THREE EASY STEPS — HOW TO APPLY

The following steps are involved in underwriting your application for Professional Overhead Expense insurance. Please understand that this process is similar to that required by all insurance companies that underwrite this type of coverage, and that, in cooperation with you, the ABE will do all they can to help make the process go smoothly.

NEW YORK LIFE

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

1. Sign and date this completed application and return in the postage-paid envelope provided. We will forward to the insurance company for underwriting. Residents of Puerto Rico: Mail your application to Global Insurance Agency, Inc., P.O. Box 9023918, San Juan, PR 00902-3918.

2. A paramedical exam (including detailed medical history along with blood and urine sample) will be required. You will be asked to verify the medical history by signing a supplement to this application. A paramedical service will contact you to arrange an appointment at your convenience. There is no cost to you for this exam and it can be done in the privacy of your home or office. All results go to the insurance company. You have the right to receive the results of your medical report.

3. No premium payment is needed now. If approved for coverage, you will be billed at the premium contribution level based on your approved monthly benefit.

OFFICE USE ONLY
Effective Date

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GROUP PROFESSIONAL OVERHEAD EXPENSE INSURANCE APPLICATION

For ABA Members

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 ID # _____

_____
Member First Name Middle Initial Last Name

_____
Home Address City State Zip

_____
Business 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 ( ) _____
Cell Phone ( ) _____
E-mail Address _____

Sex: ❑ M ❑ F **Date of Birth:** ____/____/_____ **Height:** ____ft.____in. **Weight:** _____lbs.

Do you intend to reside outside the U.S. or Canada in the next 12 months? ❑ Yes Country(ies)_____ For how long?_____ ❑ No

INSURANCE REQUESTED

❑ **New** ❑ **Increase** (Refer to brochure for eligibility, options and coverage description.)

I hereby apply for the following total monthly benefit coverage amount of (not to exceed my average monthly business expenses for the six month period immediately preceding the date of this application):.....$_____
Benefits from this plan will reduce so that when combined with benefits payable from other office overhead expense plans you may have, they do not exceed the actual expenses incurred. See plan brochure for details on eligible expenses and benefits payable.
a. What was your average monthly amount eligible overhead expenses in the past 6 months?.....$_____
b. If practicing as partnership or corporation for what percentage of these expenses were you responsible?....%_____
c. What was your average number of employees in the past 6 months?.....

PAYMENT OPTION SELECTION

❑ **OPTION 1:** AUTOMATIC MONTHLY PAYMENT – I hereby authorize the ABE to initiate debit entries to my checking account at the depository financial institution specified on the attached voided check, 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 the ABE has received written notification from me of its termination in such time and in such manner as to afford the ABE and depository financial institution a reasonable opportunity to act on it.

❑ **OPTION 2:** PERIODIC BILLING ❑ Annual ❑ Semiannual ❑ Quarterly

MEMBERSHIP AFFILIATION-OCCUPATION STATUS

Are you now a member of the ABA (membership in the ABA is required for participation in this plan)?.....❑ Yes ❑ No
What is your occupation? _____ Main duties? _____
What is the type of business?.....❑ Sole Proprietor ❑ Corporation ❑ Partnership
Active Practice: Are you now, and have you been for the last 30 days, performing all the duties of your occupation on a full-time basis for 30 or more hours per week at your usual place of business?.....❑ Yes ❑ No

YOU WILL BE CONTACTED BY A SERVICE PROVIDER ON BEHALF OF NEW YORK LIFE TO ASK ABOUT YOUR MEDICAL HISTORY

Best place and time to contact you (*Choose one of each):*

PLACE	DAY	TIME OF DAY	
❑ Residence	❑ Weekdays	❑ Morning (7:00-12:00)	❑ Afternoon (12:00-5:00)
❑ Business	❑ Weekends	❑ Evening (5:00-8:00)	❑ Night (8:00-11:00)

Be Sure to Complete and Sign Page 2

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 the plan administrator 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 redisclosed 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 **consents** 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 protected health information to MIB, Inc.; and **attests** to having read the IMPORTANT NOTICE indicated on the enclosed brochure and Fraud Notices indicated on the following page respectively, including how my information is exchanged with MIB, and that to the best of my 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.)

DIVIDEND NOTICE

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 3

FRAUD NOTICE

FRAUD NOTICES ***For Residents of all states except those listed below:*** 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 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 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 NY: Any person who knowingly and with intent to defraud any insurance company or any 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 is a crime, and shall also be subject to civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

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.

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If you have any questions, call us on our Solo/Small Firm Help Line 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.