



EXCESS MAJOR MEDICAL INSURANCE PLAN ENROLLMENT FORM FOR RESIDENTS OF: FL, IA, KS, NC & SC

ENROLLMENT
OFFICE USE ONLY
Effective Date

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

WEB

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

EXCESS MAJOR MEDICAL

ABA ID NUMBER:		
NAME:		
FIRM:		
STREET ADDRESS:		
CITY:	STATE:	ZIP:
This is My: <input type="checkbox"/> Business <input type="checkbox"/> Home <input type="checkbox"/> Both		
Are you now a member of the ABA? <input type="checkbox"/> Yes <input type="checkbox"/> No		

HEIGHT: ft. in.	WEIGHT: lbs.	SEX: <input type="checkbox"/> M <input type="checkbox"/> 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:
 \$20,000 \$25,000 \$50,000 \$100,000

I am applying for:..... PLAN II
 I hereby apply for a deductible of:
 \$25,000 \$50,000 \$100,000 \$500,000 \$1,000,000

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

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

Relationship	Name of Proposed Insured	Age	Sex	Date of Birth	Height	Weight	Place of Birth
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

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

AUTHORIZATION

Plan I enrollees- I understand that this plan will not pay benefits during the first two years after the effective date for any injury or sickness any proposed insured has now, or has had in the past 12 months. I understand that this plan will not pay any benefits for the first 30 days of hospital confinement if coverage under a basic medical plan is not in effect for the proposed insureds at the time of such confinement.

Plan II enrollees- I understand that this plan will not pay benefits during the first two years after the effective date for any injury or sickness any proposed insured has now, or has had in the past 12 months. I further understand that this plan requires proposed insureds to be covered under a basic medical plan which provides benefits at least as great as one of the following: a) benefits for charges made by a hospital for charges which are incurred during the first 70 days of confinement or, b) major medical benefits subject to 1) a cash deductible of \$2,500 or less, 2) co-insurance of 50% or less, and 3) out-of-pocket co-insurance charges of \$5,000 or less. I understand that this plan will not pay any benefits for the first 30 days of hospital confinement if coverage under a basic medical plan is not in effect for the proposed insureds at the time of such confinement.

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. Fraud provision varies by state.

If the Insurance 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 the brochure, in each November issue of the *ABA Journal*, on the Endowment website, 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/Domestic Partner (if applying for coverage): _____

GI • 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) **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

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).