UNITED STATES LIFE INSURANCE COMPANY IN THE CITY OF NEW YORK

Home Office: 70 Pine Street, New York, New York 10270 (herein called the Company)
Administrative Office: 3600 Route 66 Medical Underwriting 3-L PO Box 1588 Neptune, NJ 07754-1588

GROUP DISABILITY INSURANCE APPLICATION

Send application and check to: **American Bar Endowment 321 North Clark Street 14th Floor, Chicago IL 60654-7648**

FORM NUMBER: LTD WEB

ABA MEMBER # ______

MEMBER/ APPLICANT NAME: ______

STREET ADDRESS: ______

CITY: ______ STATE ______ ZIP: ______

Business Phone: ______

Home Phone: ______

Email: ______

1. Indicate the total monthly member benefit desired: **(not to exceed 66.66% of your monthly income)$** ______
2. Do you want the Cost of Living Adjustment (COLA) Benefit?... ❑ YES ❑ NO
3. My annual earned income (after business expenses) $ ______
4. 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
5. Indicate waiting period desired: *(60 day option not available for spouse/domestic partner)* ❑ 60 DAY ❑ 90 DAY ❑ 180 DAY

NAME AND ADDRESS OF MEMBER/APPLICANT'S PHYSICIAN

Name ______ Address ______

PERSONAL DATA

Height ____ft. ____in. Weight ______lbs. Sex ❑ M ❑ F Date of Birth____/____/____ Place of Birth ______

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

I WISH TO PAY:

❑ **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. 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 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

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

To the best of my 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 now taking prescription medication or receiving medical attention?	❑	❑

PLEASE CONTINUE THIS APPLICATION ON THE REVERSE SIDE.

APPLICATION
OFFICE USE ONLY
Plan ______ Effective Date ______

MID-TERM DISABILITY ***New*** **FOR RESIDENTS OF NEW YORK**

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

Question #	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

Will this coverage applied for replace any insurance now in force? ❑ 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 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 Medical Information Bureau, 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 an application for insurance or 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

A copy of this application will be attached to and made a part of your certificate.

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 in the enclosed brochure, on the ABE website, 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________________ MEMBER/APPLICANT SIGNATURE________________________

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 application, you are agreeing to make an *annual* decision whether to contribute. ***Please do not sign the application 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 experiencecredits@abendowment.org or online at 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.**

________________________ Date_____/_____/_____

Member’s Signature (DO NOT PRINT) X

If you have any questions, call us toll-free at 1-800-621-8981 or e-mail us at information@abendowment.org. Visit us on the web at www.abendowment.org for plan information, personalized rate quotes, to download an application, and for information on our charitable programs, including our ABE Charitable Gift Fund (Donor Advised Fund).
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