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 Term Life and First-to-Die 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

① 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: (________) ______________
AREA CODE NUMBER

Business Phone: (________) ______________
AREA CODE NUMBER

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

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. **Complete remaining application as Spouse and contact Plan Administrator for an additional form to complete.

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? ______________

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

19439

*Spouse coverage cannot exceed member's coverage.

First-to-Die Term Life Plan

A. Coverage Amount Requested:

☐ $50,000 ☐ $100,000 ☐ $150,000 ☐ $200,000

19443

B. Tobacco/Nicotine Use:

Have you or your spouse (if applying for coverage) used tobacco or nicotine in any form, including nicotine patches and nicotine gum, within the last 12 months?

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

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

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

Is the insurance applied for intended to replace, discontinue or change an existing policy?

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

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

For the FIRST-TO-DIE Plan, I understand the automatic beneficiary for the Member's coverage is the Spouse; the automatic beneficiary for the Spouse's coverage is the Member. By filling out the information below I am acknowledging my wish to designate someone other than my spouse as my beneficiary.

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 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 ______________________

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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 mental health?	☐	☐
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

⑥ Declarations

I request the group insurance shown on the previous page. To the best of my knowledge and belief the statements I have made are true and complete. I understand that New York Life Insurance Company has the right to require additional information and, if necessary, an examination by physician. I ask New York Life Insurance Company 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 any insurance subject to the incontestable period provision of the policy.

I understand that 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 of like age on the approval date. I understand that: (a) any dependent confined at home, in a hospital or other medical institution or incapacitated so far as to be unable to perform his/her normal daily activities as required, will not become insured until the day he/she is no longer confined/incapacitated, provided he/she is still eligible and (b) any dividend apportioned to the group policy will be paid to the Trustee of the Insurance Plan.

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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 AR/LA/MD: 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 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: I authorize disclosure of the types of information detailed in the AUTHORIZATION below, for New York Life's use in considering this request for insurance. I have read the IMPORTANT NOTICE, which describes how New York Life underwrites this request for insurance. 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, 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 release information covered by this AUTHORIZATION to the plan administrator 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) 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 Plan 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.

A photocopy of this AUTHORIZATION and request form shall be as valid as the original. I acknowledge that my authorized agent or I 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 to having read the Fraud Notices indicated above and 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

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

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