



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.
2. Send No Money Now. You Will Be Billed Once Coverage is Approved.
3. Mail Completed Form to:
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 Disability Income Plan Application

For Members of The Society of Petroleum Engineers

PLEASE PRINT IN INK OR TYPE ALL ANSWERS

1 Member's Full Name and Information:

Name _____
LAST FIRST MIDDLE

Home Address _____
STREET CITY STATE ZIP CODE

Home Phone: (_____) _____
AREA CODE NUMBER

Business Phone: (_____) _____
AREA CODE NUMBER

Business Address _____
STREET CITY STATE ZIP CODE

Date of Birth ____/____/____ Place of Birth _____
CITY/STATE

Height _____ Weight _____ Sex: Male Female
FT. IN. LBS.

Social Security #: - -

Do you intend to reside outside the U.S. or Canada in the next 12 months? Yes Country _____

2 Membership Affiliation—Occupational Status

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

B. What is your occupation? _____
1. Describe your main duties _____

C. "FULL-TIME WORK" means the active performance of the regular duties of your normal occupation for pay or profit on the basis of at least 20 hours per week at the place such duties are normally performed. Are you at FULL-TIME WORK? Yes No

D. Please state your annual earned income _____
(net after business expenses)

3 Insurance Requested—Insurance Status: Refer to brochure for eligibility, options and coverage description.

You may choose any Monthly Benefit Option for which you are eligible, provided it and any other disability income coverage you may have does not exceed 60% of your monthly earned income, or a total of \$15,000, whichever is less.

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

I Wish to Apply for the Following Coverage:	PLAN 1 & PLAN 2 SELECT DESIRED WAITING PERIOD	INDICATE DESIRED MONTHLY BENEFITS	I WISH TO PAY
<input type="checkbox"/> PLAN 1 TWO YEAR ACCIDENT—TWO-YEAR SICKNESS	<input type="checkbox"/> Benefits begin after 60 days	\$ _____	<input type="checkbox"/> Annually <input type="checkbox"/> Semiannually <input type="checkbox"/> Quarterly
<input type="checkbox"/> PLAN 2 TO AGE 65 ACCIDENT—TO AGE 65 SICKNESS	<input type="checkbox"/> Benefits begin after 180 days	TOTAL PREMIUM: \$ _____	<small>Please note: A \$2.00 administrative fee is added for billing modes other than annual.</small>
			20258

Do you now have or are you now applying for any other insurance which provides benefits if you are unable to work because of disability? Yes No
IF YES, PLEASE LIST

COMPANY	PLAN	MONTHLY BENEFIT	BENEFIT PERIOD

4 Statement of Health (Please initial any changes you make on this form.)

To the best of your knowledge and belief, please answer the following questions as they apply to you. **For CA Residents:** California law prohibits an HIV test from being required or used by health insurance companies as a condition for obtaining health insurance coverage.

A. Are you now ill or taking any prescribed medications or receiving or contemplating any medical attention or surgical treatment? Yes No

B. During the past five years, have you ever been medically diagnosed by a physician or other medical care practitioner as having or been treated for:
i) heart or circulatory trouble; elevated blood pressure; chest pain or pressure; gynecological or genitourinary disorders; disorder of breast or reproductive organs or functions; ulcers or digestive disorders; cancer; tumor or cyst; diabetes; mental or nervous disorder; emotional conditions; psychiatric care or psychotherapeutic treatment; fainting spells; convulsions or epilepsy; respiratory disorder; kidney or liver disorder (including hepatitis); enlarged lymph nodes or immunodeficiency disorder; thyroid disorder; blood disorder; albumin, blood, pus or sugar in urine; back trouble/disorder; arthritis; bone or joint disorder; varicose veins; hemorrhoids or hernia; disorder of eyes, ears, nose or sinuses; unexplained weight loss or accidental injury? Yes No

ii) other health or physical impairment including:
a) Being medically diagnosed as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)? Yes No
b) Chronic cough, persistent diarrhea, enlarged lymph glands, chronic fatigue in the past five years? Yes No
c) Any other impairment? Yes No

G-29066

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

Please be sure to complete and sign reverse side.

Form GPA-DI-FMU

