Aetna Life Insurance Company
Underwritten by Aetna Life Insurance Company
151 Farmington Avenue • Hartford, CT 06156

Aetna Dental® PPO Max Insurance Plan Enrollment Form

For Members of the Society of Petroleum Engineers

Applying Is Easy. Here's How:

1. Complete and Sign This Form.
2. Make Premium Check Payable to: **SPE Insurance Program**
3. Mail Completed Form and Check 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**.*

PLEASE PRINT IN INK OR TYPE ALL ANSWERS.

1 Member's Name and Address:

Member's Full Name: ______________________
LAST FIRST MIDDLE INITIAL

Date of Birth: ________ /________ /________
MONTH DAY YEAR

Gender: ☐ Male ☐ Female Social Security #: ☐ ☐ ☐ - ☐ ☐ - ☐ ☐ ☐ ☐

STREET ADDRESS

CITY

STATE (OR PROVINCE)

ZIP CODE

Phone Numbers: (________) ______________
HOME
(________) ______________
WORK

2 Membership Affiliation:

Are you now a member of the SPE? ☐ Yes ☐ No What is your membership number, if available? ______________

3 Dependent Coverage Information for Plus One and Family Coverage:

Name / Birth Date / Social Security # Gender: ☐ M ☐ F Relationship: ☐ Spouse ☐ Child

Name / Birth Date / Social Security # Gender: ☐ M ☐ F Relationship: ☐ Spouse ☐ Child

Name / Birth Date / Social Security # Gender: ☐ M ☐ F Relationship: ☐ Spouse ☐ Child

4 Select Coverage: ☐ Member ☐ Member + One ☐ Family

5 Choose Your Payment Options: (See reverse side for premium information)

Please Bill Me: ☐ Monthly ☐ Quarterly ☐ Semiannually ☐ Annually Premium Amount: ______________
Please note: A $2.00 administrative fee is added for billing modes other than annual.
20210

I Want to Pay by: ☐ Check or Money Order ☐ Monthly Bank Draft (Please enclose a voided blank check and complete deduction authorization.)

Please include your first month's payment with your completed application. Make your check payable to SPE Insurance Program.

Deduction Authorization: I hereby authorize A.G.I.A., Inc., the SPE Insurance Program Administrator, to initiate monthly debit entries to my checking account for payment of insurance premiums. This authority is to remain in effect until I cancel it by written notification to the Company at least 30 days in advance of the intended termination date of my coverage. (Any excess premiums which may accrue after termination of my coverage will be refunded to me.)

BANK NAME BANK ROUTING #

BANK STREET ADDRESS CITY STATE ZIP

CHECKING ACCOUNT # ACCOUNT NAME

SIGNATURE

Please be sure to complete and sign reverse side.

Control 861318 Suffix ________ Account ________ Plan Number ________
DEN1000GEM PPO MAX DENTAL 861318 GEODENLPPO 12/05
DEN1000GEM.FL

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

6 Sign, Date and Mail: By my signature below, I represent that all the information supplied in this application is true and complete to the best of my knowledge. I hereby agree to the conditions of enrollment stated below.

SIGNATURE ____________________ TODAY'S DATE ____________________

Conditions of Enrollment

A. Applicant Acknowledgements and Agreements

On behalf of myself and the dependents listed on the reverse side, I agree to or with the following:

1. PPO dental insurance plans are underwritten and administered by Aetna Life Insurance Company (Aetna*). The Dental PPO plan is referred to as the Participating Dental Network (PDN) in Texas.
2. I understand and agree that this enrollment/change request form may be transmitted to Aetna by its agent. I authorize any physician, other healthcare professional, hospital or any other healthcare organization ("Providers") to give Aetna or its agent information concerning the medical history, services or treatment provided to anyone listed on this enrollment/change request form, including those involving HIV/AIDS. I further authorize Aetna to use such information and to disclose such information to affiliates, providers, payors, and other insurers, third-party administrators, vendors, consultants, and governmental authorities with jurisdiction when necessary for my care or treatment, payment for services, the operation of my health plan, or to conduct related activities. I have discussed the terms of this authorization with my spouse and competent adult dependents and I have obtained their consent to these terms. I understand that this authorization is provided under state law and that it is not an "authorization" within the meaning of the federal Health Insurance Portability and Accountability Act. This authorization will remain valid for the term of the coverage and for so long thereafter as allowed by law. I understand that I am entitled to receive a copy of this authorization upon request and that a photocopy is as valid as the original.
3. The plan documents will determine the rights and responsibilities of member(s) and will govern in the event they conflict with any benefits comparison, summary or other description of the plan.
4. I understand and agree that all participating providers (including participating primary care dentists) and vendors are independent contractors and are neither agents nor employees of Aetna. The availability of any particular provider cannot be guaranteed and provider network composition is subject to change. Notice of change shall be provided in accordance with applicable state law.

B. Misrepresentation

Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for purpose of misleading, information concerning any fast material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Attention California Residents: For your protection, California law requires notice of the following to appear on this form. Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Attention Colorado Residents: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

Attention Florida and Virginia Residents: Any person who knowingly and with intent to 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.

Attention Kentucky, Ohio and Pennsylvania Residents: 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 is a crime and subjects such person to criminal and civil penalties.

Attention Louisiana and West Virginia Residents: 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.

Attention New Jersey Residents: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

Attention New York Residents: 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 is a crime, and shall be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each violation.