

For ABA Members and Spouses/Domestic Partners



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

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

OFFICE USE ONLY	
EFFECTIVE DATE	
AGENT CODE	

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			Please indicate whether address to the left is: <input type="checkbox"/> Home <input type="checkbox"/> Office		
			BUSINESS PHONE		HOME PHONE
EMAIL					MOBILE PHONE
DATE OF BIRTH	HEIGHT _____ft _____in	WEIGHT _____lbs	GENDER <input type="checkbox"/> Male <input type="checkbox"/> Female	SOCIAL SECURITY NO.	

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 plan.)

Do you or your spouse/DP (if proposed for insurance) 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		LAST NAME		INITIAL	MAIDEN NAME (if applicable)
DATE OF BIRTH	HEIGHT _____ft _____in	WEIGHT _____lbs	GENDER <input type="checkbox"/> Male <input type="checkbox"/> Female	SOCIAL SECURITY NO.	
MOBILE PHONE			EMAIL		

OCCUPATION STATUS (Spouse/DP section required if applying for spouse/DP coverage.)

MEMBER	EMPLOYER NAME & ADDRESS	Are you now, and have you been for the last 90 days, actively at work on a regular work schedule? <input type="checkbox"/> Yes <input type="checkbox"/> No
	TOTAL GROSS ANNUAL INCOME: \$	TOTAL ANNUAL NET EARNED INCOME (must be at least \$20,000) \$
SPOUSE/DP	EMPLOYER NAME & ADDRESS	Are you now, and have you been for the last 90 days, actively at work on a regular work schedule for at least 30 hours per week? <input type="checkbox"/> Yes <input type="checkbox"/> No
	TOTAL GROSS ANNUAL INCOME: \$	TOTAL ANNUAL NET EARNED INCOME (must be at least \$20,000) \$

Is your ANNUAL NET EARNED INCOME more than 25% above or below your previous year? MEMBER: Yes No SPOUSE/DP: Yes No
If yes, what was ANNUAL NET EARNED INCOME last year? MEMBER: \$ _____ SPOUSE/DP: \$ _____
If yes, what do you anticipate your ANNUAL NET EARNED INCOME will be next year? MEMBER: \$ _____ SPOUSE/DP: \$ _____

INSURANCE STATUS

Do you have any other disability insurance in force or application pending (including group coverage)?..... MEMBER: Yes No SPOUSE/DP: Yes No
(If "Yes", please indicate companies, benefit amount, and benefit period.) _____

Will this coverage applied for replace any insurance now in force?..... Yes No Yes No
(If "Yes", please indicate companies, benefit amount, and benefit period.) _____

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 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 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 NOTICES

FRAUD NOTICE – 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 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.

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 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 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.

7.13 ed.