



EXCESS MAJOR MEDICAL INSURANCE PLAN APPLICATION

APPLICATION

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

OFFICE USE ONLY Effective Date

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

ABA ID NUMBER: NAME: FIRM: STREET ADDRESS: CITY: STATE: ZIP: This is My: Business Home Both

HEIGHT: ft. in. WEIGHT: lbs. SEX: M F DATE OF BIRTH: (M) (D) (Y) PLACE OF BIRTH: AGE Please complete the following to assist us in contacting you should the need arise in processing your application. Business: Home: Fax: E-mail: Spouse/Domestic Partner Business: Spouse/Domestic Partner E-mail:

(See rates and benefits to determine which plan best fits your needs.)

I am applying for: PLAN I I hereby apply for a deductible of: \$10,000 \$15,000 \$20,000 \$25,000 \$50,000 \$100,000 Plan I includes a Convalescent Care Benefit of up to \$100 a week. I would like an increased benefit of: \$300 A WEEK \$400 A WEEK \$500 A WEEK

I am applying for: PLAN II I hereby apply for a deductible of: \$25,000 \$50,000 \$100,000 \$500,000 \$1,000,000 Plan II includes a Convalescent Care Benefit of up to \$300 a week. I would like an increased benefit of: \$400 A WEEK \$500 A WEEK

I want to cover: MYSELF MY SPOUSE/DOMESTIC PARTNER CHILD(REN)

List eligible dependents you wish to insure : (MEMBER MUST BE INSURED TO INSURE DEPENDENTS.)

Table with 8 columns: Relationship, Name of Proposed Insured, Age, Sex, Date of Birth, Height, Weight, Place of Birth. Rows include Spouse/Domestic Partner, Child, Child.

(Use separate sheet, if necessary, for additional children.)

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. 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

HEALTH INFORMATION

- A. Have you, your spouse/domestic partner or child(ren), if applying for insurance, ever had chest pains, disease or disorder of the heart, liver, kidneys or lungs, high blood pressure... MEMBER SPOUSE CHILD(REN)
B. Have you, your spouse/domestic partner or child(ren), if applying for insurance, during the past five years, consulted any physician or other practitioner, or been confined or treated in any hospital or similar institution? MEMBER SPOUSE CHILD(REN)

If "Yes" to any part of question A. or B., give details below. Use a separate sheet of paper, signed and dated, if more space is needed for your answers.

Table with 7 columns: Question #, Does Question apply to Member, Spouse/Domestic Partner, or Child (if child, please give name here), Condition, Date Occurred, Duration, Degree of Recovery, Names & Addresses of Hospitals, Physicians or Clinics Consulted

PLEASE READ ADDITIONAL INFORMATION, AND SIGN, ON REVERSE SIDE OF THIS REQUEST FORM

EXCESS MAJOR MEDICAL

## 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. 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. I understand that this plan will not pay benefits during the first two years after the effective date for any injury or sickness any insured has now, or has had in the past 12 months.

**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.

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, on the ABE 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 Signed: \_\_\_\_\_ Signature of Member (DO NOT PRINT): \_\_\_\_\_

Date Signed: \_\_\_\_\_ Signature of Spouse (if applying for coverage): \_\_\_\_\_

G-19027 (EM) Plan I Group Policy No. E-160,071, Plan II Group Policy No. E-224,814

ABE-03/09

## 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. **Do not sign the application if you do not agree with these procedures.** You may, if you wish, reclaim experience credits, if any, attributable to the member’s participation rather than leaving them with the Endowment to support its charitable program. **For any certificates issued as a result of this application, for the first policy year of participation only** (which ends on the 28th day of February 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 issue of the ABA Journal**. After the first policy year of your participation, a **written** request for refund (sent by mail, fax, or e-mail to [experiencecredits@abendowment.org](mailto:experiencecredits@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 as proof that your request was timely received. If it is not received within 3 weeks, contact the Endowment promptly to obtain another copy.

## INITIAL ELECTION

I do **NOT** choose to leave any experience credits 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 \_\_\_\_\_ Date \_\_\_\_\_

**DO NOT PRINT**

### Mail this completed application to:

American Bar Endowment  
Attn: Insurance Department  
321 North Clark Street  
Chicago, IL 60654-7648

AG6994