NYIT College of Osteopathic Medicine

CHANGE FORM

Group Insurance Program For
Medical Students

<table>
<thead>
<tr>
<th>LAST NAME</th>
<th>FIRST NAME</th>
<th>M.I.</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>MAILING ADDRESS</th>
<th>CITY</th>
<th>STATE</th>
<th>ZIP</th>
</tr>
</thead>
</table>

Change Requested (Check All Applicable Boxes)

- Add Spouse*: Date to be Added
- Add Dependent(s): Date Acquired
- Add Medical Coverage (You must show Proof of loss of other coverage.)
- Add Dental Coverage (You must show Proof of loss of other coverage.)

Effective Date

Reason

Beneficiary Change (Complete Section B): Eff. Date

Name Change (Complete Section C): Eff. Date

Other Change (Explain): Eff. Date

SECTION A (DEPENDENT INFORMATION)

(LIST ONLY THOSE AFFECTED BY THIS CHANGE)

<table>
<thead>
<tr>
<th>SEX</th>
<th>DATE OF BIRTH</th>
<th>SPouse Social Security Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>M</td>
<td></td>
<td></td>
</tr>
<tr>
<td>F</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Add Delete

- SPOUSE
- CHILDREN
- FREE FORM

SECTION B (BENEFICIARY CHANGE)

The beneficiary designation below cancels all my prior beneficiary designations for the policy.

Name, Address, Date of Birth and Relationship of New Beneficiary

<table>
<thead>
<tr>
<th>Insured's Former Name</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Insured's New Name</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

SECTION C (NAME CHANGE)

STUDENT SIGNATURE | DATE | SCHOOL ADMINISTRATOR’S SIGNATURE | DATE

STUDENT E-MAIL: ______________________@nyit.edu

TELEPHONE NUMBER: ______________________
INSTRUCTIONS AND DEFINITIONS

DEPENDENTS may be added only within the guidelines outlined in your group policy.

SECTION A
Complete this section only if you are adding or deleting coverage for your dependent (spouse and/or children).

SECTION B

BENEFICIARY - The name of the person that you designate to receive Life Insurance proceeds in the event of your death.
Please be sure to provide the full name, complete address (if different from your own), and relationship of any beneficiary named.
If you are naming more than one beneficiary, please state how the benefit should be allocated.
(EXAMPLES OF ACCEPTABLE BENEFICIARY DESIGNATIONS FOLLOW)
1. Jane B. Doe, wife
2. John A. Doe, husband & Walter Doe, son; equally or to the survivor.
3. Walter, John, & James Doe, sons; equally or to the survivor.
4. Jane B. Doe, wife, if living, otherwise to Walter Doe, son.
5. John A. Doe, husband-X%, Walter Doe, son-Y%, and James Doe, son-Z%.
6. Executors or Administrators of the estate of the insured.

For Office Use Only:

Add/Term Date: ____________________________
Medical Premium: ____________________________
Dental Premium: ____________________________
Bursar: ____________________________
Guardian: ____________________________
By: ____________________________ Date: ____________________________