WEB

GROUP ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE APPLICATION

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

No. G-11461-0

OFFICE USE ONLY
Effective Date

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

ACCIDENTAL DEATH AND DISMEMBERMENT *New*

Are you now a member of the American Bar Association? ❑ Yes ❑ No
(Membership in ABA/ABE is required for participation in the plan.)

MEMBER ID NUMBER :

NAME:

FIRM:

STREET ADDRESS:

CITY: STATE: ZIP:

This is My: ☐ **Business** ☐ **Home** ☐ **Both**

Please complete the following to assist us in contacting you should the need arise in processing your application.

Business: ( ) ______________________
Home: ( ) ______________________
Fax: ( ) ______________________
E-mail:

DATE OF BIRTH:	SEX:
(M) / (D) / (Y)	❑ Male ❑ Female

If selecting coverage for dependents, please supply the following coverage information:

Dependent's Name First, Middle Initial, Last	Age	Date of Birth M	D	Y
Spouse/Domestic Partner				
Child				
Child				
Child				

(Member must be insured in order to insure eligible dependents.) If you need more space to list your dependents, use a separate sheet of paper and attach it to your enrollment form.

PAYMENT OPTIONS (check one):

❑ **OPTION 1:** AUTOMATIC MONTHLY PAYMENT – I (we) hereby authorize the American Bar Endowment, hereinafter called COMPANY, to initiate debit entries to my (our) Checking Account at the depository financial institution specified on the attached voided check, 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 COMPANY has received written notification from me (or either of us) of its termination in such time and in such manner as to afford COMPANY and DEPOSITORY a reasonable opportunity to act on it.

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

INSURANCE REQUESTED

Refer to the brochure for eligibility, principal sum options, and coverage description. Spouse coverage amount may not exceed the member's.
I hereby apply for:

MEMBER INSURANCE AMOUNT: ❑ $500,000 ❑ $400,000 ❑ $300,000 ❑ $250,000 ❑ $100,000

SPOUSE/DOMESTIC PARTNER INSURANCE AMOUNT: ❑ $500,000 ❑ $400,000 ❑ $300,000 ❑ $250,000 ❑ $100,000

CHILD(REN) INSURANCE AMOUNT: ❑ $50,000 ❑ $25,000

Do you or your spouse, if proposed for insurance, intend to reside outside of the U.S. or Canada in the next 12 months?

Member: ❑ Yes Country__________ For how long?_____ ❑ No **Spouse**: ❑ Yes Country__________ For how long?_____ ❑ No

BENEFICIARY DESIGNATION

I hereby make the following beneficiary designation with respect to all insurance under this Plan, and if I am already covered under this Plan, I hereby revoke any prior designation. (The beneficiary for dependent coverage shall be the member as provided in the Group Policy unless I stipulate otherwise on a separate New York Life form.)

Beneficiary
Name____

Relationship to Member______________________ Social Security #______________________

Street Address______________________ City____________ State________ Zip Code________

PLEASE READ ADDITIONAL INFORMATION, AND SIGN, ON REVERSE SIDE OF THIS REQUEST FORM.

MEMBER DECLARATION

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 insurance will be effective on the first of the month following the date approved by New York Life, provided my initial contribution has been paid and the person(s) to be insured are not hospital confined on that date. Any person who is hospital confined on the date insurance would otherwise become effective will not become insured until the first of the month following release from the hospital, provided the person is still eligible.

If the Company declares a dividend 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 such dividend is claimed by the member in accordance with the procedures outlined below, in the Plan's 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 insurance dividends with the Endowment.

MEMBER'S SIGNATURE____DATE ________/__________/_________

OWNER'S SIGNATURE____DATE ________/__________/_________
(Necessary only if the member previously transferred ownership of his/her insurance under the group policy)

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. ***Please 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 31st day of July for the Accidental Death and Dismemberment Plan, 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, or email to dividends@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**

If you have any questions, call us toll-free at 1-800-621-8981, or e-mail us at information@abendowment.org.
Visit us on the web at www.abendowment.org for plan information, personalized rate quotes, to download an application, and for information on our charitable programs, including our ABE Charitable Gift Fund (Donor Advised Fund).

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