VOLUNTARY DISABILITY INCOME INSURANCE ENROLLMENT FORM

Group Benefit Associates
3963 W. Belmont Ave.
Suite 6
Chicago, IL 60618

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	

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 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.

The Guardian Life Insurance Company of America
The Guardian Insurance & Annuity Company, Inc.

EVIDENCE OF INSURABILITY FOR NON-MEDICAL COVERAGES

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

Planholder Name (Company Name)	Group Plan No.
Bakery Confectionary Tobacco Workers & Grain Millers	498437

Complete the following information for each person to be underwritten:

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

Home Address

Employee's Social Security Number	Home Phone Number	Cell Phone Number	Date of Marriage	Employee's Place of Birth (State)

Email Address	How Best to Contact

Amount In Force	Amount Being Requested

IF APPLYING FOR LIFE INSURANCE: questions 1-4 must be answered for each person to be underwritten
IF APPLYING FOR DISABILITY INSURANCE: all five questions must be answered in reference to the employee only

1. In the past 10 years been treated for or diagnosed as having: heart; liver or kidney disorder; neurological disorder; diabetes; stroke; cancer; tumor; mental or nervous disorder; or been advised to have treatment for drug abuse (including prescription drugs); or alcoholism?	**Employee** ☐ Yes ☐ No **Spouse** ☐ Yes ☐ No **Child** ☐ Yes ☐ No
2. In the past 5 years used illegal drugs?	**Employee** ☐ Yes ☐ No **Spouse** ☐ Yes ☐ No **Child** ☐ Yes ☐ No
3. (a) Ever tested positive for HIV (Human Immunodeficiency Virus) antibodies? (b) In the past year had: fever persisting more than one month; significant involuntary weight loss; diarrhea persisting more than one month; oral candidiasis (thrush); lymphadenopathy (enlarged or swollen glands)?	**Employee** ☐ Yes ☐ No **Spouse** ☐ Yes ☐ No **Child** ☐ Yes ☐ No
4. In the past year: (a) consulted or been examined by or treated by a physician, practitioner or specialist? (Include routine physicals only when there is an existing or newly diagnosed medical condition); (b) been in a hospital or other facility for observation, diagnosis, treatment or an operation?; (c) been prescribed medication(s) - (other than for colds, flu or allergies)?	**Employee** ☐ Yes ☐ No **Spouse** ☐ Yes ☐ No **Child** ☐ Yes ☐ No
5. **If applying for disability coverage, please complete these additional questions:** (a) In the past 5 years, been treated for conditions of the back, neck, spine, or arthritis?; (b) Are you currently pregnant?; (c) Excluding your employer sponsored group disability plan, are you currently insured for any other disability coverage? If **"Yes"**, what is the total amount of coverage already in-force? $_____	**Employee** ☐ Yes ☐ No

For each "Yes" answer to questions 1 through 5b give details below. (*Continue on reverse side if additional space is needed.)

Ques. No.	Name of Patient	Practitioner's Name & Address	Hospital Name & Address	Condition	Duration of symptoms, treatment & degree of recovery	Dates mo/yr

I authorize any physician, medical practitioner, hospital, clinic, other health facility, the MIB, Inc., insurance or reinsurance company, or employer to release any and all medical and non-medical information in its possession about me or my eligible dependents 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 eligible dependents. I agree that this authorization will be valid for two and one half years from the date shown below and I have read, understand, and accept the statements and provisions on the reverse side of this application.

Signature of Employee x **Date**

Signature of Spouse x **Date**

ENDORSEMENT (GUARDIAN USE ONLY)

Employee: ☐ Approved ☐ Declined Premium Class: ☐ Preferred ☐ Standard
Optional Life: $ Guardian's Universal Life: $

Child: ☐ Approved ☐ Declined
Optional Life: $ Child Term Rider: $

Spouse: ☐ Approved ☐ Declined Premium Class: ☐ Preferred ☐ Standard
Optional Life: $ Spouse Term Rider: $

Excess Life $_____ ☐ Approved ☐ Declined
Long Term Disability $_____ ☐ Approved ☐ Declined
Short Term Disability $_____ ☐ Approved ☐ Declined

Effective Date:	By:	Date:	Vice President
			Stuart J. Shaw

I hereby represent that the statements and answers to the questions on the reverse side are, to the best of my knowledge and belief, full, complete and true. I understand that they will form the basis of any coverage under the Group Plan for which Evidence of Insurability is required.

Also, it is mutually understood and agreed that (1) the Company reserves the right to request, at its expense (in the case of a late entrant, it is not at the Company's expense), that I 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 and approved by the Insurance Company at the Home Office as shown in the Endorsement; 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 will 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.

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

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 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 further authorize.

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

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

I acknowledge receipt of Guardian's notice regarding its insurance information practices, and medical records.

*** Additional space if questions 1 through 5b were answered "Yes".**

Ques. No.	Name of Patient	Practitioner's Name & Address	Hospital Name & Address	Condition	Duration of symptoms, treatment & degree of recovery	Dates mo/yr

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, 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., formerly known as 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 or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, Inc., upon request, will supply such company with the information 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 information in 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 02814-8734.

"Guardian, or its reinsurers, may also release information in its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted." Information for consumers about MIB, Inc., may be obtained on its website www.mib.com

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.

I hereby represent that the statements and answers to the questions on the attached form 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.

Also, it is mutually understood and agreed that (1) the Company reserves the right to request, at its expense (in the case of a late entrant, it is not at the Insurance Company's expense), that I be examined by an accredited medical examiner selected by the Company, (2) no Group Insurance shall be binding or in force until satisfactory evidence of insurability is submitted and approved by the Insurance Company at the Home Office as shown in the Endorsement, 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 will 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.

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