GROUP HOSPITAL MONEY INSURANCE APPLICATION

SPEC-N

For ABA Members, 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 75 years of service

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

ABA MEMBER ID#	NAME	
ADDRESS		This is my: ☐ Home ☐ Office
BUSINESS PHONE	HOME PHONE	MOBILE PHONE
EMAIL		FAX

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 Law

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

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 spousal/DP 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	MOBILE 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

INSURANCE REQUESTED

THIS IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. LACK OF MAJOR MEDICAL COVERAGE (OR OTHER MINIMUM ESSENTIAL COVERGE) MAY RESULT IN AN ADDITIONAL PAYMENT WITH YOUR TAXES.

Refer to the brochure for eligibility, options, and coverage description. Spouse/DP and/or child(ren) coverage amount may not exceed 100% of member's benefit. Benefits provided depend upon the insurance selected and the premium will vary with the amount of benefits. MN residents must be insured under a qualified major medical in order to request coverage.

I hereby apply for the following GUARANTEED ACCEPTANCE insurance coverage:

MEMBER DAILY BENEFIT:	SPOUSE/DP DAILY BENEFIT:	CHILD(REN) DAILY BENEFIT:	OPTIONAL SURGICAL BENEFIT: *(for all proposed insureds)*
☐ $500/Day	☐ $500/Day	☐ $500/Day	☐ $2,000
☐ $400/Day	☐ $400/Day	☐ $400/Day	☐ $1,000
☐ $300/Day	☐ $300/Day	☐ $300/Day	
☐ $200/Day	☐ $200/Day	☐ $200/Day	

AUTHORIZATION AND SIGNATURE

By signing and dating this application, the member **requests** the insurance indicated (subject to the pre-existing condition clause); and the member **attests** to having read the Fraud Notice 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 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.)

I HEREBY ATTEST THAT I AM PURCHASING THIS POLICY AS A SUPPLEMENT TO MY HEALTH COVERAGE, WHICH MEETS THE FEDERAL REQUIREMENTS OF MINIMUM ESSENTIAL COVERAGE.

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 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 Hospital Money 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

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.

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: 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.

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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