ABE
AMERICAN BAR ENDOWMENT
Insuring your life's needs. Advancing your life's work.
WEB

RETIREMENT CONTRIBUTION DISABILITY INSURANCE APPLICATION

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

APPLICATION
OFFICE USE ONLY

Plan	Effective Date

FORM NUMBER: RCI

New RETIREMENT CONTRIBUTION DISABILITY

1 Complete the information below *Please print or type.*

ABA ID Number _____
Name _____
Address _____
City _____
State _____
Zip Code _____
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: (_____) _____
E-mail: _____

Select the monthly contribution and waiting period right for you
(monthly contribution cannot be higher than your current retirement plan contribution):

1. Monthly contribution . . . . . ◯ $1,200 ◯ $2,500 ◯ $3,500
◯ Or, your current monthly retirement plan contribution, rounded down to the nearest $100 (minimum $1,000; maximum of $3,500): $ _____
2. Waiting period . . . . . ◯ 180-day ◯ 365-day

2 Select your preferred payment mode *(No payments will be processed until your application is approved.)*

◯ OPTION 1: AUTOMATIC MONTHLY PAYMENT – I hereby authorize the American Bar Endowment, hereinafter called COMPANY, to initiate debit entries to my 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 acknowledge that the origination of ACH transactions to my 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 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

3 Health Section

Height _____ft. _____in. Weight _____lbs. Sex ◯ M ◯ F Date of Birth _____/_____/_____
Place of Birth _____ Occupation/Specialty _____

4 Answer these questions

1. Are you now, and have you been for the last 30 days, performing all the duties of your occupation for 30 or more hours per week at your place of business? . . . . . ◯ YES ◯ NO

2. Have you ever had or been treated for (Circle specific disorders experienced):

a. Disease or disorder of the heart or murmur, chest pain, rheumatic fever, elevated blood pressure, stroke? . . . . . ◯ YES ◯ NO
b. Injury, pain or disorder of the neck or back? Sciatica? Any disabling injury? . . . . . ◯ YES ◯ NO
c. Arthritis, chronic pain, chronic fatigue, fibromyalgia, bursitis or rheumatism, or any other neurological disorder? . . . . . ◯ YES ◯ NO
d. Dizziness, epilepsy, convulsions, recurrent headaches, glaucoma, cataract or other disorder of the eyes or ears? . . . . . ◯ YES ◯ NO
e. Disease or disorder of the rectum or anus? Varicose veins or other vascular disorder? . . . . . ◯ YES ◯ NO
f. Diabetes or elevated glucose? Sugar, albumin or pus in urine? Thyroid or other glandular disorder? . . . . . ◯ YES ◯ NO
g. Duodenal or stomach ulcer, or other disorder of stomach, liver (including hepatitis), gall bladder? Colitis, diverticulitis, or other disorder of small or large intestine? . . . . . ◯ YES ◯ NO
h. Prostate disorder? Kidney stone or colic, nephritis, nephrosis or other kidney disorder? Urinary infection? . . . . . ◯ YES ◯ NO
i. Menstrual, uterine or ovarian disorder? Disorder of the breast? . . . . . ◯ YES ◯ NO
j. Bronchitis, emphysema, pleurisy, difficult breathing, blood spitting or other disorder of the lung or nose? . . . . . ◯ YES ◯ NO
k. Cancer or other tumor? Deformity or loss of limb? Congenital defect? . . . . ◯ YES ◯ NO
l. Mental or emotional problem requiring help of a physician or psychologist? . . . . . ◯ YES ◯ NO
m. A surgical operation? A surgical operation advised but not performed? . . . ◯ YES ◯ NO
n. Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) or disorders of the immune system? . . . . . ◯ YES ◯ NO
o. Alcohol or drug abuse? . . . . . ◯ YES ◯ NO

3. Have you ever had treatment by, or consultation with, any hospital, institution, physician or practitioner within the past 5 years, other than stated above? (This includes any self-diagnosis, treatment or medication.) . . . . . ◯ YES ◯ NO

If you answered "Yes" to any part of question 2 a-o or 3, give details below. Use a separate sheet of paper, sign and date, if more space is needed for answers.
Please check whether you've attached a separate sheet of paper. . . . . ◯ YES ◯ NO

Question Number	Condition	Date Occurred	Duration	Degree of Recovery	Names, Addresses and Phone Numbers of Physicians, Hospitals or Clinics Consulted

Please complete the reverse side of this application →

5 Please answer the following, then sign and date below to apply

1. Do you have any retirement income disability insurance in force or pending? (If "Yes," please indicate companies and amounts.) . . . . . ○YES ○NO

2. Will this coverage applied for replace any insurance now in force? (If "Yes," please indicate which insurance.) . . . . . ○YES ○NO

AUTHORIZATION AND DECLARATION OF EACH PERSON GIVING A STATEMENT OF INSURABILITY – 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 the insurance company 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 transmission 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 insurance company to collect and transmit such information. I understand that this information will be used by the insurance company 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 the insurance company has taken in reliance upon this authorization. I understand that 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. 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 while there is no change in the insurability or health of such person from that stated in 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 below, 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.

IMPORTANT NOTICE: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent act, which may be a crime.
RESIDENTS OF PENNSYLVANIA: 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 act, which may be a crime and subjects such person to criminal and civil penalties.

✗ Member's Signature _____ Date ____/____/____

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 not 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 procedure below. When you sign the enrollment form, you are agreeing to make an *annual* decision whether to contribute. ***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, e-mail to dividends@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 deduction on my income tax return.**

✗ Member's Signature _____ Date ____/____/____

Please sign and date the election form, below, before returning this application.

This form authorizes the insurance company to pay your selected benefit into an annuity contract should you become disabled.

for Benefit Payments

Group Policyholder: American Bar Endowment
Group Policy No.: G-610,155

The Insured irrevocably directs and authorizes The United States Life Insurance Company in the City of New York (the "Company") to remit and pay, and hereby irrevocably assigns and transfers, to the Institution identified below or its designee (the "Institution"), any and all disability income benefits ("Benefits") payable under the above Group Policy. If and when Benefits are payable under the Group Policy, upon written request by the Company, the Applicant shall promptly designate the annuity contract ("Annuity Contract") to be credited with such Benefit payments. The undersigned represents and warrants that he/she has not assigned, pledged or otherwise encumbered Benefits or his/rights under the above Group Policy.

American General Life Insurance Company,
2929 Allen Parkway
Houston, Texas 77019

The United States Life Insurance Company in the City of New York,
70 Pine Street
New York, NY 10270

This Election Form is subject to written approval by the Company. Such approval may be withdrawn by the Company if, on the date Benefits are payable, the Annuity Contract (i) is not available or (ii) does not have a surrender charge provision. In either of such events, the Company or its designee shall issue an annuity contract to the Applicant into which Benefits shall be payable.
The Applicant consents thereto.

IN WITNESS WHEREOF, I have signed my name this ____ day of _____, 200__ at _____.

Print Name of Applicant

Signature of Applicant
✗

For Office Use Only:
APPROVED BY THE COMPANY: _____