GROUP HOSPITAL MONEY PLAN INSURANCE ENROLLMENT FORM

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

For ABA Members, Spouses/Domestic Partners, and Children

Request for Group Insurance from:
New York Life Insurance Company, 51 Madison Avenue, New York, NY 10010
Please complete this form and return it with your check made payable to
American Bar Endowment (ABE) • 321 N. Clark Street • Chicago, IL • 60654-7648
Residents of Puerto Rico: Mail your application and premium payment to
Global Insurance Agency, Inc., P.O. Box 9023918, San Juan, PR 00902-3918.
Please print in ink or type. Do not use correction fluid or gel pens. Initial and date any changes.

NEW YORK LIFE

Group Policy No. G-11459-0

OFFICE USE ONLY
Effective Date

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MEMBER INFORMATION

ABA ID # _____

_____
Member First Name Middle Initial Last Name

_____
Home Address City State Zip

_____
Business Address City State Zip

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

Home Phone ( ) _____
Work Phone ( ) _____
Cell Phone ( ) _____
E-mail Address _____
Spouse/Domestic Partner Phone ( ) _____

Sex: ❑ M ❑ F **Date of Birth:** ____/____/_____

ARE YOU NOW AN ABA MEMBER?: ❑ **YES** ❑ **NO**
(Membership in ABA is required for participation in this plan.)

Marital Status: ❑ Married ❑ Domestic Partner (DP) ❑ Civil Union* ❑ Divorced ❑ Single

** Eligibility of Civil Unions is determined by state law.*

INSURANCE REQUESTED

Refer to the brochure for eligibility, options, and coverage description.
MN residents must be insured under a qualified major medical plan in order to request coverage.
Spouse/DP coverage amount may not exceed the member's; child(ren) cannot be insured for more than 50% of the spouse's benefit.

I hereby apply for the following insurance coverage:

MEMBER INSURANCE AMOUNT:	❑ $500/Day Benefit	❑ $400/Day Benefit	❑ $300/Day Benefit
SPOUSE/DP INSURANCE AMOUNT:	❑ $500/Day Benefit	❑ $400/Day Benefit	❑ $300/Day Benefit
CHILD(REN) INSURANCE AMOUNT:	❑ $250/Day Benefit	❑ $200/Day Benefit	❑ $150/Day Benefit

I also request, for all proposed insureds, the optional **Surgical Benefit** for the option indicated here: ❑ $2,000 ❑ $1,000

Benefits provided depend upon the plan selected and the premium will vary with the amount of benefits.

Please complete if you are requesting dependent coverage. List eligible dependents you wish to insure. If you need more space, list them on a separate sheet and include when mailing your Enrollment Form. MEMBER MUST BE INSURED TO INSURE DEPENDENTS.

RELATIONSHIP	**NAME** First, Middle Initial, Last	**BIRTH DATE**
Spouse/DP		
Child		
Child		
Child		

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/DP: ❑ Yes Country_____ For how long?_____ ❑ No

PAYMENT OPTION SELECTION

❑ **OPTION 1:** AUTOMATIC MONTHLY PAYMENT – I hereby authorize the ABE to initiate debit entries to my checking account at the depository financial institution specified on the attached voided check, and to debit the same to such account. I acknowledge that the origination of ACH transactions to my account must comply with the provisions of U.S. law. This authorization is to remain in full force and effect until the ABE has received written notification from me of its termination in such time and in such manner as to afford the ABE and depository financial institution a reasonable opportunity to act on it.

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

Be Sure to Complete and Sign Page 2

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PREEXISTING CONDITIONS CLAUSE

I understand and it is agreed that if any person for whom insurance is being requested has received medical treatment or advice, or has taken prescribed drugs or medicine, for an accidental bodily injury or diagnosed sickness during the 12-month period before that person was insured under the policy, no benefits will be payable for that injury, sickness, or related condition until the earlier of: (a) the day after a 12 consecutive-month period has elapsed from the time that person was insured and during which no medical treatment or advice or drugs were received for that injury, sickness, or related condition; or (b) the day after a 24-consecutive month period has elapsed from the time that person was insured. Payment will be made only for losses sustained after such 12-month or 24-month period and will be in accordance with the provisions of the policy.

SIGNATURE

By signing and dating this application, the member **requests** the insurance indicated; and the member **attests** to having read the Fraud Notices indicated on the following page, and that to the best of his/her knowledge and belief, the answers provided to the questions are true and complete.

I further understand and agree that any dividends payable on the group policy will be paid to the American Bar Endowment (ABE) to support its charitable work in the field of law unless such dividends are claimed by me pursuant to the procedures described in the plan brochures, on the back of ABE premium notices, on the ABE website and in each November issue of the *ABA Journal.* (Notice of the approximate percentage of premium available (if any) for contribution or refund will be published in that issue.)

Member's Signature X _____ Date _____
(Please sign and date in ink.)

Spouse/DP's Signature X _____ Date _____
(Necessary only if spouse/DP coverage is requested.)

DIVIDEND NOTICE

DIVIDEND NOTICE **Please note:** Members who wish to contribute dividends 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 dividends 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, or 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 leave any dividends with ABE 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**

FRAUD NOTICE

FRAUD NOTICES ***For Residents of all states except those listed below:*** 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 CA, 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. The falsity of any statement in the application for any policy shall not bar the right to recovery under the policy unless such false statement was made with actual intent to deceive or unless it materially affected either the acceptance of the risk or the hazard assumed by the insurer.

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 NY: Any person who knowingly and with intent to defraud any insurance company or any 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 civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

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 PUERTO RICO: Any person who, knowingly and with the intent to defraud, presents false information in an insurance request form, or who presents, helps or has presented a fraudulent claim for the payment of a loss or other benefit, or presents more than one claim for the same damage or loss, will incur a felony, and upon conviction will be penalized for each violation with a fine no less than five thousand (5,000) dollars nor more than ten thousand (10,000) dollars, or imprisonment for a fixed term of three (3) years, or both penalties. If aggravated circumstances prevail, the fixed established imprisonment may be increased to a maximum of five (5) years; if attenuating circumstances prevail, it may be reduced to a minimum of two (2) years.

RESIDENTS OF TN/WA: 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.

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If you have any questions, call us toll-free at 800-621-8981 or our toll-free Solo/Small Firm Help Line at 877-621-7676.
Or email us at information@abendowment.org.
Visit us online at www.abendowment.org for plan information or a personalized rate quote.