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

Applying Is Easy. Here's How:

1. Complete and Sign This Form in Ink.
2. Send No Money Now. You Will Be Billed Once Coverage "is" Approved.
3. Mail Completed Form to:
   SPE Insurance Program
   P.O. Box 9159, Phoenix, AZ 85068-9159

Have a Question or Need Additional Information? Please Call 1-800-337-3140 or E-mail: speinsurance@agia.com.

Group Term Life Insurance Application

For Members of the Society of Petroleum Engineers

PLEASE PRINT IN INK OR TYPE ALL ANSWERS

① Member's Full Name and Information:

Social Security#: ☐☐☐-☐☐-☐☐☐☐

Name _____ (LAST / FIRST / MIDDLE)

Place of Birth _____

Street Address _____

City _____ State (or Province) _____

City _____

Home Phone: (_____) _____ (AREA CODE / NUMBER)

State (or Province) _____ Zip Code _____-_____

Business Phone: (_____) _____ (AREA CODE / NUMBER)

Marital Status: ☐ Married ☐ Divorced ☐ Single ☐ Widowed ☐ Civil Union* or Domestic Partner*

*As applicable only where jurisdictional law so mandates. Call the Administrator for Declaration of Domestic Partnership Form, complete, and return with application. (Not applicable in OR.)

Are you presently insured under any other SPE Life Plans? ☐ Yes ☐ No

If "Yes," indicate which Plan(s) and provide details below (person insured and amount of insurance) ☐ Term Life ☐ First-to-Die Life ☐ 10-Year Level Term Life

Details: _____

		Date of Birth Mo. Day Yr.	Height	Weight Lbs.	Sex
Member:	_____ (Member's Date of Birth Required if Requesting Only Spouse Coverage)	___/___/___	___ ft. ___ in.	_____	☐ M ☐ F
☐ **Spouse*** or ☐ **Domestic Partner***					
	_____ (Name if Proposed for Insurance)	___/___/___	___ ft. ___ in.	_____	☐ M ☐ F
Child(ren)*:	_____ (Name if Proposed for Insurance)	___/___/___	___ ft. ___ in.	_____	☐ M ☐ F
	_____ (Name if Proposed for Insurance)	___/___/___	___ ft. ___ in.	_____	☐ M ☐ F

If more than two children are proposed for insurance, attach a separate sheet. Please sign and date the additional sheet.
*See Plan Information for definition of eligible dependents.

In the next 12 months, does any person proposed for insurance intend to reside outside the U.S. or Canada?

Member ☐ Yes ☐ No Country(ies) _____

Spouse ☐ Yes ☐ No Country(ies) _____

② Membership Affiliation:

Are you now a member of the SPE? ☐ Yes ☐ No What is your membership number, if available? _____

Continued on reverse side.

③ Insurance Requested *Refer to brochure for eligibility, options, and coverage 3 description.*

Term Life Plan

A1. For Members Not Currently Insured:
I request Group Term Life Insurance in the *INITIAL* amount of $ _____ for myself; $ _____ for my spouse/domestic partner*.
I also request coverage for my eligible child(ren). ☐ Yes ☐ No

A2. For Members Currently Insured:
I wish to INCREASE amounts of insurance as follows: from $ _____ to $ _____ for myself.
from $ _____ to $ _____ for my spouse*.

I wish to ADD dependent coverage as follows: for my spouse* in the initial amount of $_____ .
for my child(ren) ☐ Yes ☐ No

*Spouse coverage cannot exceed member's coverage.

B. Tobacco/Nicotine Use: Have you or your spouse (if proposed for coverage) used tobacco or any nicotine substitute in any form (including nicotine patches and nicotine chewing gum)? **Member** ☐ Yes ☐ No **Spouse** ☐ Yes ☐ No
If "Yes," please state when you last used tobacco or nicotine products and specify the product used.

Member: _____ (MM/YYYY) _____ (Product) Spouse: _____ (MM/YYYY) _____ (Product)

C. I Wish to Pay: ☐ **Annually** ☐ **Semiannually** **Enter Premium Contribution:** _____
Please note: A $2.00 administrative fee is added for billing modes other than annual.

D. Insurance Replacement

IMPORTANT REPLACEMENT INFORMATION FOR RESIDENTS OF NEW YORK

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. **Member** ☐ Yes ☐ No **Spouse** ☐ Yes ☐ No
Is the Life Insurance applied for intended to replace, in whole or in part, any existing insurance or annuity?

RESIDENTS OF ALL OTHER STATES: Is the insurance applied for intended to replace, discontinue, or change an existing policy? **Member** ☐ Yes ☐ No **Spouse** ☐ Yes ☐ No

E. Do you have other life insurance applications pending? If "Yes," indicate amount and company:

Member: $ _____ Company _____

Spouse: $ _____ Company _____

④ Beneficiary Designation *Insert name, relationship, and address.*

For the TERM LIFE Plan, I hereby make the following beneficiary designation with respect to all the insurance on my life under this Group Term Life Insurance Plan and, if I am already covered under the Plan, I hereby revoke any prior beneficiary designation. The beneficiary for dependent coverage shall be the insured member as provided in the Group Policy. (If you wish to name a different beneficiary for spouse coverage, contact the Administrator.) 1.) If naming more than one beneficiary, please note if each is to be primary and/or secondary, and also indicate the percentage of death proceeds to be distributed to each. 2.) If naming a trust, please indicate the full name and date of the trust. (Attach a separate sheet if necessary, then sign and date it.)

☐ Primary ☐ Secondary % _____

Beneficiary Name _____

Beneficiary's Relationship to Member _____

Beneficiary's Date of Birth _____

Beneficiary's Social Security # _____

Street Address _____

City _____

State _____ Zip Code _____

Beneficiary's Phone Number _____

☐ Primary ☐ Secondary % _____

Beneficiary Name _____

Beneficiary's Relationship to Member _____

Beneficiary's Date of Birth _____

Beneficiary's Social Security # _____

Street Address _____

City _____

State _____ Zip Code _____

Beneficiary's Phone Number _____

1-800-337-3140
speinsurance@agia.com
www.speinsurance.com

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⑤ Statement of Health: *(Please initial any changes you make to this form)*

To the best of your knowledge and belief, please answer the following questions as they apply to you and all dependents to be insured.

		Yes	No
A.	Are you or any other person to be insured disabled or receiving any disability or workers' compensation benefits or on waiver of premium for life or health insurance?	☐	☐
B.	Are you or any other person to be insured now ill or receiving medical attention or surgical treatment?	☐	☐
C.	During the past five years, has any person to be insured consulted any physician or other medical care practitioner other than for a routine physical examination, or check up, or been hospitalized or had an operation or had any illness, disease or injury?	☐	☐
D.	Are you or any person to be insured taking any kind of medication or, so far as you know, in impaired physical or mental health?	☐	☐
E.	Is any person to be insured now pregnant?	☐	☐
F.	During the past five years, has any person to be insured ever been medically diagnosed by a physician as having been treated for:	☐	☐

		Yes	No
1.	Heart or circulatory trouble, high blood pressure, pain or pressure in chest?	☐	☐
2.	Arthritis, back trouble, bone or joint disorder?	☐	☐
3.	Fainting spells, convulsions, or epilepsy?	☐	☐
4.	Sugar, blood, albumin or pus in urine?	☐	☐
5.	Diabetes, kidney trouble, ulcers or digestive disorder?	☐	☐
6.	Disorder of breasts or reproductive organs or functions?	☐	☐
7.	Nervous or mental disorder, emotional condition or psychiatric care?	☐	☐
8.	Cancer, tumor or cyst?	☐	☐
9.	Varicose veins, hemorrhoids or hernia?	☐	☐
10.	Disorder of eyes, ears, nose or sinuses?	☐	☐
11.	Thyroid, liver or respiratory disorder?	☐	☐
12.	Alcoholism or drug habit?	☐	☐
13.	Disorder of the blood?	☐	☐
14.	Other health or physical impairment including:		
(i).	Being medically diagnosed as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS-related complex (ARC)?	☐	☐
(ii).	Chronic cough, persistent diarrhea, enlarged lymph glands, chronic fatigue, in the past five years?	☐	☐
(iii).	Any other impairment?	☐	☐

IF YOU HAVE ANSWERED ANY QUESTIONS "YES," GIVE COMPLETE DETAILS BELOW:

(If you need more space, use a signed and dated separate sheet. Please avoid the use of such terms as "etc.," "various," or "miscellaneous.")

Question Letter/No.	Name(s) of Proposed Insured	Illness or Condition—Date of Onset—Duration—Treatment—Operations—Degree of Recovery and Date	Name and Address of Physicians or Other Medical Care Practitioners and Hospitals Where Confined or Treated

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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.

FOR 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.

FOR 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.

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 authorize any licensed physician, medical practitioner, hospital, 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 the plan administrator about the physical and mental health of any persons proposed for insurance, including significant history, findings, diagnosis and treatment, but excluding psychotherapy notes.

A photocopy of this AUTHORIZATION and request form shall be as valid as the original. In all circumstances, my authorized agent or representative, or I may request a copy of this AUTHORIZATION. This AUTHORIZATION may be used for a period of 24 months from the date signed, unless sooner revoked as stated in the IMPORTANT NOTICE.

By signing and dating this application, the member requests the insurance indicated; and the member and any person proposed for insurance consent to authorize the disclosure of information to and from the providers noted in the IMPORTANT NOTICE, 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 [above, below, on the reverse of this page, on the attached, enclosed], 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.

Member's Signature X _____ _____
(PLEASE SIGN AND DATE IN INK) DATE

Spouse's Signature X _____ _____
(NECESSARY ONLY IF SPOUSE COVERAGE IS REQUESTED) DATE