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

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:	**IBEW Local 109:**	**IUOE Local 399:**
☐ Short Term Disability Income Insurance $250 per week	☐ Short Term Disability Income Insurance	☐ Short Term Disability Income Insurance
☐ Short Term Disability Income Insurance $500 per week	**IBEW Local 134:**	☐ Long Term Disability Income Insurance
☐ Long Term Disability Income Insurance	☐ Short Term Disability Income Insurance	**Sheet Metal Workers Local 73:**
	☐ Long Term Disability Income Insurance	☐ 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.

GUARDIAN℠

Evidence of Insurability for Group Insurance

Please complete in ink. Erasures and changes invalidate this form.

1. Employee: 2. Employer: 3. Group Plan #: **G-**

4. Not applicable.

5. Home Address:

6. Date of Full Time Employment: 7. Occupation: 8. Annual Earnings:

9. Do you actively work full time for full pay at least 30 hours weekly, year round for the above named employer? ☐ Yes ☐ No

10. Social Security Number: 11. Sex : ☐ Male ☐ Female

12. Beneficiary Name (last, first, middle) and relationship:

13. Give full name of each person (last, first, middle)	Place of Birth	Date of Birth: mo./day/yr.	Height: ft./in.	Weight: lbs.
Employee				

Have you

14. ever applied to Guardian for insurance? ☐ Yes ☐ No If Yes, list plan/policy number:

15. ever been rated, declined, for life, accident or health insurance or ever had such insurance postponed, modified or renewal declined or received disability payments for more than 6 months? **Employee** ☐ Yes ☐ No

16. in the past 10 years been treated for or diagnosed as having heart disorder, high blood pressure, diabetes, rheumatic fever, stroke, stomach or intestinal trouble, genito-urinary disorder, cancer, tumor, injury to or pain or disorder of the back or neck, arthritis, chest pain, asthma, allergies, or respiratory illness, mental or nervous disorder, blood disorder, gonorrhea, genital herpes, genital warts, syphilis, herpes simplex? **Employee** ☐ Yes ☐ No

17. within 10 years ever used drugs other than as prescribed by a physician; been advised to have treatment or been treated for drug abuse or alcoholism? **Employee** ☐ Yes ☐ No

18. **a)** been treated for or diagnosed as having AIDS or AIDS Related Complex? **Employee** ☐ Yes ☐ No

b) in the past year had fever persisting more than one (1) month; significant involuntary weight loss; diarrhea persisting more than one (1) month; oral candidacies (thrush); lymphadenopathy (enlarged or swollen glands)? If Yes, provide complete details on the reverse side. **Employee** ☐ Yes ☐ No

19. in the past five years: **a)** consulted or been examined by or treated by a physician, practitioner or specialist? Do not include routine annual physicals unless: 1) they were in connection with an existing or prior medical condition, 2) existing symptoms were being checked or, 3) a specific medical condition was found. **Employee** ☐ Yes ☐ No

b) been in a hospital, sanitarium, or other institution for observation, diagnosis, treatment or an operation? **Employee** ☐ Yes ☐ No

C) been prescribed medication(s)? **Employee** ☐ Yes ☐ No

20. Are you or any of your dependents pregnant? ☐ Yes ☐ No If Yes, list due date:mo day yr.
Any complications? ☐ Yes ☐ No

For each "Yes" answer to questions 15 through 20, give details on the reverse side.
Be certain to read, sign, date and have this application witnessed on the reverse side.

ENDORSEMENT BY The Guardian Life Insurance Company of America

Group plan #: G- Certificate #: Effective Date: mo day yr.

Initial Amount of Insurance ($): Life Supp. Life AD&D Dep. Life A&S LTD

Health Insurance: **Emp.** ☐ Yes ☐ No **Spouse** ☐ Yes ☐ No **Child** ☐ Yes ☐ No Dental Insurance: **Emp.** ☐ Yes ☐ No **Dep.** ☐ Yes ☐ No

This application is ☐ **Approved** ☐ **Rejected** Secretary: Date: By:

Risk Classification: Life Health Disability

GG-695 REV. 8/87

Detailed Explanation (Question 15-20)

Ques.	Name of Person	Medical Practitioner's Name and Address	Name and Address of Hospital	Condition	Duration of symptoms, treatment & degree of recovery	Dates

If additional space is needed, refer to question number and use separate sheet. Be certain to include signature, date, and witness.

I hereby apply for insurance to which I am entitled or may become entitled under any group insurance plan issued to _____ _____ by THE GUARDIAN Life Insurance Company of America (hereinafter called the Company). In addition, I hereby authorize my Employer to deduct from my earnings my required contributions, if any, toward premiums for this insurance. I hereby represent that the statements and answers to the questions are to the best of my knowledge and belief, full, complete and true. I understand that they shall form the basis upon which I may be included for insurance under the group plan.

IT IS MUTUALLY AGREED THAT: (1) The insurance applied for shall not become effective unless (a) the first premium has been paid to the Company, (b) the undersigned employee is unconditionally approved by the Company for such insurance as shown in the Endorsement, (c) the undersigned employee is actively at work for full pay on a full-time basis (at least 30 hours weekly) on the Effective Date specified in the Endorsement; otherwise he will become insured on the date he returns to work and satisfies these requirements (an employee will be deemed to have met the actively at work requirements on a regular Non-working day (excluding vacation days) if he was actively at work full-time for full pay on the last preceding regular work day). (2) No person, except the President, a Vice President or a Secretary of the Company, has authority to determine whether any contract(s) of insurance shall be issued on the basis of the application, to waive or modify any of the provisions of the application or any of the Company's requirements, to 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 to accept any information or representation not contained in the written application; (3) The employer is hereby designated the Proposed Insured's representative for the purpose of receiving premiums and remitting them to the Company.

I have read both sides of this application including the Pre-Notices concerning the Medical Information Bureau and Fair Credit Reporting Act, copies of which have been received by me.

Signed at _____ Date _____

Witnessed by: _____ Signature of applicant: _____

INSURANCE INFORMATION PRACTICES: Important: This authorization must be signed by applicant.

INVESTIGATIVE CONSUMER REPORT: I authorize The Guardian Life Insurance Company of America to obtain or have prepared an investigative consumer report as described in this notice.

MEDICAL RECORDS AND OTHER INFORMATION: I authorize any physician, medical practitioner, hospital, clinic, other health facility, consumer reporting agency, the Medical Information Bureau, insurance or reinsurance company, or employer to release any and all medical and Non-medical information in its possession about me or my minor children 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, mental or physical condition, or treatment of me or my minor children.

I understand The Guardian Life Insurance Company of America will use the information obtained by this authorization to determine eligibility for insurance or eligibility for benefits under an existing plan. Guardian will not release any information obtained to any person or organization *except* to a reinsurance company, the Medical Information Bureau, or other persons or organization performing business or legal services in connection with my application, claim, or as may be lawfully permitted or required, or as I may further authorize.

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

I agree that a photocopy of this authorization shall be as valid as the original.

I acknowledge receipt of Guardian's notice regarding its Insurance Information Practices, the Fair Credit Reporting Act, the Medical Information Bureau, and Medical Records.

I agree that this authorization shall be valid for two and one half years from the date shown below.

Signed at _____ Date _____

Signature of applicant: _____ Signature of spouse: _____

IMPORTANT: READ AND DETACH FOR YOUR RECORDS

Thank you for choosing Guardian insurance. This notice is given to you at the time you apply for life or health 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. 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 Corporate Secretary, Guardian Life Insurance Company of America, 7 Hanover Square, New York, NY 10004-2616

Fair Credit Reporting Act Pre-Notice: When we begin to process your application, we may ask for a consumer report from a consumer reporting agency. All or part of that report may be an investigative consumer report. Such a report will include information about your character, general reputation, personal characteristics or mode of living. It will be obtained through personal interviews with people who know you. You may request to be interviewed in connection with this report. We may request later consumer reports, other than an investigative consumer report, at a future update, renewal or extension of the insurance for which you have applied.

At your request, we will tell you if we have asked for a consumer report or an investigative consumer report in the initial processing of your application. If we have, we will tell you the name and address of the consumer reporting agency to which we have made our request for a report. At your written request, we will give you more detailed information about the nature and scope of this kind of investigation.

Medical Information Bureau Pre-Notice: The Medical Information Bureau is a nonprofit membership organization of life insurance companies. The Bureau provides an information exchange for its members. On the request of any of its member companies to which you apply for life or health insurance, or to which you make a claim for benefits, the Bureau will supply the inquiring company with information in its files.

Guardian or our reinsurers may make a brief report of objective findings about you to the Bureau. We will not report what action we have taken on your application.

If you so request of the Bureau, it will arrange to disclose the information it may have in your file. But medical information will be disclosed only to your doctor. If you question the accuracy of the information in the Bureau's file, you may contact the Bureau and seek to correct the information according to procedures set forth in the Federal Fair Credit Reporting Act. The Bureau's address is Post Office Box 105, Essex Station, Boston, MA 02112, telephone 617-426-3660.

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.