SPEC-MN,VT

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

FORM NUMBER: GTD-MTD

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: ____________________

Home: ____________________

Fax Number: ____________________

Email: ____________________

I WOULD LIKE TO ENROLL IN THE DISABILITY PROGRAM:

1. Indicate the total monthly member benefit desired: $ __________ **(in $100 increments)** (not to exceed 66 2/3% of your monthly income) (for benefits greater than $7,500, not to exceed 60% of your monthly income)
2. My annual earned income (after business expenses) for the 12 months immediately preceding the date of this application is: .... $ __________
3. Date Employed:... _____/_____/_____
4. Indicate member waiting period desired:
   ❑ 60 DAY ❑ 90 DAY ❑ 180 DAY

MEMBER'S EMPLOYER

Name ____________________

Address ____________________

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

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

Height _____ft. _____in. Weight _______lbs. Sex ❑ M ❑ F Date of Birth_____/_____/_____ Place of Birth ______________

ANSWER EACH QUESTION BY CHECKING THE "YES" OR "NO" BOX, AS IT APPLIES.

	YES	NO
1. HAVE YOU EVER HAD OR BEEN TREATED FOR: *(Circle specific disorders experienced.)*		
a. Heart disease or disorder of the heart, murmur, chest pain, rheumatic fever, elevated blood pressure, stroke?	❑	❑
b. Injury, pain or disorder of neck or back? Sciatica? Any disabling injury?	❑	❑
c. Arthritis, gout, bursitis or rheumatism?	❑	❑
d. Dizziness, epilepsy, convulsions, recurrent headaches, glaucoma, cataract, or other disorder of the eyes or ears?	❑	❑
e. Disease or disorder of rectum or anus? Varicose veins, or other vascular disorder?	❑	❑
f. Diabetes? Sugar, albumin, or pus in urine? Thyroid or other glandular disorder?	❑	❑
g. Duodenal or stomach ulcer, or other disorder of stomach, liver, gall bladder? Colitis, diverticulitis, or other disorder of small or large intestine?	❑	❑
h. Prostate disorder? Kidney stone or colic, nephritis, nephrosis, or other kidney disorder? Urinary infection?	❑	❑
i. Menstrual, uterine, or ovarian disorder? Disorder of the breast?	❑	❑
j. Bronchitis, emphysema, pleurisy, difficult breathing, blood spitting, or other disorder of lung or nose?	❑	❑
k. Cancer or other tumor? Deformity or loss of limb? Congenital defect?	❑	❑
l. Mental or emotional problem requiring help of a physician or psychologist?	❑	❑
m. A surgical operation? A surgical operation advised but not performed?	❑	❑
2. Other than stated under questions 1a-m, have you ever had treatment by, or consultation with, any hospital, institution, physician, or practitioner within the past 5 years?	❑	❑

PLEASE CONTINUE THIS APPLICATION ON THE REVERSE SIDE.

If you answered "Yes" to any question 1a-m or 2, please explain fully in the chart below. Should you require additional space, please use a separate piece of paper, sign and date, and attach it to this form.

Question #1	Proposed Insured	Condition	Date Occurred	Duration	Degree of Recovery	Names & Addresses of Hospitals, Physicians, or Clinics Consulted
			/ /			
Question #2	Proposed Insured	Condition	Date Occurred	Duration	Degree of Recovery	Names & Addresses of Hospitals, Physicians, or Clinics Consulted
			/ /			

Do you have any oher Disability Insurance in force or application pending--including group coverage? (Give full details.): ❑ Yes ❑ No

Proposed Insured	Insuring Company	Amount of Monthly Indemnity	How Long are Benefits Payable ACCIDENT	SICKNESS

Are you replacing any current disability coverage (including ABE coverage) you have? .... ❑ Yes ❑ No

If yes, please indicate which insurance: ____

DECLARATION OF MEMBER GIVING STATEMENT OF INSURABILITY

1.To the best of my knowledge and belief, all statements made on this application are true and complete. 2. 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 while there is no change in the insurability or health of such person from that stated in the application.

AUTHORIZATION

1. I hereby authorize any licensed physician, medical practitioner, hospital, clinic, or other medical or medically related facility, insurance company, the Medical Information Bureau, or other organization, institution or person that has any records or knowledge of me or my health, to give to United States Life or its reinsurers any such information. Such information will pertain to my employment, or other insurance carrier or medical care, advice, treatment or supplies for any physical or mental condition. This includes that 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 Medical Information Bureau, to give such records or knowledge to any agency employed by United States Life to collect and transmit such information.
2. I understand that this information will be used by United States Life solely to determine eligibility for insurance.
3. I understand that I may revoke this authorization at any time. I agree that such revocation will not affect any action which United States Life has taken in reliance upon this authorization. I understand this authorization will not be valid after 24 months from the effective date of coverage, if not revoked earlier.
4. I know that I should retain a copy of this authorization for my records.
5. I agree that a photocopy of this authorization is as valid as the original.
6. I understand and agree that the indemnity for the Disability insurance herein applied for, together with the indemnity for all other disability insurance policies that I have or am applying for does not exceed the lesser of $20,000 or 66 2/3% for benefit amounts up to and including $7,500, or the lesser of $20,000 or 60%, for benefit amounts greater than $7,500, of my basic monthly pay (average of the 12 months earned income after business expenses, immediately preceding the date of the application).

Important Notice: Any person who knowingly and with intent to defraud any insurance company or other person, files or causes to be filed, a claim for payment of a loss, containing any false or incomplete informaiton commits a fraudlent 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 any such 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 ____

G-19025 Group Policy No. G-164,155 Form Number: GTD-MTD 8/12

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.

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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.