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:
   The SPE Insurance Program
   P.O. Box 189, Santa Barbara, CA 93102-0189

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

Group 10-Year Level Term Life Insurance Plan Application

FOR MEMBERS OF THE SOCIETY OF PETROLEUM ENGINEERS

Not for Residents of New York State

Please print in ink or type all answers. Do not use correction fluid or gel pens. Initial and date any changes you make.

① Member's Full Name and Information:

Name ______________________________
LAST FIRST MIDDLE

Street Address ______________________________

City ______________________________

State (or Province) ______________ Zip Code ________-________

Social Security #: ☐☐☐ - ☐☐ - ☐☐☐☐

City ______________ State (or Province) ______________

Home Phone: (________) ______________
AREA CODE NUMBER

Business Phone: (________) ______________
AREA CODE NUMBER

E-mail Address ______________________________

Marital Status: ☐ Married ☐ Divorced ☐ Single ☐ Widowed

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:	______________ 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 if 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 or a cooperating society? ☐ Yes ☐ No

What is your membership number, if available? ______________________

Membership in SPE is required for participating in this plan.

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

A. I Hereby Apply For the Following Group 10-Year Level Term Life Insurance Coverage:

Member ☐ Insurance Requested: $ ______________ I Also Request Coverage For My Eligible Children** ☐ Yes ☐ No

Spouse* ☐ Insurance Requested: $ ______________ *Spouse coverage cannot exceed member's coverage. **Member coverage must be in force to request child coverage.

B. Tobacco/Nicotine Use:

Have you or your spouse (if proposed for insurance) used tobacco or nicotine in any form, including nicotine patches and nicotine gum, within the last 24 months?

Member	**Spouse**
☐ Yes ☐ No	☐ Yes ☐ No

If "Yes," when did such person use tobacco or nicotine products? Member: ____________ Spouse: ____________
Month/Year Month/Year

C. I Wish to Pay: ☐ **Annually** ☐ **Semiannually**

Please note: A $2.00 administrative fee is added for billing modes other than annual.

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Continued next page.

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

D. Insurance Replacement

	Member	Spouse
Is the insurance applied for intended to replace, discontinue or change an existing policy?	☐ Yes ☐ No	☐ Yes ☐ No

Do you have other life insurance in force? If "Yes," total amount in all companies: Member $ ____________ Spouse $ ____________

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

Member: $ ____________ Company ____________________

Spouse: $ ____________ Company ____________________

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

I hereby make the following beneficiary designation with respect to all the insurance on my life under this Group 10-Year Level 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 Social Security # ____________________

Street Address ____________________

City ____________________

State ____________ Zip Code ____________

☐ Primary ☐ Secondary % ____________

Beneficiary Name ____________________

Beneficiary's Relationship to Member ____________________

Beneficiary's Social Security # ____________________

Street Address ____________________

City ____________________

State ____________ Zip Code ____________

⑤ Statement of Health *(Please initial and date 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?	☐	☐

	Yes	No
G. (This question does not apply to residents of Maryland.) Have you or has your spouse had a parent, brother or sister who, prior to age 60, was medically diagnosed by a physician as having, or being treated for, cancer, stroke, paralysis, hypertension, diabetes, heart disease, kidney disease, or neuromuscular or mental illness?	☐	☐
H. Within the past two years have you or has your spouse (if proposed for insurance) participated in, or do either of you within the next two years plan to participate in: aircraft flying other than as a passenger, scuba diving, ultralight flying, ballooning, parachuting, mountaineering, organized motorcycle racing, rodeo riding, snowmobiling, any type of motorized racing, hang-gliding, parasailing or bungee jumping?	☐	☐
I. Driver's License No.: Member ____________ Spouse ____________ State in Which Issued: Member ____________ Spouse ____________ Have you or has your spouse (if proposed for insurance) had driver's license suspended or revoked, or had any moving violations, within the past five years?	☐	☐
J. Except for residents of CT and MN, in the last seven years, have you or your spouse (if proposed for insurance) been convicted of a crime or served time in prison because of a conviction, or have an arrest pending? **For residents of CT and MN only**, in the last seven years have you and/or your spouse (if proposed for insurance) been convicted of a crime or served time in prison because of a conviction or been arrested and convicted for any reason?	☐	☐

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Please be sure to complete and sign the following page.

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

6 Declarations

I request the group insurance shown above. To the best of my knowledge and belief: (a) I am eligible for such insurance: and (b) the statements I have made are true and complete. I understand that New York Life has the right to require additional information and, if necessary, an examination by 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 and that any material misstatements or failures to report information material to the risk may be used as the basis for rescission of my insurance subject to the incontestable period provision of the policy.

I understand that: (a) insurance will become effective on the date approved by New York Life Insurance Company if the initial premium contribution is paid no later than 31 days after the date I am billed and I and any approved dependents are actively performing the normal activities of a person in good health of like age (NC residents: person of like age) on the approval date. Any person who is not performing his/her normal daily activities as required will not become insured until the day he/she is performing such activities, provided such date is within three months of the date insurance would have been effective and the person is still eligible, and (b) any dividend apportioned to the group policy will be paid to the Trustee of the Insurance Plan.

Fraud Warning Statements

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.

For 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.

For residents of DC, the following also applies: 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 LA: 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 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 PR: 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 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 VA: Any person who, with intent to defraud or knowingly 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: I authorize disclosure of the types of information detailed in the AUTHORIZATION below, for New York Life Insurance Company's use in considering my request for insurance. I have read the IMPORTANT NOTICE, which describes how New York Life Insurance Company underwrites this request for insurance, including how information is exchanged with MIB (Medical Information Bureau). My request for coverage will not be accepted unless this AUTHORIZATION is signed. I authorize any physician, medical practitioner, hospital, medical or medically related facility, insurance company or MIB to release information to New York Life Insurance Company, its subsidiaries or the Plan Administrator about the physical and mental health of any persons proposed for insurance, including significant history, findings, diagnosis or treatment, but excluding psychotherapy notes. MIB and other insurance companies may also furnish to New York Life Insurance Company, its subsidiaries or the Plan Administrator with non-medical information (such as driving records, any criminal activity or association, hazardous sport or aviation activity, use of alcohol or drugs, and other applications for insurance). I understand that the information provided may include information that may predate the time frame selected on the medical questions section on this application. I also understand and agree that this information may be used during the underwriting and claims processes, where permitted by law. New York Life Insurance Company may release information covered by this AUTHORIZATION to the Plan Administrator, MIB, or other insurance companies and to others whom I authorize in writing. However, this will not be done in connection with information concerning Acquired Immune Deficiency Syndrome (AIDS). This AUTHORIZATION may be used for a period of 24 months from the date signed below unless sooner revoked. I may revoke this AUTHORIZATION at any time by notifying the Plan Administrator in writing at the address given on this form. My revocation will not be effective to the extent 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. A photocopy of this request form shall be as valid as the original. I acknowledge that I or my authorized agent may request a copy of this signed AUTHORIZATION.

By signing and dating this application, I and my spouse (if proposed for insurance), request the insurance indicated, understand the effective date criteria, consent to authorize the disclosure of information to the providers noted, and attest that to the best of my knowledge and belief, the statements made regarding my health 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

Owner Information, required if owner is other than the member (if Owner is a Trust, please submit a copy of the document with this application).

Full Name ______________________________ LAST FIRST MIDDLE INITIAL Relationship to Proposed Insured __________

Mailing Address ______________________________ STREET CITY STATE ZIP CODE

Tax ID# __________ Date of Birth ____/____/____ Social Security #: ☐☐☐-☐☐-☐☐☐☐

Owner's Signature X ______________________________ (NECESSARY ONLY IF OTHER THAN MEMBER) __________ DATE