



**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 Comprehensive HealthCare 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

Occupation _____

Home Address _____
STREET CITY STATE ZIP CODE

Home Phone: (_____) _____
AREA CODE NUMBER

SPE Membership Number, if available _____

Business Phone: (_____) _____
AREA CODE NUMBER

Business Address _____
STREET CITY STATE ZIP CODE

Date of Birth ____/____/____

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

Social Security #: - -

2 Insurance Requested I hereby apply for the following coverages based upon all my statements made in this application.

Comprehensive HealthCare

Type of Coverage Desired:

- Member Member/Spouse
 Member/Child(ren) Member/Spouse/Child(ren)

Payment Mode:

- Quarterly Monthly Semiannually Annually

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

Deductible:

- \$1,000 (available to members with or without covering dependents)
 \$2,000 (available only to the member when dependents are covered)
 \$5,000 (available to members with or without covering dependents)

19503

I Wish to Have my Coverage Become Effective on:

- The day my application is received at the administrator's office, or The date indicated here: _____

Is this coverage meant to replace any group medical care insurance which was in force for at least 18 months (without a break in coverage of more than 63 days) on yourself or any other person to be insured? If yes, please attach a copy of the certificate of creditable coverage from the prior insurance plan. Yes No

If Dependent Coverage is Requested, List Eligible Dependents (i.e., lawful spouse and unmarried, dependent children under age 26):

Spouse or Domestic Partner* Name _____ Date of Birth ____/____/____

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

*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.

Child (Name)	Date of Birth	Ht.	Wt.	Child (Name)	Date of Birth	Ht.	Wt.	Child (Name)	Date of Birth	Ht.	Wt.

3 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 or your spouse:

- A.** Are you or any other person to be insured now receiving any disability or workers' compensation benefits or on waiver of premium for life or health insurance? Yes No
- B.** Are you or any other person to be insured now ill, receiving or contemplating any medical attention or surgical treatment? Yes No
- C.** During the past five years has any person to be insured consulted any physician or other practitioner, been hospitalized or had an operation or had any illness, disease or injury? Yes No
- D.** Are you or any other person to be insured under any kind of medication or, so far as you know, in impaired physical or mental health? Yes No
- E.** Is any person to be insured now pregnant? Yes No

G-29065

Form GPA-AC-1, AS Amd by GMA-5-NYFR

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

Please be sure to complete and sign reverse side.

③ Statement of Health (cont.) (Please initial any changes you make to this form)

- F.** During the past five years, has any person to be insured been medically diagnosed by a physician as having been treated for:
- | | | | |
|--|--|--|--|
| 1. Heart or circulatory trouble, high blood pressure, pain or pressure in chest? | <input type="checkbox"/> Yes <input type="checkbox"/> No | 11. Thyroid, liver or respiratory disorder? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 2. Arthritis back trouble, bone or joint disorder? | <input type="checkbox"/> Yes <input type="checkbox"/> No | 12. Alcoholism or drug habit? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 3. Fainting spells, convulsions, or epilepsy? | <input type="checkbox"/> Yes <input type="checkbox"/> No | 13. Disorder of the blood? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 4. Sugar, blood, albumin or pus in urine? | <input type="checkbox"/> Yes <input type="checkbox"/> No | 14. Other health or physical impairment including: | |
| 5. Diabetes, kidney trouble, ulcers or digestive disorder? | <input type="checkbox"/> Yes <input type="checkbox"/> No | (i). Being medically diagnosed as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS-related complex (ARC)? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 6. Disorder of breasts or reproductive organs or functions? | <input type="checkbox"/> Yes <input type="checkbox"/> No | (ii). Chronic cough, persistent diarrhea, enlarged lymph glands, chronic fatigue, in the past five years? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 7. Nervous or mental disorder, emotional condition or psychiatric care? | <input type="checkbox"/> Yes <input type="checkbox"/> No | (iii). Any other impairment? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 8. Cancer, tumor or cyst? | <input type="checkbox"/> Yes <input type="checkbox"/> No | 15. Any other disorder of the immune system? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 9. Varicose veins, hemorrhoids or hernia? | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 10. Disorder of eyes, ears, nose or sinuses? | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |

G. If you have answered any of the above Questions "Yes," give complete details below. (Attach a separate sheet, if necessary, sign and date.)

Illness or Condition—Date of Onset—Duration—Treatment—Operation—Degree of Recovery and Date:	Name and Address of Physicians or Other Practitioners and Hospitals Where Confined or Treated:

I request the group insurance shown on the reverse side. To the best of my knowledge and belief 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 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.

I understand that insurance will become effective on the later of (1) the date the application is received at the administrator's office or (b) a later date if specified by me on this request for insurance provided the initial contribution is paid within 31 days after the date I am billed. I also understand that any dividend apportioned to the group policy will be paid to the Trustee of the Insurance Plan.

I also understand that in the event I cannot provide evidence that I, or if applicable, my dependents(s) had 18 months of creditable medical coverage (with no break in coverage of more than 63 days), that benefits will not be paid for up to 12 months after the effective date of coverage for losses due to a disease or condition which I or my dependent(s) now have or have had whether physical or mental, regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment was recommended or received within the six months immediately preceding the effective date of coverage.

AUTHORIZATION: I authorize disclosure of the types of information detailed in this AUTHORIZATION, for New York Life's use in considering this request for coverage. I have read the IMPORTANT NOTICE, which describes how New York Life underwrites this request for coverage. 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, laboratory or insurance company 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 subsidiaries or the plan administrator regarding the physical and mental health of any persons proposed for insurance, including *significant history, findings, diagnosis and treatment, but excluding psychotherapy notes. Other insurance companies may also furnish New York Life, its subsidiaries or the plan administrator with non-medical information (such as driving records, past convictions, hazardous sport or aviation activity, use of alcohol or drugs, and other applications for insurance). I understand that the information provided might include information that may predate the time frame stated on the medical questions section, if any, of 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 may use or disclose information about me without my further written authorization as described in the HIPAA NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION. New York Life may release information covered by this AUTHORIZATION to others whom I authorize in writing. However, this will not be done in connection with information concerning Acquired Immune Deficiency Syndrome (AIDS), or Human Immunodeficiency Virus (HIV). 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 Administrator in writing at the address given on this form. My revocation will not be effective to the extent that New York Life 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 has a legal right to contest a claim under an insurance certificate or the certificate itself. The information New York Life obtains through this AUTHORIZATION may become subject to further disclosure. For example, New York Life 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 this AUTHORIZATION. A photocopy of this AUTHORIZATION and request form shall be as valid as the original. I acknowledge that if I am requesting medical coverage, my authorized agent or I will receive a copy of this signed AUTHORIZATION, and that in all circumstances, my authorized agent or I may request a copy of this AUTHORIZATION.

By signing and dating this application, the member and any person proposed for insurance, **request** the insurance indicated, **understand** the effective date criteria, **consent** to authorize the disclosure of information by the providers noted, and **attest** to having read the Fraud Notices enclosed, 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 _____

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

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PREMIUM PAYMENT FOR INSURANCE DOES NOT MEAN THERE IS ANY COVERAGE IN FORCE BEFORE THE EFFECTIVE DATE AS SPECIFIED BY NEW YORK LIFE.

4/10 ed.—4/10

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 AR/LA/MD/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 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 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.