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

SPEC-IL

GROUP MID-TERM DISABILITY INSURANCE APPLICATION

Underwritten By: The United States Life Insurance Company in the City of New York (Herein called the Company)

Mail Your Application To: **AMERICAN BAR ENDOWMENT** • 321 North Clark Street • Chicago, Illinois 60654-7648

APPLICATION

OFFICE USE ONLY	
Plan	Effective Date

MID-TERM DISABILITY

ABA MEMBER #

NAME:

FIRM:

STREET ADDRESS:

CITY: STATE: ZIP:

This is my: ❑ **Business** ❑ **Home** ❑ **Both**

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

Business Phone:

Home Phone:

Cell Phone:

Fax Number:

Email:

PERSONAL DATA (Must be completed in full prior to any underwriting consideration.)

Age:_____ Height __ft. ___in. Weight _____lbs. Sex ❑ M ❑ F Date of Birth___/___/_____ Place of Birth _____

Are you now, and have you been for the last 90 days, performing all the duties of your regular occupation for at least 30 hours per week for your present employer? ❑ YES ❑ NO

Annual Earned Income (after business expenses): $ _____ Date of Hire: _____

Employer Name and Address: _____

Name and Address of Member's Physician: _____

DISABILITY INSURANCE REQUESTED:

1. Waiting Period: ❑ 60 DAY (not available for spouse/domestic partner) ❑ 90 DAY ❑ 180 DAY

2. Monthly Benefit (in $100 increments) (not to exceed 66 2/3% of your monthly income) **$** _____

(For benefit amounts greater than $7,500, not to exceed 60% of your monthly income)

I PREFER TO PAY: (Send no money now - we will send premium notice upon approval.)

❑ **OPTION 1:** AUTOMATIC MONTHLY PAYMENT (ACH) – I (we) hereby authorize the American Bar Endowment (ABE), to initiate debit entries to my (our) checking or savings account at the depository financial institution specified on the attached voided check or completed Auto-Pay Enrollment Form (available at abendowment.org/pay), 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 ABE has received written notification from me (or either of us) of its termination in such time and in such manner as to afford ABE and DEPOSITORY a reasonable opportunity to act on it.

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

PLEASE ANSWER THESE BRIEF QUESTIONS.

To the best of your knowledge and belief:

	YES	NO
1. Have you ever had or been treated for: *(Circle specific disorders experienced.)*		
a. Disease or disorder of the heart, murmur, chest pain, rheumatic fever, elevated blood pressure, stroke, aneurysm or transient ischemic attack?	❑	❑
b. Injury, pain or disorder of the neck or back? Sciatica? Any disabling injury or disorder of the bones, joints or muscles? Connective tissue disorder?	❑	❑
c. Arthritis, chronic pain, chronic fatigue, fibromyalgia, bursitis or rheumatism, or any other neurological disorder?	❑	❑
d. Dizziness, epilepsy, convulsions, recurrent headaches, glaucoma, cataract or other disorder of the eyes or ears?	❑	❑
e. Disease or disorder of the rectum? Vascular or blood disorder?	❑	❑
f. Diabetes or elevated glucose? Sugar or albumin in urine? Thyroid or other glandular disorder?	❑	❑
g. Ulcer, or disorder of stomach, liver, gall bladder or pancreas? Colitis, Hepatitis, or other disorder of small or large intestine?	❑	❑
h. Prostate disorder? Nephritis, nephrosis or other kidney disease or disorder?	❑	❑
i. Menstrual, uterine or ovarian disorder? Complications of pregnancy? Disorder of the breast?	❑	❑
j. Bronchitis, emphysema, sleep apnea, difficult breathing, or other respiratory disease or disorders?	❑	❑
k. Cancer, tumor or mass? Deformity or loss of limb? Congenital defect? Disease or disorder of the lymphatic system?	❑	❑
l. Mental or emotional problem requiring help of a physician, psychologist or counselor?	❑	❑
m. A surgical operation? Or a surgical operation advised but not performed?	❑	❑
n. Alcohol or drug abuse?	❑	❑
2. Have you ever received medical treatment or been diagnosed by a medical professional as having Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) or disorders of the immune system?	❑	❑
3. Have you during the past 5 years, consulted any physician or other practitioner or been confined or treated in any hospital or similar institution, for any reason other than those stated above?	❑	❑
4. Are you now taking prescription medication or receiving medical attention?	❑	❑

COMPLETE AND SIGN REVERSE SIDE OF THIS APPLICATION.

For "Yes" answers to questions 1-4 above, please provide details in the space provided below. If more space is needed, use a separate sheet of paper, signed and dated. If additional information is attached, check "Yes" ❑ Yes ❑ No

Question #	Proposed Insured	Condition	Date Occurred	Duration	Degree of Recovery	Names & Addresses of Hospitals, Physicians, or Clinics Consulted
			/ /			
			/ /			
			/ /			

EXISTING AND PENDING INSURANCE SECTION

Do you have any disability insurance in force or pending? (including group Coverage) ❑ Yes ❑ No
(If "Yes", please indicate companies and amounts) _____
Will this coverage applied for replace any insurance now in force? (including group Coverage) ❑ Yes ❑ No
(If "Yes", please indicate which insurance and the amount being replaced) _____

AUTHORIZATION AND DECLARATION OF EACH PERSON GIVING A STATEMENT OF INSURABILITY

I hereby authorize any licensed physician, medical practitioner, pharmacy, pharmacy benefit manager and other sources, hospital, clinic, or other medical or medically related facility, insurance company, the MIB, Inc., formerly known as the Medical Information Bureau, or other organization, institution or person that has any records or knowledge of me or my health, to give to the Company or its reinsurers any such information. Such information will pertain to my employment, or other insurance coverage and medical care, advice, treatment or supplies for any physical or mental condition. This includes information obtained in connection with the preparation or procurement of an investigative consumer report as defined under the Fair Credit Reporting Act(s). To facilitate the rapid submission of such information, I authorize all said sources, except the MIB, to give such records or knowledge to any agency employed by the Company to collect and transmit such information. I understand that this information will be used by the Company solely to determine eligibility for insurance. I understand that I may revoke this authorization at anytime by giving written notice to the Company. I agree that such revocation will not affect any action, that any source has taken in reliance upon this authorization. I understand this authorization will be valid for 24 months from the effective date of coverage, if not revoked earlier. I know that I should retain a copy of this authorization for my records. I agree that a photocopy of this authorization is as valid as the original. To the best of my knowledge and belief, all statements made above are true and complete. I understand that my application for group insurance will be accepted or declined on the basis of these statements. Insurance will take effect only if a certificate is issued based on this application and the first premium is paid in full (a) during the lifetime of all proposed insureds; and (b) while there is no change in the insurability or health of such person from that stated in the application.

Important Notice: Any person who knowingly and with intent to defraud any insurance company, files or causes to be filed, a claim for payment of a loss, containing any false or incomplete information commits a fraudulent insurance act that may be a crime and may subject such person to incarceration, fines and denial of benefits.

A copy of this Application will be attached and become part of your Certificate of Insurance.

If the Company declares an experience credit 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 I reclaim my share of any experience credit in accordance with the procedures outlined on the next page, 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 tax return if I leave experience credits with the Endowment.

DATE_____ SIGNATURE OF MEMBER _____

EXPERIENCE CREDIT NOTICE - PLEASE READ CAREFULLY

EXPERIENCE CREDITS NOTICE **Please note:** Members who wish to contribute experience credits 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 experience credits 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 October 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, 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 donate any experience credits to ABE for its charitable mission ***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 800-621-8981. Solo/Small Firm Members, call us at 877-621-7676.
Or email us at information@abendowment.org.
Visit us online at www.abendowment.org for plan information and rate quotes.

AG-9948

These Notices must be retained by the applicant.

MIB DISCLOSURE NOTICE

Information regarding your insurability will be treated as confidential. The United States Life Insurance Company in the City of New York or its reinsurers may, however, make a brief report thereon to the MIB, Inc., formerly known as Medical Information Bureau, a not for profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information about you in its file. Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at 866 6926901 (TTY 866 3463642). If you question the accuracy of the information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734. The United States Life Insurance Company in the City of New York, or its reinsurers, may also release information from its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.

NOTICE AS REQUIRED UNDER THE FAIR CREDIT REPORTING ACT(S)

This is to inform you that as part of our procedure for processing your insurance application, an investigative consumer report may be requested for the preparation of a report whereby information is obtained through personal interviews with your neighbors, friends, or others with whom you are acquainted or who may have knowledge of any such items of information. This inquiry includes information as to your character, general reputation, personal characteristics, and mode of living. You have the right to make a written request to be informed as to whether or not such consumer report was requested, and if such report was requested, the name and address of the consumer reporting agency to whom the request was made. You may receive a copy of this report by contacting such agency.