

Sign Up for this Convenient Payment Plan Option in Two Easy Steps:*

- 1) Complete and sign this form.
- 2) Mail this form with a payment for one month's premium.

To calculate a one month premium payment, divide a quarterly premium by 3, a semiannual premium by 6, or an annual premium by 12.

**This payment option is only available to members who have checking or savings accounts at U.S. banks and is not available to residents of Ontario or Quebec, Canada.*

What's Next?

The first automatic deduction will be made for the next month's premium due. Thereafter, we will automatically deduct your payment from your checking or savings account on the first business day of each month. Please note, if the first of the month falls on a weekend or holiday, your account will be debited the next business day. If the amount of your monthly payment is changed for any reason, you will be notified in writing. All changes (closing your account, changing banks, termination of automatic deduction) in the ABE Automatic Payment Plan must be submitted to our office in writing.

1 Please complete the following:

Your Name	Certificate Holder ID
Business Phone	Cell Number
E-mail	Fax Phone
Account Type <input type="radio"/> Checking <input type="radio"/> Savings <i>For your convenience, you may attach a voided check.</i>	
Bank Name	Bank State
Account Number <small>(Be sure to include all spaces and/or dashes.)</small>	Routing Number

2 I would like to participate in the ABE Automatic Payment Plan for the following Group Insurance coverages:

- | | | |
|-------------------------------------------------------------|-------------------------------------------------------------|-------------------------------------------------------------------|
| <input type="checkbox"/> Term Life | <input type="checkbox"/> Disability Income | <input type="checkbox"/> Excess Major Medical |
| <input type="checkbox"/> Hospital Money | <input type="checkbox"/> Accidental Death and Dismemberment | <input type="checkbox"/> Professional Overhead Expense Disability |
| <input type="checkbox"/> Retirement Contribution Disability | <input type="checkbox"/> Critical Illness | |

3 Please read the following, then sign and date below to authorize this automatic payment:

I authorize the American Bar Endowment, hereinafter called "ABE," to initiate debit entries to my checking or savings account for the monthly premium due for my above indicated ABE Insurance coverage(s). I authorize the financial institution above, hereinafter called "Institution," to credit the amount of such entries to my account, to correct any errors, and to deposit any such corrections to my account.

This authority is to remain in full force and effect until I revoke the agreement in writing as hereafter provided. Any revocation is effective only after ABE, has received written notification from me to terminate this agreement in such time and manner as to afford a reasonable opportunity to act upon the notice. I have the right to stop payment of a debit by notification to Institution, in such time and manner as to afford a reasonable opportunity to act prior to charging the account.

I have completed the bank information for the checking or savings account from which I want these future deductions made for the programs indicated and enclosed payment for my first monthly premium contribution. I understand that by signing up for the ABE Automatic Payment Plan, I will no longer receive a notice of premium due for my insurance premium contribution, and that this process will continue until I notify you in writing to terminate the deductions.

X Member Signature

Today's Date / /

IMPORTANT NOTICE: Please mail this completed enrollment form with the first monthly premium to

Attention: ABE Automatic Payment Plan Enrollment Department
 American Bar Endowment • 321 North Clark Street • Chicago, IL 60654-7648
800-621-8981 • www.abendowment.org