

If you have any questions, call ABE at 1-800-621-8981.

GROUP TERM LIFE INSURANCE AND GROUP AD&D INSURANCE APPLICATION

For ABA Members, Spouses, and Children

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

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

WEB

1. MEMBER INFORMATION

ABA Member ID # _____

Member First Name _____ Middle Initial _____ Last Name _____

Billing Address _____ City _____ State _____ Zip _____

Home Address _____ City _____ State _____ Zip _____

Are you presently insured under any other ABE Group Life Plans (Group Term Life; 10-Year Level Term Life; 20-Year Level Term Life)? If yes, provide details (person insured, plan, and amount of insurance): Yes No

Person Insured	Plan	Amount of Insurance

Do you or your spouse, if proposed for insurance, intend to reside outside of the U.S. or Canada in the next 12 months?:

Member: Yes, Country _____ For how long? _____ No

Spouse: Yes, Country _____ For how long? _____ No

Marital Status: Married Domestic Partner-CA Widow/er Divorced Single

Proposed for Insurance	Date of Birth			Height ft./in.	Weight Lbs.	Sex
	Mo.	Day	Yr.			
Member: (Member must be insured to insure spouse or children)						<input type="checkbox"/> M <input type="checkbox"/> F
Spouse/CA Domestic Partner*: (Full name, First, Last, Middle Initial, if proposed for insurance)						<input type="checkbox"/> M <input type="checkbox"/> F
Child(ren)*: (Name if proposed for insurance)						<input type="checkbox"/> M <input type="checkbox"/> F

* See product information for definition of eligible dependents. If more than one child is proposed for insurance, attach a separate sheet. Please sign and date the additional sheet.

2. MEMBERSHIP AFFILIATION

Are you now an ABA member? (Membership in the ABA is required for participation in the plan.) Yes No

3. 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 receive 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

4. INSURANCE REQUESTED-INSURANCE STATUS

Refer to product information for a summary of eligibility, options, and coverage.

I HEREBY APPLY FOR THE FOLLOWING COVERAGES:

Group Term Life Insurance

- A. Total Member Amount Desired:** \$750,000 \$500,000 Other: \$ _____
 (Must be in \$10,000 increments.)
- Total Spouse/CA Domestic Partner Amount Desired: \$750,000 \$500,000 Other: \$ _____
 (Spouse coverage cannot exceed 100% of member's coverage.) (Must be in \$10,000 increments.)
- I also request coverage for my eligible children: \$5,000 per child (Check if desired.)

- B. Tobacco/Nicotine Use:** Have you or your spouse (if proposed for coverage) used tobacco or nicotine in any form, including nicotine patches and nicotine chewing gum, within the last 12 months?
 Member: Yes No Spouse: Yes No

If "Yes," when did you last use tobacco or nicotine products? Member: Month _____ Year _____ Spouse: Month _____ Year _____

C. Insurance Replacement:

RESIDENTS OF NEW YORK - IMPORTANT REPLACEMENT INFORMATION: It may not be in your best interest to replace existing life insurance policies on annuity contracts in connection with the purchase of a new life insurance policy, whether issued by the same or a different insurance company. A replacement will occur if, as part of your purchase of a new life insurance policy, existing coverage has been, or is likely to be, lapsed, surrendered, forfeited, assigned, terminated, changed or modified into paid-up insurance or other forms of benefits, loaned against or withdrawn from, reduced in value by use of cash values or other policy values, changed in the length of time or in the amount of insurance that would continue or continued with a stoppage or reduction in the amount of premium paid. Prior to completing a replacement transaction, you may want to contact the insurance company or agent who sold you the life insurance or annuity contract that will be replaced, to help you decide whether the replacement is in your best interest.

RESIDENTS OF NEW YORK: I have read the Important Replacement Information above. Is the Life Insurance applied for intended to replace, in whole or in part, any existing insurance or annuity?

Member: Yes No Spouse: Yes No

RESIDENTS OF OTHER STATES: Is the Life Insurance applied for intended to replace, discontinue or change an existing insurance policy?

Member: Yes No Spouse: Yes No

ALL RESIDENTS: Do you have other life insurance in force? If "yes," total amount in all companies:

Member \$ _____ Spouse \$ _____ Company _____

Do you have other insurance applications pending? If "yes," indicate amount and company:

Member \$ _____ Company _____ Spouse \$ _____ Company _____

Group Accidental Death and Dismemberment Insurance

(Spouse coverage may not exceed the member's)

- Member Coverage: \$500,000 \$400,000 \$300,000 \$250,000 \$100,000
- Spouse Coverage: \$500,000 \$400,000 \$300,000 \$250,000 \$100,000
- Child Coverage: \$50,000 \$25,000

(Note: You will receive a separate Certificate of Insurance for this Plan.)

5. BENEFICIARY DESIGNATION

The following beneficiary designation(s) is made for all member and spouse coverage provided under Group Term Life Insurance Policy G-2766-3 and Group AD&D Policy G-11461-0, and if I and my spouse are already covered under the plans, I hereby revoke any prior beneficiary designation. The member is automatically the beneficiary for any dependent child coverage, unless initial ownership is by someone other than the member, as provided in the Group Policy. If naming more than one beneficiary, note if each is to be primary and/or secondary, and the percentage of death proceeds to be distributed to each. If naming a trust as a beneficiary, please indicate the full name and date of the trust. (Attach a separate sheet if necessary, then sign and date it.)

Beneficiary Name	Address	Social Security #	Relationship to Insured	Percent
Member Life:				
Spouse Life:				

6. STATEMENT OF HEALTH

Please initial any changes you make on this form.

To the best of your knowledge and belief, answer the following questions as they apply to you and all dependents to be insured.

- | | Yes | No |
|--|--------------------------|--------------------------|
| a. Are you or any other person to be insured disabled or receiving any disability or workers' compensation benefits or on waiver of premium for life or health insurance? <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Are you or any other person to be insured now ill, or receiving medical attention or surgical treatment? <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| c. During the past five years, has any person to be insured consulted any physician or other medical care practitioner other than for a routine physical examination, or checkup, or been hospitalized or had an operation or had any illness, disease or injury? <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Are you or any other person to be insured under any kind of medication or, so far as you know, in impaired physical or mental health? <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Is any person to be insured now pregnant? <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| f. During the past 5 years, has any person to be insured ever been medically diagnosed by a physician as having or been treated for: | | |
| Yes | No | |
| 1. Heart or circulatory trouble, high blood pressure, pain or pressure in the chest? <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Arthritis, back trouble, bone or joint disorder? <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Fainting spells, convulsions or epilepsy? <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Sugar, blood, albumin or pus in urine? <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Diabetes, kidney trouble, ulcers or digestive disorder? <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Disorder of the breast or reproductive organs or functions? <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Nervous or mental disorder, emotional condition or psychiatric care? <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Cancer, tumor or cyst? <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Varicose veins, hemorrhoids or hernia? <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Disorder of eyes, ears, nose or sinuses? <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Thyroid, liver or respiratory disorder? <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Alcoholism or drug habit? <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Disorder of the blood? <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Other health or physical impairment including: | | |
| (i) Being medically diagnosed as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS related Complex (ARC)? <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| (ii) Chronic cough, persistent diarrhea, enlarged lymph glands, chronic fatigue or undiagnosed symptoms in the past 5 years? <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| (iii) Any other impairment? <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

IF YOU HAVE ANSWERED ANY QUESTIONS "YES," GIVE COMPLETE DETAILS BELOW.

(If you need more space, use a signed and dated separate sheet. Please avoid the use of such terms as "etc.," "various," or "miscellaneous.")

Question letter/no.	Name(s) of proposed insured	Illness or condition, date of onset, duration, treatment, operations, degree of recovery and date	Name and address of physicians or other medical care practitioners and hospitals where confined or treated

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.

I request the group insurance shown on this application. 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 New York Life has the right to require additional information and, if necessary, an examination by a physician. I ask New York Life to rely on all such statements made on this form, and any supplements to it, while considering this request. I also understand that the coverage afforded will be in consideration of the answers and statements set forth above and that any misstatements or failures to report information material to the risk may be used as the basis for rescission of my insurance subject to the incontestable period provision of the policy.

I understand that: (a) Insurance will become effective on the first day of the month following the date approved by New York Life provided the initial premium contribution has been paid and I and any approved dependents are alive on the date of approval; (b) any person proposed for insurance who is disabled or confined at home or in a hospital or other institution on the day insurance would otherwise have taken effect, will not become insured until the day such person is not so disabled or confined, provided such date is within three months of the date insurance would have been effective and the person is still eligible for insurance, and (c) benefits will not be payable for up to two years for losses due to a disease or condition which I or my spouse now have or have had in the past and which are not disclosed on this form.

AUTHORIZATION: I authorize disclosure of the types of information detailed in this AUTHORIZATION, for New York Life's use in considering this request for coverage. I have read the IMPORTANT NOTICE, which describes how New York Life underwrites this request for coverage, including how information is exchanged with MIB (Medical Information Bureau). My request for coverage will not be accepted unless this AUTHORIZATION is signed.

I authorize any physician, medical practitioner, hospital, medical or medically related facility, laboratories, insurance company or MIB to release prescription drug records and related information maintained by physicians, pharmacy benefit managers, and other sources of information to New York Life Insurance Company Insurance Company, its subsidiaries or the Endowment about the physical and mental health of any persons proposed for insurance, including significant history, findings, diagnosis or treatment, but excluding psychotherapy notes. MIB and other insurance companies may also furnish New York Life, its subsidiaries or the Endowment with non-medical information (such as driving records, any criminal activity or association, hazardous sport or aviation activity, use of alcohol or drugs, and other applications for insurance). I understand that the information provided may include information that may predate the time frame stated on the medical questions section of this application. I also understand and agree that this information may be used during the underwriting and claims processes, where permitted by law.

New York Life may release information covered by this AUTHORIZATION to the plan administrator, MIB, other insurance companies and to others whom I authorize in writing. However, this will not be done in connection with information concerning Acquired Immune Deficiency Syndrome (AIDS). This AUTHORIZATION may be used for a period of 24 months from the date signed below unless sooner revoked. I may revoke this AUTHORIZATION at any time by notifying the Endowment in writing at the address given on this form. My revocation will not be effective to the extent New York Life or any other person already has disclosed or collected information or taken other action in reliance on it, or to the extent that New York Life has a legal right to contest a claim under an insurance certificate or the certificate itself. A photocopy of this AUTHORIZATION and request form shall be as valid as the original. I acknowledge that I or my authorized agent may request a copy of this signed AUTHORIZATION.

I further understand and agree that any dividend apportioned to the group policy will be paid to the American Bar Endowment to support its charitable work in the field of law unless such dividends are claimed by me pursuant to the procedures described below in the Dividend Notice, in the brochure, in each November issue of the ABA Journal and on the back of the premium notice.

To the best of my knowledge and belief, the statements made regarding my health and tobacco/nicotine use are true and complete.

Member's Signature X _____ Date _____
(Please sign and date in ink.)

To the best of my knowledge and belief, the statements made regarding my health and tobacco/nicotine use are true and complete.

Spouse's Signature X _____ Date _____
(Necessary only if spouse coverage is requested.)

Owner's Signature X _____ Date _____
(Necessary only if you previously transferred ownership of your insurance under Group Policy(s).)

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 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 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 May for Group Term Life and July 31st for Group AD&D 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 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.
X _____ Date ____/____/____
Member's Signature (DO NOT PRINT) **Date**