American Bar Endowment
Insuring your life's needs.
Advancing your life's work.

To Apply: Complete this application and return it to:
American Bar Endowment (ABE), 321 North Clark Street, Chicago, IL 60654-7648

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

OFFICE USE ONLY
Effective Date

New

WEB

TERM LIFE INSURANCE APPLICATION

For ABA Members, Spouses/Domestic Partners 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.

MEMBER INFORMATION

ABA Member ID # _____

_____
Member First Name | Middle Initial | Last Name

_____
Billing Address | City | State | Zip

_____
Home Address | City | State | Zip

Please complete the following to assist us in contacting you should the need arise in processing your application:

Home Phone (_____) _____

Work Phone (_____) _____

Fax (_____) _____

E-mail Address _____

Are you presently insured under any other ABE Group Life Plans (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/domestic partner, 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/Domestic Partner: ❑ Yes, Country _____ For how long? _____ ❑ No

Marital Status: ❑ Married ❑ Domestic Partner (DP) ❑ Civil Union* ❑ Divorced ❑ Single

** Eligibility of Civil Unions is determined by state law.*

Proposed for Insurance	Date of Birth Mo.	Day	Yr.	Height ft./in.	Weight Lbs.	Sex
Member: (Member must be insured to insure spouse or children)						❑ M ❑ F
Spouse/DP*: (Full name, First, Last, Middle Initial, if proposed for insurance)						❑ M ❑ F
Child(ren)*: (Name if proposed for insurance)						❑ M ❑ 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.

MEMBERSHIP AFFILIATION

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

PAYMENT OPTION SELECTION

❑ **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

Be Sure to Complete Pages 2, 3, & 4 and Sign Page 4

GMA-PR1

INSURANCE REQUESTED-INSURANCE STATUS

Refer to product information for a summary of eligibility, options, and coverage.
I HEREBY APPLY FOR THE FOLLOWING COVERAGES:

Term Life Insurance

A. Total Member Amount Desired: ❑ $750,000 ❑ $500,000 ❑ Other: $_____
(Must be in $10,000 increments.)

Total Spouse/DP 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 any nicotine substitute in any form, including nicotine patches and nicotine chewing gum? Member: ❑ Yes ❑ No Spouse/DP: ❑ Yes ❑ No

If "Yes," please state when you last used tobacco or nicotine products and specify the product used.

Member: Month_____ Year_____ Product_____

Spouse/DP: Month_____ Year_____ Product_____

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

Member $_____ Spouse/DP $_____ Company _____

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

Member $_____ Company _____ Spouse/DP $_____ Company _____

D. **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 of 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 replace, 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/DP: ❑ 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/DP: ❑ Yes ❑ No

BENEFICIARY DESIGNATION

The following beneficiary designation(s) is made for all member and spouse/domestic partner coverage provided under Term Life Insurance Policy G-2766-3, and if I and my spouse are already covered under the plan, 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/DP Life:				

Be Sure to Complete Pages 3, & 4, and Sign Page 4

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?	❑	❑
b. Are you or any other person to be insured now ill, or receiving medical attention or surgical treatment?	❑	❑
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?	❑	❑
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?	❑	❑
e. Is any person to be insured now pregnant?	❑	❑

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?	❑	❑
2. Arthritis, back trouble, bone or joint disorder?	❑	❑
3. Fainting spells, convulsions or epilepsy?	❑	❑
4. Sugar, blood, albumin or pus in urine?	❑	❑
5. Diabetes, kidney trouble, ulcers or digestive disorder?	❑	❑
6. Disorder of the breast or reproductive organs or functions?	❑	❑
7. Nervous or mental disorder, emotional condition or psychiatric care?	❑	❑
8. Cancer, tumor or cyst?	❑	❑
9. Varicose veins, hemorrhoids or hernia?	❑	❑
10. Disorder of eyes, ears, nose or sinuses?	❑	❑
11. Thyroid, liver or respiratory disorder?	❑	❑
12. Alcoholism or drug habit?	❑	❑
13. Disorder of the blood?	❑	❑
14. Other health or physical impairment including:		
(i) Being medically diagnosed as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS related Complex (ARC)?	❑	❑
(ii) Chronic cough, persistent diarrhea, enlarged lymph glands, chronic fatigue or undiagnosed symptoms in the past 5 years?	❑	❑
(iii) Any other impairment?	❑	❑

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

Be Sure to Complete and Sign Page 4

AUTHORIZATION AND SIGNATURE

I understand that New York Life Insurance Company 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.

AUTHORIZATION: I hereby authorize any licensed physician, medical practitioner, hospital, pharmacy, clinic or other medical or medically related facility, laboratory, insurance company, MIB, Inc. ("MIB"), or other organization, institution or person, that has any records or knowledge of me or my health to release information, including prescription drug records, maintained by physicians, pharmacy benefit managers, and other sources of information, to New York Life Insurance Company, its reinsurers, its subsidiaries or ABE about the physical and mental health of any persons proposed for insurance, including significant history, findings, diagnosis and treatment, but excluding psychotherapy notes for the purpose of evaluating my application for insurance. Health information obtained will not be re-disclosed without my authorization unless permitted by law, in which case it may not be protected under federal privacy rules. For example, New York Life may be required to provide it to insurance, regulatory, or other government agencies. In this case, the information may no longer be protected by the rules governing your AUTHORIZATION.

A photocopy of this AUTHORIZATION and request form shall be as valid as the original. In all circumstances, my authorized agent, representative, or I may request a copy of this AUTHORIZATION. This AUTHORIZATION shall be valid for a period of 24 months from the date signed, unless sooner revoked. The AUTHORIZATION may be revoked at any time by sending written notice to New York Life Insurance Company. My revocation will not be effective to the extent that 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.

By signing and dating this application, the member **requests** the insurance indicated; and the member and any person proposed for insurance **consent** to authorize the disclosure of information to and from the providers noted above and in the IMPORTANT NOTICE, including making a brief report of my/our protected health information to MIB, Inc.; and **attest** to having read the IMPORTANT NOTICE and Fraud Notices indicated in the enclosed brochure and on the following page respectively, including how my/our information is exchanged with MIB, and that to the best of my/our knowledge and belief, the answers provided to the questions are true and complete.

I further understand and agree that any dividends payable on the group policy will be paid to the American Bar Endowment (ABE) to support its charitable work in the field of law unless such dividends are claimed by me pursuant to the procedures described in the plan brochures, on the back of ABE premium notices, on the ABE website and in each November issue of the *ABA Journal.* (Notice of the approximate percentage of premium available (if any) for contribution or refund will be published in that issue.)

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

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

Owner information – Required if owner is other than member. (If owner is a trust, please submit a copy of the document with this application.)

Full Name: _____
Last First Middle Initial Relationship to Proposed Insured Daytime Phone

Mailing Address: _____
Street City State Zip Code

Tax ID# _____

Date of Birth: _____ Social Security Number _____

Owner's Signature X _____ Date: _____
(Necessary only if other than member.)

DIVIDEND NOTICE **Please note:** Members who wish to contribute dividends payable on this group policy to ABE to support its charitable mission need not do anything further. However, members who do not want to contribute these dividends are required to "opt out" each year, using the procedures described below. By signing this application, you are agreeing to make an ***annual*** decision whether to opt out. **Do not sign the application if you do not agree with these procedures.**

For the first policy year of participation only (which ends on May 31st following the effective date of your insurance), if you want to opt out, sign and date the initial election below. After the first policy year of your participation, a ***written*** request for refund **must be made each year and must reach ABE by December 15th.** Written requests may be sent by mail, fax, or e-mail to dividends@abendowment.org. You will be sent a confirmation; retain this for your records. If it is not received within 3 weeks, contact ABE promptly to obtain another.

INITIAL ELECTION (**For new applicants only.** Members currently insured in this plan must send a written request each year to ABE anytime during the year, but no later than December 15.) I do **not** choose to leave any dividends with ABE 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**

Please See Fraud Notices on Page 5

FRAUD NOTICE

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.

RESIDENTS OF AL/AR/LA/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 CA: 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. The falsity of any statement in the application for any policy shall not bar the right to recovery under the policy unless such false statement was made with actual intent to deceive or unless it materially affected either the acceptance of the risk or the hazard assumed by the insurer.

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 MD: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

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 PUERTO RICO: Any person who, knowingly and with the intent to defraud, presents false information in an insurance request form, or who presents, helps or has presented a fraudulent claim for the payment of a loss or other benefit, or presents more than one claim for the same damage or loss, will incur a felony, and upon conviction will be penalized for each violation with a fine no less than five thousand (5,000) dollars nor more than ten thousand (10,000) dollars, or imprisonment for a fixed term of three (3) years, or both penalties. If aggravated circumstances prevail, the fixed established imprisonment may be increased to a maximum of five (5) years; if attenuating circumstances prevail, it may be reduced to a minimum of two (2) years.

RESIDENTS OF TN/WA: 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.

If you have any questions, call us toll-free at 800-621-8981 or our toll-free Solo/Small Firm Help Line at 877-621-7676.
Or email us at information@abendowment.org.
Visit us online at www.abendowment.org for plan information or a personalized rate quote.