



GROUP OFFICE OVERHEAD EXPENSE INSURANCE APPLICATION

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

Group Policy No. G-5381-0

Complete this form and return, with your check payable to: American Bar Endowment, 321 N. Clark St., Chicago, IL 60654-7648. Please print in ink or type all answers. Do not use correction fluid or gel pens. Initial and date any changes you make.



OFFICE USE ONLY
Effective Date

MEMBER INFORMATION

ABA ID NUMBER:
NAME: First MI Last
FIRM:
STREET ADDRESS:
CITY: STATE: ZIP:
This is My: Business Home Both

HEIGHT: ft. in. WEIGHT: lbs. SEX: M F
DATE OF BIRTH
Please complete the following to assist us in contacting you should the need arise in processing your application.
Business:
Home:
Fax:
E-mail:

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

I hereby apply for a monthly benefit 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 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.
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

STATEMENT OF HEALTH

(Please initial and date any changes you make on this form.)
To the best of your knowledge and belief, answer the following questions as they apply to you.

[California Residents: California law prohibits any HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.]

[For ME Residents only: You are not required to disclose whether you have been tested for HIV if you have not developed symptoms of the disease, AIDS, or AIDS-Related Complex (ARC) in your answer to any of the following questions.]

[For MN Residents only: The applicant does not have to disclose an HIV (AIDS Virus) test which was administered: (1) to a criminal offender or crime victim as a result of a crime that was reported to police; (2) to a patient who received the services of emergency medical services personnel at a hospital or medical care facility; (3) to emergency medical personnel who were tested as a result of performing emergency medical services. Refer to the Authorization section for a definition of "Emergency Medical Personnel."]

- 1. Are you now ill or taking any prescribed medication or receiving or contemplating any medical attention or surgical treatment? Yes No
2. During the past five years, have you ever been medically diagnosed by a physician or other medical care practitioner as having or been treated for:
a. Heart or circulatory trouble, elevated blood pressure, chest pain or pressure, gynecological or genitourinary disorders, disorder of breast or reproductive organs or functions, ulcers or digestive disorders, cancer, tumor or cyst, diabetes, mental or nervous disorders, emotional conditions, psychiatric care or psychotherapeutic treatment, fainting spells, convulsions or epilepsy, respiratory disorder, kidney or liver disorder (including hepatitis), enlarged lymph nodes or immunodeficiency disorder, thyroid disorder, blood disorder, albumin, blood, pus or sugar in urine, back trouble/disorder, arthritis, bone or joint disorder, varicose veins, hemorrhoids or hernia, disorder of eyes, ears, nose or sinuses, unexplained weight loss or accidental injury? Yes No
[NC residents only: "immunodeficiency disorder" includes hyperimmune conditions, disorders of gammaglobulin synthesis (hyper gammaglobulinemia), of white blood cell production and maturation, the immune-deficiency disorders, both congenital and acquired. Also included are lupus erythematosus, Grave's disease, rheumatoid arthritis, primary biliary cirrhosis, and others. "blood disorder" includes all conditions of the blood presently recognized as disorders, both primary disorders of the blood (e.g. anemia, polycythemia, leukopenia, leukocytosis, clotting disorders, platelet disorders, immune disorders whether congenital or acquired, disorders of gammaglobulin) and disorders that reflect other disease processes (e.g. infections, malignancies, sources of blood loss, biliary tract disease.)]
b. Other Health or physical impairment including:
i. [This question applies to all applicants EXCEPT FL residents] Being medically diagnosed as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS-Related Complex (ARC)? Yes No

[Florida residents only--answer the following!]
Have you ever been tested positive for exposure to the HIV infection, or been diagnosed as having ARC (AIDS-Related Complex) or AIDS(Acquired Immune Deficiency Syndrome) caused by the HIV infection, or other sickness or condition derived from such infection? Yes No

[NC residents only: "AIDS-Related Condition (ARC)" is a condition with signs and symptoms which may include generalized Lymphadenopathy (swollen lymph nodes), loss of appetite, weight loss, fever, oral thrush, skin rashes, unexplained infections, dementia, depression or other psychoneurotic disorders with no known cause.]

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- ii. Chronic cough, persistent diarrhea, enlarged lymph glands, chronic fatigue in the past five years? Yes No
- iii. Any other impairment? Yes No
- 3. During the past five year, have you ever been counseled, treated or hospitalized for the use of alcohol or drugs? Yes No
- 4. Are you now pregnant? Yes No
- 5. Are you now disabled, applied or applying for, or receiving any disability or Workers' Compensation benefit or on waiver of premium for life or health insurance? Yes No
- 6. During the past two years, have you participated in, or do you plan to participate in: aircraft flying other than as a passenger, scuba diving, ultra light flying, ballooning, parachuting, mountaineering, rodeo riding, snowmobiling, hang gliding, parasailing, bungee jumping or organized motorcycle racing, or any type of organized motorized racing? Yes No
- 7. Driver's License No.: _____ State Issued: _____
- 8. During the past five years, has your driver's license been suspended or revoked, or have you had any moving violations? Yes No
- 9. During the past 24 months, have you ever used tobacco or nicotine in any form including nicotine patches and nicotine chewing gum? Yes No
- 10. Are you currently incarcerated or have an arrest pending, or during the past 15 years (7 in Maryland) served time in prison? ... Yes No
- 11. If you answered any of the above Questions 1-10 "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/Number	Illness or Condition Date of Onset-Duration-Treatment-Operation-Degree of Recovery and Date	Name and Address of Physicians or other 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 the reverse side. 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 reserves 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 of the policy.

I understand that: (a) insurance will become effective on the first day of the month following the date of approval by New York Life if the initial contribution has been paid and I am in Active Practice (as defined on the reverse side) on the later of the date insurance is effective or the date the contribution is paid; (b) if I am not in Active Practice on the day insurance would otherwise become effective, I will not be insured until the date I am in Active Practice, provided such date is within three months of the date insurance would have been effective and I am still eligible for such insurance

AUTHORIZATION: I authorize disclosure of the types on 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, its subsidiaries or the American Bar Endowment about the physical and mental health of any persons proposed for insurance, including significant history, findings, diagnosis and treatment, but excluding psychotherapy notes. MIB and other insurance companies may also furnish New York Life, its subsidiaries or the American Bar 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 in this AUTHORIZATION to the American Bar Endowment, 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.

For MN Residents: This authorization excludes the release of information about HIV (AIDS virus) tests which were administered: (1) to a criminal offender or crime victim as a result of a crime that was reported to the police; (2) to a patient who received the services of emergency medical services personnel at a hospital or medical facility; (3) to emergency medical personnel who were tested as a result of performing emergency medical services. The term "emergency medical personnel" includes individuals employed to provide pre-hospital emergency services: licensed police officers, firefighters, paramedics, emergency medical technicians, licensed nurses, rescue squad personnel, or other individuals who serve as volunteers of an ambulance service who provide emergency medical services; crime lab personnel; correctional guards, including security guards at the Minnesota security hospital, who experience significant exposure to an inmate who is transported to a facility for emergency medical care; and other persons who render emergency care or assistance at the scene of an emergency, or while an injured person is being transported to receive medical care and who would qualify for immunity under the Good Samaritan Law.

If New York Life 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 claimed by me in accordance with the procedures outlined below, in the 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.

To the best of my knowledge and belief, the statements I have made regarding my health are true and complete.

X _____ / ____ / ____
Member's Signature (Please sign in ink and DO NOT PRINT) Date

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 30th day of June 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 _____ / ____ / ____
Member's Signature (DO NOT PRINT) Date