UNITED STATES LIFE INSURANCE COMPANY IN THE CITY OF NEW YORK

Home Office: One World Financial Center, 200 Liberty St., New York, NY 10281 (herein called the Company)
Administrative Office: 3600 Route 66 Medical Underwriting 3-L PO Box 1584 Neptune, NJ 07754-1584

GROUP DISABILITY INSURANCE APPLICATION

Send application and check to: **American Bank Endowment 321 North Clark Street 14th Floor, Chicago IL 60654-7648**

SPEC-NY

FORM NUMBER: GTD-MTD

ABA MEMBER #

MEMBER NAME:

STREET ADDRESS:

CITY: STATE: ZIP:

Business Phone:

Home Phone:

Email:

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

1. Indicate the total monthly member benefit desired: $_____
(in $100 increments, not to exceed 66.66% 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) $_____
3. 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
4. Indicate waiting period desired:*
❑ 60 DAY ❑ 90 DAY ❑ 180 DAY

** Please see next page for details on pre-existing conditions and waiting period benefits.*

MEMBER'S EMPLOYER

Name_____

Address _____

NAME AND ADDRESS OF MEMBER'S PHYSICIAN

Name_____

Address _____

PERSONAL DATA

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

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

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

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 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 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. Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) or disorders of the immune system?	❑	❑
o. Alcohol or drug abuse?	❑	❑
2. 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?	❑	❑
3. Are you now taking prescription medication or receiving medical attention?	❑	❑

PLEASE CONTINUE THIS APPLICATION ON THE REVERSE SIDE.

MID-TERM DISABILITY FOR RESIDENTS OF NEW YORK

APPLICATION

OFFICE USE ONLY	
Plan	Effective Date

For "Yes" answers to questions 1-3 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
			/ /			
			/ /			
			/ /			

PRE-EXISTING CONDITIONS AND WAITING PERIOD BENEFITS

The Certificate may contain a provision regarding the benefits paid for "pre-existing conditions" and the applicable limitations. Pre-existing condition means an injury or sickness within 12 months before you were insured for which you:

1. Incurred charges
2. Received medical treatment, consultation, care, or services, including diagnostic measures,
3. Took prescribed drugs or medicines.

There is a *Waiting Period* for benefits. No benefits will be paid until you have been continually insured for 12 months. The pre-existing condition waiting period and the *Waiting Period* are satisfied concurrently from the date of disability.

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 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 is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

A copy of this application will be attached to and made a part of your certificate.

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, on the ABE website, 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.

MIB-19431

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.

FCRA-19432