VOLUNTARY DISABILITY INCOME INSURANCE CHANGE 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 109
- ☐ IUEC Local 2
- ☐ IBEW Local 134
- ☐ IUOE Local 399
- ☐ Teamsters 179 Bus Driver
- ☐ Sheet Metal Workers Local 73
- ☐ BCTGM Local 1
- ☐ 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	

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

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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.

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.