

To apply, complete this form and return it with your check payable to: American Bar Endowment  
321 North Clark Street, Chicago, IL 60654-7648



**GROUP HOSPITAL MONEY PLAN  
INSURANCE APPLICATION**

Request for Group Insurance from New York Life Insurance  
Company, 51 Madison Avenue, New York, NY, 10010



POLICY NO. G-11459-0

OFFICE USE ONLY	
Effective Date	

WEB

Please print in ink or type. Do not use correction fluid or gel pens. Initial and date any changes you make.

MEMBER ID NUMBER:		
NAME: First, Middle Initial, Last		
FIRM:		
STREET ADDRESS:		
CITY:	STATE:	ZIP:
This is My: <input type="checkbox"/> Business <input type="checkbox"/> Home <input type="checkbox"/> Both		

DATE OF BIRTH: (M) / (D) / (Y)	SEX: <input type="checkbox"/> M <input type="checkbox"/> F
ARE YOU NOW AN ABA MEMBER?: <input type="checkbox"/> YES <input type="checkbox"/> NO (Membership in ABA is required for participation in this plan.)	
Please complete the following to assist us in contacting you should the need arise in processing your application.	
Business:	( )
Home:	( )
Fax:	( )
E-mail:	

**Insurance Requested:** (Refer to brochure for eligibility, options, and coverage description.)

I hereby apply for an insurance amount for MYSELF

\$500/Day Benefit  \$400/Day Benefit  \$300/Day Benefit  \$200/Day Benefit

I hereby apply for an insurance amount for MY SPOUSE/DOMESTIC PARTNER

\$500/Day Benefit  \$400/Day Benefit  \$300/Day Benefit  \$200/Day Benefit

I hereby apply for an insurance amount for MY CHILD(REN)

\$250/Day Benefit  \$200/Day Benefit  \$150/Day Benefit  \$100/Day Benefit

*Spouse cannot be insured for more than the member's benefit; child(ren) cannot be insured for more than 50% of the spouse's benefit.*

I also request, for all proposed insureds, the optional **Surgical Benefit** for the option indicated here:  \$2,000  \$1,000

*Benefits provided depend upon the plan selected and the premium will vary with the amount of benefits.*

Please complete if you are requesting dependent coverage. List eligible dependents you wish to insure. If you need more space, list them on a separate sheet and include when mailing your Enrollment Form. **MEMBER MUST BE INSURED TO INSURE DEPENDENTS.**

RELATIONSHIP	NAME First, Middle Initial, Last	BIRTH DATE
SPOUSE/ DOMESTIC PARTNER		
CHILD		
CHILD		
CHILD		

**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

**PREEXISTING CONDITIONS CLAUSE**

I understand and it is agreed that if any person for whom insurance is being requested has received medical treatment or advice, or has taken prescribed drugs or medicine, for an accidental bodily injury or diagnosed sickness during the 12-month period before that person was insured under the policy, no benefits will be payable for that injury, sickness, or related condition until the earlier of: (a) the day after a 12 consecutive-month period has elapsed from the time that person was insured and during which no medical treatment or advice or drugs were received for that injury, sickness, or related condition; or (b) the day after a 24-consecutive month period has elapsed from the time that person was insured. Payment will be made only for losses sustained after such 12-month or 24-month period and will be in accordance with the provisions of the policy.

**Please read additional information, and sign, on reverse side of this application form**

G-11459-0

GMA-GI-L/H

HOSPITAL MONEY PLAN New



**FRAUD NOTICE:** For residents of all states except those listed below and NEW YORK: 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 may be a crime and may subject such person to criminal and civil penalties. **RESIDENTS OF CO**, the following also applies: Any insurance company or agent who defrauds or attempts to defraud an insured shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

**FOR RESIDENTS OF AR/LA/MD/RI:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**FOR RESIDENTS OF D.C., WARNING:** It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

**RESIDENTS OF FL:** Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

**RESIDENTS OF KS:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance may be guilty of insurance fraud as determined by a court of law.

**RESIDENTS OF ME:** It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

**RESIDENTS OF NJ:** WARNING: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

**RESIDENTS OF OK:** WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

**RESIDENTS OF TN:** It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

**RESIDENTS OF VA:** Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing false or deceptive statements may have violated state law.

## DECLARATION

I request the group insurance shown on the previous page. To the best of my knowledge and belief: (a) I am eligible for such insurance; and (b) the statements I have made are true and complete. I understand that: (a) the insurance will become effective on the first day of the month following receipt of this form provided the initial premium is paid within 30 days of such date; and (b) if I am hospital confined or if any of my dependents for whom I am requesting coverage is hospital confined on the date coverage would otherwise become effective, coverage will not become effective for me until the first day of the month following termination of my hospital confinement or effective for any dependent until termination of his or her hospital confinement; and (c) that the American Bar Endowment will not enter into negotiations with insured members and/or the Company on any matters pertaining to claims.

**If the company declares a dividend 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 dividend is reclaimed by me in accordance with the procedures outlined below, in the accompanying brochure, in each November issue of the *ABA Journal* and on the back of the premium notice. I have been advised that I am eligible for a charitable contribution deduction on my individual income tax return if I choose to leave my dividend with the Endowment.**

DATE: \_\_\_\_\_ MEMBER'S SIGNATURE: X \_\_\_\_\_

DATE: \_\_\_\_\_ OWNER'S SIGNATURE: X \_\_\_\_\_

(necessary only if you previously transferred ownership of your insurance under the group policy)

## DIVIDEND 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 dividends 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 dividends, 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 dividends 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](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.

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

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date

If you have any questions, call us toll-free at 1-800-621-8981 or email us at [information@abendowment.org](mailto:information@abendowment.org). Visit us on the Web at [www.abendowment.org](http://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)