

THREE STEPS TO APPLY



The following steps are involved in underwriting your application for term life insurance. Please understand that this process is similar to that required by all insurance companies that underwrite life coverage, and that, in cooperation with you, the ABE will do all it can to help make the process go smoothly.

1. Sign and date this completed application and return to ABE, 321 N. Clark St., Chicago, IL 60654-4714, in the postage-paid envelope provided. We will forward it to the insurance company for underwriting.
2. A paramedical exam (including detailed medical history along with blood and urine sample) will be required. You will be asked to verify the medical history by signing a supplement to this application. A paramedical service will contact you to arrange an appointment at your convenience. There is no cost to you for this exam and it can be done in the privacy of your home or office. All results go to the insurance company. You have the right to receive the results of your medical report.
3. No premium payment is needed now. If approved for coverage, you will be billed at the premium contribution level determined by medical underwriting of your application. We will notify you of your effective date and premium contribution level with your billing notice.



Effective Date

GROUP 20-YEAR LEVEL TERM LIFE INSURANCE APPLICATION

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

MEMBER INFORMATION

MEMBER ID NUMBER: _____
 NAME (First, Middle Initial, Last) _____
 FIRM _____
 STREET 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 (_____) _____
 Email Address _____
 Spouse/Domestic Partner Phone (_____) _____

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

Best place and time to contact you
 (Choose one of each):

PLACE		DAY		TIME OF DAY	
<input type="checkbox"/> Residence	<input type="checkbox"/> Business	<input type="checkbox"/> Weekdays	<input type="checkbox"/> Weekends	<input type="checkbox"/> Morning (7:00-12:00)	<input type="checkbox"/> Afternoon (12:00-5:00)
<input type="checkbox"/> Business		<input type="checkbox"/> Weekends		<input type="checkbox"/> Evening (5:00-8:00)	<input type="checkbox"/> Night (8:00-11:00)

(Attach a separate sheet with contact information for your spouse/DP, if applicable.)

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

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

*Eligibility of Civil Unions is determined by state law.

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

Proposed for Insurance	(Full name: First, Last, Middle Initial, SSN)	Date of Birth (MM/DD/YYYY)	Height	Weight	Sex
Member:			ft. in.	lbs.	<input type="checkbox"/> M <input type="checkbox"/> F
Spouse/DP*:			ft. in.	lbs.	<input type="checkbox"/> M <input type="checkbox"/> F
Child(ren)*:			ft. in.	lbs.	<input type="checkbox"/> M <input type="checkbox"/> F

* Member must be insured to insure spouse/DP or children. 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.

MEMBERSHIP AFFILIATION

Are you now an ABA member? (Membership in the ABA is required for participation in the plan.) Yes No

PAYMENT OPTION SELECTION — Please select one of the following

- 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

INSURANCE REQUESTED — INSURANCE STATUS

Refer to the back of the letter for eligibility, options and coverage description.

I HEREBY APPLY FOR THE FOLLOWING GROUP 20-YEAR LEVEL TERM LIFE COVERAGE:

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. **Amounts available range from \$100,000 to \$2,000,000 in \$10,000 increments.**

A. **20-Year Level Term Life Insurance – G-29168-0 (20YLTL)** (available to members under 65) under the certificate resulting from this application

Member Amount: \$2,000,000 \$1,500,000 \$1,000,000 \$750,000 \$500,000 Other: \$ _____ (Must be in \$10,000 increments.)
Spouse/DP Amount: \$2,000,000 \$1,500,000 \$1,000,000 \$750,000 \$500,000 Other: \$ _____ (Must be in \$10,000 increments.)
 (Spouse/DP coverage cannot exceed 100% of member's coverage.)

I hereby apply for \$5,000 Term Life Insurance on my Dependent Child(ren) under G-29168-0, as applicable.

Child coverage is limited to \$5,000 maximum, under only one group policy and under only one member certificate.

B. Do you have other life insurance in force? Member: Yes No Spouse/DP: Yes No
 If "yes," total amount in all companies: Member: \$ _____ Spouse/DP: \$ _____
 Do you have other insurance applications pending? Member: Yes No Spouse/DP: Yes No
 If "yes," indicate amount and company: Member: \$ _____ Spouse/DP: \$ _____
 Member Company: _____ Spouse/DP Company: _____

C. I hereby apply for the Waiver of Premium (WOP) feature (available to members and spouses/DPs under 55).

Member: Yes No Spouse/DP: Yes No

D. 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 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

BENEFICIARY DESIGNATION

The following beneficiary designation(s) is made for all member and spouse/DP coverage under any Group 20-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-29168-0	-	Succession	-	Percent
Member Beneficiary - Full Name & Address, Relationship, Social Security Number	20LTL	-	1st	-	%
	20LTL	-	2nd	-	%
Spouse/DP Beneficiary - Full Name & Address, Relationship, Social Security Number	20LTL	-	1st	-	%
	20LTL	-	2nd	-	%

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, the member **requests** the insurance indicated; and the member 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 brochure, 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 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

Tax ID# _____
Date of Birth: _____ 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 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

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.

RESIDENTS OF AL/AR/LA/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 MD: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

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 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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