiliates, other persons, representatives and/or organizations performing functions on behalf of the Company and their affiliates, my employer, or as required by law, including any mandated reporting to state agencies. I understand that I may request details about any of the information gathered about me that relates to this application and that such requested information and the identity of the source of the information shall be released to me or, in the case of medical information, to a licensed medical professional of my choice.

I/We authorize Hartford Life and Accident Insurance Company, or its reinsurers, to make a brief report of my/our personal health information to Medical Information Bureau.

I agree that a photocopy of this authorization is valid as the original and I understand that I or my authorized representative is entitled to receive a copy of this authorization upon request.

This authorization shall be valid for twenty-four (24) months from the date signed below. This authorization may be revoked upon written request to the Company, and will not remain valid beyond the date the revocation is received by the Company. I understand the revocation may be a basis for denying my insurance application, and that it does not alter the Company's right to use the application for purposes of determining misrepresentation once coverage has been issued.

I have received and read a copy of the Notice of Insurance Information Practices.

Fraud

For any Applicants that do not reside in the following states: Alabama, Colorado, District of Columbia, Florida, Kentucky, Maine, Maryland, New Jersey, Oregon, Pennsylvania, Puerto Rico, Tennessee and Washington: 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 may be guilty of a crime and may be subject to fines and confinement in prison.

For residents of Alabama: 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 restitution fines or confinement in prison, or any combination thereof.

For residents of 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.

For residents of District of Columbia: 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.

For residents of 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.

For residents of Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim or 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.

For residents of Maine, Tennessee 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 and denial of insurance benefits.

For residents of 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.

For residents of New Jersey: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

For residents of Oregon: 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 that the insurer relied upon is subject to a denial and/or reduction in insurance benefits and may be subject to any civil penalties available.

For residents of 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 hereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

For residents of Puerto Rico: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances be present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

PRE-EXISTING CONDITIONS LIMITATION – Applicable to Accident and Health Insurance Only – For Residents of NY

With respect to group disability insurance, I understand that the policy/certificate may include a pre-existing condition provision that limits or excludes coverage for a period of time if I have a pre-existing condition as defined on the date my coverage becomes effective. I also understand that I may obtain additional information regarding this provision by referring to the group policy and/or certificate.

Certification

I hereby represent that I have reviewed the above questions and that all statements and answers contained herein are full, complete, and true to the best of my knowledge and belief. For residents of Virginia only: I have read, or had read to me, the completed application, and I realize that any false statement or misrepresentation in the application may result in loss of coverage under the policy.

This application will be made a part of the Policy.

_____ _____

Employee Signature **Date Signed**

Please mail the completed **Employer Group Benefits Coverage Information page** and **Evidence of Insurability** application to:

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