GROUP 10-YEAR LEVEL TERM LIFE INSURANCE APPLICATION

SPEC-N

For ABA Members, Spouses/Domestic Partners, and Children

OFFICE USE ONLY
EFFECTIVE DATE

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

Please complete this form and return it to:
American Bar Endowment
321 N. Clark St. Ste 1400
Chicago, IL 60654-7654

MEMBER INFORMATION Please print in ink or type in answers. Do not use correction fluid or gel pens. Initial and date any changes.

ABA MEMBER ID#	NAME

ADDRESS	Please indicate whether address to the left is: ☐ Home ☐ Office	
	BUSINESS PHONE	HOME PHONE
CITY, STATE ZIP	EMAIL	

DATE OF BIRTH	HEIGHT	WEIGHT	GENDER	SOCIAL SECURITY NO.
	_______ft _______in	________lbs	☐ Male ☐ Female	

MARITAL STATUS ☐ Married ☐ Single ☐ Civil Union* ☐ Domestic Partner (DP) *Eligibility of Civil Unions is determined by state.

Are you currently a member of the ABA? ☐ **Yes** ☐ **No** (ABA membership is required for participation in this plan.)

Do you or your spouse/DP (if proposed for insurance) intend to reside outside of the U.S. in the next 12 months?

Member: ☐ Yes, Country ____________________ Length of Stay __________ ☐ No

Spouse/DP: ☐ Yes, Country ____________________ Length of Stay __________ ☐ No

SPOUSE INFORMATION (If applying for spousal coverage)

FIRST NAME	INITIAL	LAST NAME	MAIDEN NAME (if applicable)

DATE OF BIRTH	HEIGHT	WEIGHT	GENDER	SOCIAL SECURITY NO.
	_______ft _______in	________lbs	☐ Male ☐ Female	

BUSINESS PHONE	HOME PHONE	EMAIL

CHILD INFORMATION (If applying for child coverage)*

FIRST NAME	INITIAL	LAST NAME

DATE OF BIRTH	HEIGHT	WEIGHT	GENDER	SOCIAL SECURITY NO.
	_______ft _______in	________lbs	☐ Male ☐ Female	

* See product information for definition of eligible dependents. If more than one child is proposed for insurance, attach a separate sheet. Please sign and date the additional sheet.

PAYMENT OPTION SELECTION — Save time and postage by selecting our auto-pay option.

☐ **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

YOU MAY BE CONTACTED BY A SERVICE PROVIDER ON BEHALF OF NEW YORK LIFE TO ASK YOU ABOUT YOUR MEDICAL HISTORY

Best place to contact you: ☐ **Residence** ☐ **Business** **Contact Number:** ______________________________

(Attach a seperate contact sheet with contact information for your spouse, if applicable.)

LIFE INSURANCE REQUESTED — INSURANCE STATUS

Are you presently insured under any ABE Group Life Plans (Term Life; 10-Year Level Term Life; 20-Year Level Term Life)? ☐ Yes ☐ No

If yes, provide details (person insured, plan, and amount of insurance):

PERSON INSURED	PLAN	AMOUNT OF INSURANCE

A. I hereby apply for the following group 10-Year Level Term Life COVERAGES:

Refer to the enclosed brochure for eligibility, options, and coverage description.

Notes: The maximum available under all ABE Group Term Life policies underwritten by New York Life Insurance Company for any individual is $2,000,000 whether coverage is in one or divided among several group policies. Member and spouse/DP benefit amounts available from $100,000 - $2,000,000 in $10,000 increments. Spouse/DP coverage cannot exceed 100% of member's coverage. Child coverage is limited to $25,000 maximum in $5,000 increments, under only one group policy and under only one member certificate.

☐ **10-Year Level Term Life Insurance – G-29104-0 (10LTL)** *(available to members and spouse/DPs under 65)*

MEMBER

Benefit Amount: $____________________

($100,000 - $2,000,000 in $10,000 increments)

☐ Waiver of Premium Benefit

(available to members under age 55)

SPOUSE/DP

Benefit Amount: $____________________

($100,000 - $2,000,000 in $10,000 increments)

☐ Waiver of Premium Benefit

(available to spouse/DPs under age 55)

CHILD

Benefit Amount: $____________________

($5,000 - $25,000 in $5,000 increments)

B. Do you have other life insurance in force?
If "Yes," total amount in all companies:

Member: ☐ Yes ☐ No
Member: $____________________

Spouse/DP: ☐ Yes ☐ No
Spouse/DP: $____________________

Do you have other insurance applications pending?
If "Yes," indicate amount and company:

Member: ☐ Yes ☐ No
Member: $____________________
Member Company: ____________________

Spouse/DP: ☐ Yes ☐ No
Spouse/DP: $____________________
Spouse/DP Company: ____________________

C. INSURANCE REPLACEMENT

RESIDENTS OF NEW YORK–IMPORTANT REPLACEMENT INFORMATION

It may not be in your best interest to replace existing life insurance policies or annuity contracts in connection with the purchase of a new life insurance policy, whether issued by the same or a different insurance company. A replacement will occur if, as part of your purchase of a new life insurance policy, existing coverage has been, or is likely to be, lapsed, surrendered, forfeited, assigned, terminated, changed or modified into paid-up insurance or other forms of benefits, loaned against or withdrawn from, reduced in value by use of cash values or other policy values, changed in the length of time or in the amount of insurance that would continue or continued with a stoppage or reduction in the amount of premium paid. Prior to completing a replacement transaction, you may want to contact the insurance company or agent who sold you the life insurance or annuity contract that will be replaced, to help you decide whether the replacement is in your best interest.

Residents of New York: I have read the Important Replacement Information above. Is the Life Insurance applied for intended to replace, in whole or in part, any existing insurance or annuity? Member: ☐ Yes ☐ No Spouse/DP: ☐ Yes ☐ No

Residents of All Other States: Is the Life Insurance applied for intended to replace, discontinue or change an existing insurance policy?
Member: ☐ Yes ☐ No Spouse/DP: ☐ Yes ☐ No

LIFE INSURANCE BENEFICIARY DESIGNATION

The following beneficiary designation(s) is made for all member and spouse/DP coverage under any Group 10-Year Level Term Life Insurance certificate(s) that results from this application. The member is automatically the beneficiary for any dependent child coverage, unless initial ownership is by someone other than the member, as provided in the Group Policy. If naming more than one beneficiary, note if each is to be primary or secondary, and the percentage of death proceeds to be distributed to each. If naming a trust as a beneficiary, please indicate the full name and date of the trust. (Attach a separate sheet if necessary, then sign and date it.)

	G-29104-0 - Succession - Percent
Member Beneficiary - Full Name & Address, Relationship, Social Security Number	10LTL - 1st - %
	10LTL - 2nd - %
Spouse/DP Beneficiary - Full Name & Address, Relationship, Social Security Number	10LTL - 1st - %
	10LTL - 2nd - %

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AUTHORIZATION AND SIGNATURE

I understand that New York Life Insurance Company has the right to require additional information and, if necessary, an examination by a physician. I ask New York Life to rely on all such statements made on this form, and any supplements to it, while considering this request. I also understand that the coverage afforded will be in consideration of the answers and statements set forth above.

AUTHORIZATION: I hereby authorize any licensed physician, medical practitioner, hospital, pharmacy, clinic or other medical or medically related facility, laboratory, insurance company, MIB, Inc. ("MIB"), or other organization, institution or person, that has any records or knowledge of me or my health to release information, including prescription drug records, maintained by physicians, pharmacy benefit managers, and other sources of information to New York Life Insurance Company, its reinsurers, its subsidiaries or ABE about the physical and mental health of any persons proposed for insurance, including significant history, findings, diagnosis and treatment, but excluding psychotherapy notes for the purpose of evaluating my application for insurance. Health information obtained will not be re-disclosed without my authorization unless permitted by law, in which case it may not be protected under federal privacy rules. For example, New York Life may be required to provide it to insurance, regulatory, or other government agencies. In this case, the information may no longer be protected by the rules governing your AUTHORIZATION.

A photocopy of this AUTHORIZATION and request form shall be as valid as the original. In all circumstances, my authorized agent, representative, or I may request a copy of this AUTHORIZATION. This AUTHORIZATION shall be valid for a period of 24 months from the date signed, unless sooner revoked. The AUTHORIZATION may be revoked at any time by sending written notice to New York Life Insurance Company. My revocation will not be effective to the extent that New York Life or any other person already has disclosed or collected information or taken other action in reliance on it, or to the extent that New York Life has a legal right to contest a claim under an insurance certificate or the certificate itself.

By signing and dating this application, I **request** the insurance indicated; and I and any person proposed for insurance **consent** to authorize the disclosure of information to and from the providers noted above and in the IMPORTANT NOTICE, including making a brief report of my/our protected health information to MIB, Inc.; and attest to having read the IMPORTANT NOTICE and Fraud Notice in the enclosed rate chart, including how my/our information is exchanged with MIB, and that to the best of my/our knowledge and belief, the answers provided to the questions are true and complete.

I (or the certificate owner, if different) 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.)

Owner information – Required if owner is other than member. (If owner is a trust, please submit a copy of the trust document with this application.)

Full Name: ____________________
Last First Middle Initial Relationship to Proposed Insured Daytime Phone

Mailing Address: ____________________
Street City State Zip Code

Date of Birth: __________ Tax ID# __________ Social Security Number __________

Owner's Signature **X** ____________________ Date: __________
(Necessary only if other than member.)

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 May 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 email 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 available dividends to 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**