



GROUP LONG-TERM DISABILITY INSURANCE APPLICATION

APPLICATION

OFFICE USE ONLY table with Plan and Effective Date columns

Underwritten By: The United States Life Insurance Company in the City of New York

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

WEB ABA MEMBER #

FORM NUMBER: LTD

NAME: 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:

I WOULD LIKE TO ENROLL IN THE DISABILITY PROGRAM:

- 1. Indicate the total monthly member benefit desired: (in \$100 increments)
2. Do you want the Cost of Living Adjustment (COLA) Benefit?
3. My annual earned income (after business expenses) for the 12 months immediately preceding the date of this application is:
4. Date Employed:
5. Indicate member waiting period desired: 60 DAY 90 DAY 180 DAY 365 DAY

I WOULD LIKE TO ENROLL MY SPOUSE:

(Member must be insured to insure spouse.)

- 1. Spouse's Name:
2. Occupation:
3. Title:
4. Employer's Name:
5. Address:
6. Business Phone:
7. Business Fax:
8. Business Email:

- 9. Indicate the total monthly Spouse benefit desired: (in \$100 increments)
10. Does your Spouse want the Cost of Living Adjustment (COLA) Benefit?
11. Spouse's annual earned income (after business expenses) for the 12 months immediately preceding the date of this application is:
12. Is your Spouse now working at least 30 hours per week with his/her present employer?
13. Date Employed:
14. Indicate Spouse waiting period desired: 90 DAY 180 DAY 365 DAY

PAYMENT OPTION SELECTION

OPTION 1: AUTOMATIC MONTHLY PAYMENT - I (we) hereby authorize the American Bar Endowment, hereinafter called COMPANY, 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.

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

OPTION 2: PERIODIC BILLING Annual Semiannual Quarterly

HEALTH SECTION (Must be completed in full prior to any underwriting consideration)

Member: Height ft. in. Weight lbs. Sex M F Date of Birth / / Place of Birth
Spouse: Height ft. in. Weight lbs. Sex M F Date of Birth / / Place of Birth

ANSWER EACH QUESTION BY CHECKING THE "YES" OR "NO" BOX, AS IT APPLIES.

Table with 4 columns: MEMBER YES, MEMBER NO, SPOUSE YES, SPOUSE NO. Rows 1-14 with various health questions.

LONG-TERM DISABILITY New

MEMBER SPOUSE  
YES NO YES NO

1. Mental or emotional problem requiring help of a physician or psychologist? .....
- m. A surgical operation? A surgical operation advised but not performed? .....
2. Other than stated under questions 1a-m, have you ever had treatment by, or consultation with, any hospital, institution, physician, or practitioner within the past 5 years? .....

If you or your spouse answered "Yes" to any question 1a-m or 2, please explain fully in the chart below. Should you require additional space, please use a separate piece of paper, sign and date, and attach it to this form.

Question #1	Proposed Insured	Condition	Date Occurred	Duration	Degree of Recovery	Names & Addresses of Hospitals, Physicians, or Clinics Consulted
			/ /			
Question #2	Proposed Insured	Condition	Date Occurred	Duration	Degree of Recovery	Names & Addresses of Hospitals, Physicians, or Clinics Consulted
			/ /			

Do you have any other Disability Insurance in force or application pending--including group coverage? (Give full details.):  Yes  No

Proposed Insured	Insuring Company	Amount of Monthly Indemnity	How Long are Benefits Payable	
			ACCIDENT	SICKNESS

Are you replacing any current disability coverage (including ABE coverage) you have? .....Member:  Yes  No Spouse:  Yes  No

If yes, please indicate which insurance: \_\_\_\_\_

## DECLARATION OF MEMBER AND SPOUSE GIVING STATEMENT OF INSURABILITY

1. To the best of my knowledge and belief, all statements made on this application are true and complete. 2. 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 while there is no change in the insurability or health of such person from that stated in the application.

## AUTHORIZATION

- I hereby authorize any licensed physician, medical practitioner, hospital, clinic, or other medical or medically related facility, insurance company, the Medical Information Bureau, or other organization, institution or person that has any records or knowledge of me or my health, to give to United States Life or its reinsurers any such information. Such information will pertain to my employment, or other insurance carrier or medical care, advice, treatment or supplies for any physical or mental condition. This includes that 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 Medical Information Bureau, to give such records or knowledge to any agency employed by United States Life to collect and transmit such information.
- I understand that this information will be used by United States Life solely to determine eligibility for insurance.
- I understand that I may revoke this authorization at any time. I agree that such revocation will not affect any action which United States Life has taken in reliance upon this authorization. I understand this authorization will not be valid after 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.
- I understand and agree that the indemnity for the Disability insurance herein applied for, together with the indemnity for all other disability insurance policies that I have or am applying for does not exceed the lesser of \$20,000 or 66 2/3% for benefit amounts up to and including \$7,500, or the lesser of \$20,000 or 60%, for benefit amounts greater than \$7,500, of my basic monthly pay (average of the 12 months earned income after business expenses, immediately preceding the date of the application).

If the Company declares an experience credit in any given policy year, I understand and agree that it will be retained by the American Bar Endowment to support its charitable work in the field of law unless such experience credit is reclaimed by the member in accordance with the procedures outlined on the Web site, in each November issue of the ABA Journal, and on the back of the premium notice. I have been advised that the member is eligible for a charitable contribution deduction on their individual tax return if experience credits are left with the Endowment.

DATE \_\_\_\_\_ SIGNATURE OF MEMBER \_\_\_\_\_

DATE \_\_\_\_\_ SIGNATURE OF SPOUSE \_\_\_\_\_

(Signature of Spouse necessary only if Spouse coverage is requested)

G-19025

Group Policy No. G-164,156

Form Number: LTD 5/03

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

### EXPERIENCE CREDITS NOTICE

(To be used by **New Member Applicants Only**. Members currently insured in this plan must send a written request each year to the Endowment anytime during the year but no later than December 15th.) **Please note:** Members who do not want to contribute experience credits to ABE are required to "opt out" each year, using the procedures below. When you sign the enrollment form, you are agreeing to make an *annual* decision whether to contribute. **Please do not sign the enrollment form if you do not agree with these procedures.** Members may, if they wish, reclaim experience credits, if any, attributable to their participation rather than leaving them with the Endowment to support its charitable program. **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 reclaim experience credits by signing and dating the request below. In subsequent years, notice of the approximate percentage of premium available for refund (if any) will be published in each **November's ABA Journal**. After the first policy year of your participation, a **written** request for refund (sent by mail, fax, email to [dividends@abendowment.org](mailto:dividends@abendowment.org) or online at [www.abendowment.org](http://www.abendowment.org)) **must be made each year and must reach the Endowment by December 15th**. You will be sent a confirmation; retain this for your records. If it is not received within 3 weeks, contact the Endowment promptly to obtain another.

### INITIAL ELECTION

I do **not** choose to leave any dividends with the Endowment 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.

Member's Signature (DO NOT PRINT) X \_\_\_\_\_

Date / /