ABE
American Bar Endowment
Insuring your life's needs.
Advancing your life's work.

SPEC

GROUP MID-TERM DISABILITY INSURANCE APPLICATION

Underwritten By: The United States Life Insurance Company in the City of New York (Herein called the Company)

Mail Your Application To: **AMERICAN BAR ENDOWMENT,** 321 North Clark Street • Chicago, Illinois 60654-7648

APPLICATION

OFFICE USE ONLY	
Plan	Effective Date

MID-TERM DISABILITY

NAME:

ABA MEMBER #

FIRM:

STREET ADDRESS:

CITY: STATE: ZIP:

This is my: ❑ **Business** ❑ **Home** ❑ **Both**

Please enter the following information to assist us in contacting you should the need arise in processing your application:

Business:

Home:

Fax Number:

Email:

PERSONAL DATA (Must be completed in full prior to any underwriting consideration.)

Age:_____ Height __ft. ___in. Weight _____lbs. Sex ❑ M ❑ F Date of Birth___/___/_____ Place of Birth _____

Are you now, and have you been for the last 90 days, performing all the duties of your regular occupation for at least 30 hours per week for your present employer? ❑ YES ❑ NO

Annual Earned Income (after business expenses): $ _____ Date of Hire: _____

Employer Name and Address: _____

Name and Address of Member's Physician: _____

Are you applying as a: ❑ Member ❑ Spouse/Domestic Partner of a Member

DISABILITY INSURANCE REQUESTED:

1. Waiting Period: ❑ 60 DAY (not available for spouse/domestic partner) ❑ 90 DAY ❑ 180 DAY
2. Monthly Benefit (in $100 increments) (not to exceed 66 2/3% of your monthly income) $ _____
   (For benefit amounts greater than $7,500, not to exceed 60% of your monthly income)

I WISH TO PAY:

❑ **OPTION 1:** AUTOMATIC MONTHLY PAYMENT – I (we) hereby authorize the American Bar Endowment (ABE) to initiate debit entries to my (our) Checking Account at the depository financial institution specified on the attached voided check, hereafter called DEPOSITORY, and to debit the same to such account. I (we) acknowledge that the origination of ACH transactions to my (our) account must comply with the provisions of U.S. law.

This authorization is to remain in full force and effect until ABE has received written notification from me (or either of us) of its termination in such time and in such manner as to afford ABE and DEPOSITORY a reasonable opportunity to act on it.

❑ **OPTION 2:** PERIODIC BILLING ❑ Annual ❑ Semiannual ❑ Quarterly

PLEASE ANSWER THESE BRIEF QUESTIONS.

To the best of your knowledge and belief:

	YES	NO
1. Have you ever had or been treated for: *(Circle specific disorders experienced.)*		
a. Disease or disorder of the heart, murmur, chest pain, rheumatic fever, elevated blood pressure, stroke, aneurysm or transient ischemic attack?	❑	❑
b. Injury, pain or disorder of neck or back? Sciatica? Any disabling injury or disorder of the bones, joints or muscles? Connective tissue disorder?	❑	❑
c. Arthritis, chronic pain, chronic fatigue, fibromyalgia, bursitis or rheumatism, or any other neurological disorder?	❑	❑
d. Dizziness, epilepsy, convulsions, recurrent headaches, glaucoma, cataract, or other disorder of the eyes or ears?	❑	❑
e. Disease or disorder of rectum? Vascular or blood disorder?	❑	❑
f. Diabetes or elevated glucose? Sugar or albumin in urine? Thyroid or other glandular disorder?	❑	❑
g. Ulcer, or disorder of stomach, liver, gall bladder or pancreas? Colitis, Hepatitis, or other disorder of small or large intestine?	❑	❑
h. Prostate disorder? Nephritis, nephrosis or other kidney disease or disorder?	❑	❑
i. Menstrual, uterine or ovarian disorder? Complications of pregnancy? Disorder of the breast?	❑	❑
j. Bronchitis, emphysema, sleep apnea, difficult breathing, or other respiratory disease or disorders?	❑	❑
k. Cancer, tumor or mass? Deformity or loss of limb? Congenital defect? Disease or disorder of the lymphatic system?	❑	❑
l. Mental or emotional problem requiring help of a physician, psychologist or counselor?	❑	❑
m. A surgical operation? Or a surgical operation advised but not performed?	❑	❑
n. Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) or disorders of the immune system?	❑	❑
o. Alcohol or drug abuse?	❑	❑
2. Have you during the past 5 years, consulted any physician or other practitioner or been confined or treated in any hospital or similar institution, for any reason other than those stated above?	❑	❑
3. Are you taking prescription medication or receiving medical attention?	❑	❑

COMPLETE AND SIGN REVERSE SIDE OF THIS APPLICATION

For "Yes" answers to questions 1-3 on the reverse, please provide details in the space below. If more space is needed, use a separate sheet of paper, signed and dated. If additional information is attached, check "Yes": ❑Yes ❑ No

Question #	Proposed Insured	Condition	Date Occurred	Duration	Degree of Recovery	Names & Addresses of Hospitals, Physicians, or Clinics Consulted
			/ /			
			/ /			
			/ /			

EXISTING AND PENDING INSURANCE SECTION

Do you have any disability insurance in force or pending? (including group coverage) ❑ Yes ❑ No

(If "Yes", please indicate companies and amounts) _____

Will this coverage applied for replace any insurance now in force? (including group coverage) ❑ Yes ❑ No

(If "Yes", please indicate which insurance and the amount being replaced) _____

AUTHORIZATION AND DECLARATION OF EACH PERSON GIVING A STATEMENT OF INSURABILITY

I hereby authorize any licensed physician, medical practitioner, pharmacy, pharmacy benefit manager and other sources, hospital, clinic, or other medical or medically related facility, insurance company, the MIB, Inc., formerly known as the Medical Information Bureau, or other organization, institution or person that has any records or knowledge of me or my health, to give to the Company or its reinsurers any such information. Such information will pertain to my employment, or other insurance coverage and medical care, advice, treatment or supplies for any physical or mental condition. This includes information obtained in connection with the preparation or procurement of an investigative consumer report as defined under the Fair Credit Reporting Act(s). To facilitate the rapid submission of such information, I authorize all said sources, except the MIB, to give such records or knowledge to any agency employed by the Company to collect and transmit such information. I understand that this information will be used by the Company solely to determine eligibility for insurance. I understand that I may revoke this authorization at anytime by giving written notice to the Company. I agree that such revocation will not affect any action, that any source has taken in reliance upon this authorization. I understand this authorization will be valid for 24 months from the effective date of coverage, if not revoked earlier. I know that I should retain a copy of this authorization for my records. I agree that a photocopy of this authorization is as valid as the original. To the best of my knowledge and belief, all statements made above are true and complete. I understand that my application for group insurance will be accepted or declined on the basis of these statements. Insurance will take effect only if a certificate is issued based on this application and the first premium is paid in full (a) during the lifetime of all proposed insureds; and (b) while there is no change in the insurability or health of such person from that stated in the application.

Important Notice: Any person who knowingly and with intent to defraud any insurance company or other person, files or causes to be filed, a claim for payment of a loss, containing any false or incomplete informaiton commits a fraudlent insurance act that may be a crime and may subject such person to incarceration, fines and denial of benefits. (For state-specific variations, refer to page 3.)

A copy of this Application will be attached and become part of your Certificate of Insurance.

I further understand and agree that any experience credits payable on the group policy will be paid to the American Bar Endowment (ABE) to support its charitable work in the field of law unless such experience credits are claimed by me pursuant to the procedures described in the plan brochure, on the back of ABE premium notices, and in each November issue of the *ABA Journal*. (Notice of the approximate percentage of premium available (if any) for contribution or refund will be published that issue.)

DATE_____ SIGNATURE OF MEMBER _____

G-19463 Group Policy No. G-164,155 Form Number: MTD 5/03

EXPERIENCE CREDITS NOTICE Please note: Members who wish to contribute experience credits payable on this group policy to ABE to support its charitable mission need not do anything further. However, members who do not want to contribute these experience credits are required to "opt out" each year, using the procedures described below. By signing this application, you are agreeing to make an *annual* decision whether to opt out. **Do not sign the application if you do not agree with these procedures.**

For the first policy year of participation only (which ends on the 31st day of October following the effective date of your insurance), you may opt not to contribute experience credits to ABE by signing and dating the initial election below. After the first policy year of your participation, a ***written*** request for refund **must be made each year and must reach the Endowment by December 15th.** Written requests may be sent by mail, fax, e-mail to dividends@abendowment.org or online at www.abendowment.org. You will be sent a confirmation; retain this for your records. If it is not received within 3 weeks, contact ABE promptly to obtain another.

INITIAL ELECTION (**For new applicants only.** Members currently insured in this plan must send a written request each year to ABE anytime during the year, but no later than December 15.) I do **not** choose to leave any experience credits with ABE for its charitable work ***for the first policy year in which I participate in this program.*** In so choosing, I understand that I will not be entitled to a charitable contribution deduction on my income tax return.

X_____ _____/_____/_____

Member's Signature (DO NOT PRINT) **Date**

IMPORTANT NOTICE

For residents of Arkansas, Louisiana and West Virginia: 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 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 the District of Columbia: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an issuer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

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 include imprisonment, fines and denial of insurance benefits.

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

For residents of New Mexico: 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 CIVIL FINES AND CRIMINAL PENALTIES.

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

For residents of Oklahoma: Warning: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

For residents of Pennsylvania: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance o statement of claim 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 and subjects such person to criminal and civil penalties.

For residents of Virginia: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

These Notices must be retained by the applicant.

MIB DISCLOSURE NOTICE

Information regarding your insurability will be treated as confidential. The United States Life Insurance Company in the City of New York or its reinsurers may, however, make a brief report thereon to the MIB, Inc., formerly known as Medical Information Bureau, 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 member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information about you in its file. Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at 866 6926901 (TTY 866 3463642). If you question the accuracy of the information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734. The United States Life Insurance Company in the City of New York, or its reinsurers, may also release information from 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 may be obtained on its website at www.mib.com.

NOTICE AS REQUIRED UNDER THE FAIR CREDIT REPORTING ACT(S)

This is to inform you that as part of our procedure for processing your insurance application, an investigative consumer report may be requested for the preparation of a report whereby information is obtained through personal interviews with your neighbors, friends, or others with whom you are acquainted or who may have knowledge of any such items of information. This inquiry includes information as to your character, general reputation, personal characteristics, and mode of living. You have the right to make a written request to be informed as to whether or not such consumer report was requested, and if such report was requested, the name and address of the consumer reporting agency to whom the request was made. You may receive a copy of this report by contacting such agency.