GROUP 10-YEAR LEVEL TERM LIFE INSURANCE APPLICATION

SPEC-N

For Bar Association Members[1], Spouses/Domestic Partners, and Children

OFFICE USE ONLY
EFFECTIVE DATE
AGENT CODE

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

AMERICAN BAR ENDOWMENT
More than 80 years of service

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

For Puerto Rico residents, please mail to:
Global Insurance Agency, Inc.
P.O. Box 9023918
San Juan, PR 00902-3918

QUESTIONS?
CALL 800-621-8981
8:15am to 4:30pm, CST
Monday-Friday

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

NAME	EMAIL
ADDRESS	This is my: ☐ Home ☐ Office
BUSINESS PHONE	HOME PHONE	MOBILE PHONE
DATE OF BIRTH	HEIGHT _____ft _____in	WEIGHT _____lbs	GENDER ☐ Male ☐ Female	SOCIAL SECURITY NO.

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

BAR ASSOCIATION MEMBERSHIPS (list in order state, local, specialty bars)

Are you currently an active member of a state, local, or specialty bar association ☐ **Yes** ☐ **No**

Do you or your Spouse/DP (if proposed for coverage) intend to reside outside the U.S. or Canada in the next 12 months?
Member: ☐ **No** ☐ **Yes** Country_____ Duration_____ Spouse/DP: ☐ **No** ☐ **Yes** Country_____ Duration_____

SPOUSE/DP INFORMATION (If applying for Spouse/DP coverage)

FIRST NAME	INITIAL	LAST NAME	MAIDEN NAME (if applicable)
DATE OF BIRTH	HEIGHT _____ft _____in	WEIGHT _____lbs	GENDER ☐ Male ☐ Female	SOCIAL SECURITY NO.
BUSINESS PHONE	HOME PHONE	MOBILE PHONE
EMAIL		

CHILD INFORMATION (If applying for child coverage)*

FIRST NAME	INITIAL	LAST NAME
DATE OF BIRTH	HEIGHT _____ft _____in	WEIGHT _____lbs	GENDER ☐ Male ☐ Female	SOCIAL SECURITY NO.

* 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

[1] *The terms "Bar Association Member" and "Member" when used herein mean a practicing lawyer who is a member of the American Bar Association (ABA) or any entity that is represented in the ABA's House of Delegates, including state and many local and specialty bar associations. A list of all such entities is available at https://abendowment.org/resources.*

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

Please indicate the best contact number for a Service Provider to contact you and/or your Spouse/DP on behalf of New York Life Insurance Company for Medical History. (Please provide a contact number for each applicant that has the ability to accept voice messages for missed calls.)

Member Contact #_____ ☐ Residence ☐ Business ☐ Mobile

Spouse/DP Contact #_____ ☐ Residence ☐ Business ☐ Mobile

INSURANCE STATUS

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

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

PERSON INSURED	PROGRAM	AMOUNT OF INSURANCE

INSURANCE REQUESTED Please refer to the Brochure for eligibility, principal sum options, and coverage description.

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

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)

Do you have any other life insurance in force? ☐ **No** ☐ **Yes**, total amount in all companies: Member $_____ Spouse/DP $_____

Do you have any other insurance applications pending? ☐ **No** ☐ **Yes**, total amount in all companies: Member $_____ Spouse/DP $_____

Have you or your Spouse/DP (if proposed for insurance) used tobacco or nicotine or any nicotine substitute in any form (including nicotine patches and nicotine chewing gum)?

Member: ☐ **No** ☐ **Yes** Type of product _____ Last used tobacco or nicotine products_____ (mm/dd/yyyy)

Spouse/DP: ☐ **No** ☐ **Yes** Type of product _____ Last used tobacco or nicotine products_____ (mm/dd/yyyy)

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

BENEFICIARY DESIGNATION *If needed, please attach a separate signed and dated sheet to provide additional beneficiary information.*

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 - %

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 in the brochure, including making a brief report of my/our protected health information to MIB, Inc.; and **attest** to having read the IMPORTANT NOTICE and Fraud Notices indicated on page 4 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 below, in the program brochures, on the back of ABE premium notices, on the ABE website and in each December/January 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

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 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 ABE-sponsored 10 Year Level Term Insurance 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 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 _____ _____/_____/_____
SIGNATURE OF MEMBER DATE

BE SURE TO REVIEW PAGE 4

FRAUD NOTICES

FRAUD NOTICES *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 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.

RESIDENTS OF CA: For your protection California law requires the following to appear on this form.
Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

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 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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