

Voluntary Disability Income Insurance Enrollment Form

Member of: IBEW Local 109 IUOE Local 399
 IBEW Local 134 Sheet Metal Workers Local 73

First Name MI Last Name

Street Address

City State Zip Code

(____) _____
Home Phone Number

E-mail Address (optional)

____/____/____
Date of Birth

____-____-____
Social Security Number

____/____/____
Initiation Date into Union

\$ _____ per hour
Hourly Wage Rate

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.

I am electing to enroll in the following Disability Income Insurance Programs:

- Short Term Disability Income Insurance ONLY
- Long Term Disability Income Insurance ONLY (Not available to IBEW 109)
- Both Short and Long Term Disability Income Insurance (Not available to IBEW 109)

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 bank account 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

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Premium for this policy is due monthly and is collected by bank draft (ACH) or credit card. There is not an invoice option for this policy.

Premium Arrangement

I agree to pay the monthly premium from the account specified below on the 20th of each month for coverage of the following month. The monthly rate may only change when the policy renews on its annual anniversary date or if I make changes to the coverage including modifications to my insured wage rate. I certify that I am the owner, or joint owner, of the account designated and am entitled to provide this authorization. I authorize Babbitt Municipalities, Inc. d.b.a. Group Benefit Associates to initiate electronic debit entries, and if necessary, credit entries and adjustments for any debit entries in error to my account listed below for the purpose of collecting premium on the disability insurance policy for which I have applied. **This authorization will remain in effect until Group Benefit Associates receives written notice of cancellation from me**, in such time and manner as to afford reasonable opportunity for Group Benefit Associates and the Financial Institution(s) to act on it. If I change or terminate my account without notifying Group Benefit Associates, I understand that my disability insurance coverage can be terminated for non-payment of premium after a 30 day grace period has expired.

Please complete the following to pay by bank draft (ACH):

Name on account: _____

Account type: Checking Savings

Routing Number: _____

Account Number: _____

I hereby authorize Babbitt Municipalities, Inc. (d.b.a. Group Benefit Associates) to draft my bank account as listed above on or near the 20th of each month for the purpose of collecting premiums for the disability policy I have accepted.

Signature of premium payer

Date

Please complete the following to pay by credit card:

Name on account: _____

Account type: Visa Mastercard

Credit Card Number: _____

Expiration Date: _____

I hereby authorize Babbitt Municipalities, Inc. (d.b.a. Group Benefit Associates) to draft my credit card as listed above on or near the 20th of each month for the purpose of collecting premiums for the disability policy I have accepted.

Signature of premium payer

Date