# ABE-SPONSORED MID-TERM DISABILITY INSURANCE APPLICATION

SPEC-N

For ABA Members and Spouses/Domestic Partners

| 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 | Please indicate whether address to the left is: ❑ Home ❑ Office | |
| | BUSINESS PHONE | HOME PHONE |
| EMAIL | | MOBILE PHONE |

| 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 Union 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 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 | WEIGHT | GENDER | SOCIAL SECURITY NO. |
|---|---|---|---|---|
| | _____ft _____in | _____lbs | ☐ Male ☐ Female | |

| 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? ❑ Yes ❑ 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? ❑ Yes ❑ 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

| | MEMBER: | SPOUSE/DP: |
|---|---|---|
| Do you have any other disability insurance in force or application pending (including group coverage)? | ❑ Yes ❑ No | ❑ 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.)_____ | | |

## INSURANCE REQUESTED — Please refer to brochure for eligibility, options and coverage descriptions.

**I hereby apply for the coverage indicated below, based upon all my statements in this application.**

**MEMBER**

**Waiting Period**
❑ 14 Days ❑ 30 Days ❑ 60 Days ❑ 90 Days ❑ 180 Days

**Monthly Benefit $**_____
(up to $12,000, in increments of $100, not to exceed 66 2/3% of your monthly income. For benefits greater than $7,500, not to exceed 60% of your monthly income.)

**SPOUSE/DP**

**Waiting Period** ❑ 90 Days ❑ 180 Days

**Monthly Benefit $**_____
(up to $5,000, in increments of $100, not to exceed 9 times the member benefit. Member must be insured to insure spouse/DP. The 66 2/3% and 60% limitations also apply. )

## 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

## 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

## 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 Insurance Company 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 Insurance Company 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 Insurance Company 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 Insurance Company 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 protected health information to MIB, Inc.; and **attest** to having read the IMPORTANT NOTICE and Fraud Notice on Page 3, including how my information is exchanged with MIB, and that to the best of my 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 on page 3, in 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.)*

## 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 Mid-Term Disability 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 NOTICES

**FRAUD NOTICE – For Residents of all states <u>except</u> 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.:** <u>WARNING:</u> 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:** <u>WARNING:</u> 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:** <u>WARNING:</u> 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.

*7.2013 ed.*