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

Group Accidental Death & Dismemberment Enrollment Form

For Members of the Society of Petroleum Engineers

PLEASE PRINT IN INK OR TYPE ALL ANSWERS.

❶ Member's Full Name and Information:

Name _____
LAST FIRST MIDDLE

Street Address _____

City _____

State (or Province) _____ Zip Code _____-_____

Social Security #: ☐☐☐ – ☐☐ – ☐☐☐☐

Place of Birth _____

City _____ State (or Province) _____

Home Phone: (_____) _____

Business Phone: (_____) _____

E-Mail: _____

Member: _____ ____/____/____

☐ **Spouse* or** ☐ **Domestic Partner****

_____ ____/____/____
Name if Proposed for Insurance

Child(ren)*: _____ ____/____/____

_____ ____/____/____

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) _____

❷ Membership Affiliation:

Are you now a member of the SPE? ☐ Yes ☐ No

What is your membership number, if available? _____

❸ Payment Option Selection: *Choose only one.*

Option 1: Direct Billing: ☐ Annual (April 1) ☐ Semi Annual (April 1 and October 1) Enclosed is my check in the amount of _____. (66971)

Option 2: Electronic Funds Transfer: I request and authorize the GeoCare Benefits Insurance Program to make ☐ monthly ☐ quarterly ☐ semi-annual ☐ annual withdrawals against the account specified on the attached voided check, statement savings account deposit slip, or any account subsequently named by me, and such bank to process these withdrawals as if I had signed them, for the purpose of collecting premium contributions due under this Accidental Death and Dismemberment Plan (enclose a VOIDED check or deposit slip, as applicable).

Option 3: Credit Card: I authorize premium contributions to be charged to my credit card:

☐ American Express ☐ Discover ☐ MasterCard ☐ Visa Credit Card # _____ Exp. Date _____

_____

Signature(s) as required on checks/withdrawals issued against this account Date

❹ Insurance Requested: Refer to brochure for eligibility, Principal Sums, premium, and coverage description.

I request insurance in the following amount(s):

Myself (Member)		**Spouse**	**Children**
☐ $ 50,000	☐ $300,000	☐ $50,000	☐ $10,000
☐ $100,000	☐ $350,000	☐ $100,000	(for each child regardless of how many)
☐ $150,000	☐ $400,000	☐ $150,000	
☐ $200,000	☐ $450,000	☐ $200,000	
☐ $250,000	☐ $500,000	☐ $250,000	

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

I make the following beneficiary designation with respect to all the insurance on my life under this Accidental Death & Dismemberment 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 want to name a different beneficiary for spouse coverage, please contact the Administrator.) (1) In naming more than one beneficiary, please note if each is to be primary and/or secondary and 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 _____
LAST FIRST MIDDLE INITIAL

Relationship to Member _____ Beneficiary's Date of Birth _____ Beneficiary's Phone Number _____

☐ Primary ☐ Secondary Beneficiary Name _____
LAST FIRST MIDDLE INITIAL

Relationship to Member _____ Beneficiary's Date of Birth _____ Beneficiary's Phone Number _____

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 statedvalue 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 willbe 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.

By signing and dating this application, I and my spouse/domestic partner (if proposed for insurance), request the insurance indicated, understand the effective date criteria, and attest to having read the Fraud Notices indicated above, and that to the best of my knowledge and belief, the answers to the questions are true and complete.

Member's Signature: X_____ _____
(PLEASE SIGN AND DATE IN INK.) (DATE)

Member's Signature: X_____ _____
(PLEASE SIGN AND DATE IN INK.) (DATE)

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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***

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