# CHANGE FORM

## Group Insurance Program For Medical Students

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

- [ ] Delete Spouse-Eff. Date ________________
- [ ] Delete Dependent(s)-Eff. Date ________________
- [ ] Delete Medical Coverage
- [ ] Cancel Medical Coverage
- [ ] Cancel Dental Coverage

Effective Date ___________________ Reason __________________________________________________________________________________

- [ ] Beneficiary Change (Complete Section B)-Eff. Date ________________
- [ ] Name Change (Complete Section C)-Eff. Date ________________
- [ ] Other Change (Explain)___________________________________________________________________

### SECTION A (DEPENDENT INFORMATION) (LIST ONLY THOSE AFFECTED BY THIS CHANGE)

<table>
<thead>
<tr>
<th>Add</th>
<th>Delete</th>
<th>LAST NAME</th>
<th>FIRST</th>
<th>M.I.</th>
<th>SEX</th>
<th>DATE OF BIRTH</th>
<th>SPOUSE SOCIAL SECURITY NUMBER</th>
</tr>
</thead>
</table>
- [ ] SPOUSE ____________________________________________
- [ ] CHILDREN __________________________________________

If you have more than 4 children use additional 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 ___________________________________________________________________________________________

### SECTION C (NAME CHANGE)

Insured's Former Name ___________________________________________________________________________________________

Insured's New Name ___________________________________________________________________________________________

STUDENT SIGNATURE ________________________ DATE ____________ SCHOOL ADMINISTRATOR’S SIGNATURE ________________________ DATE ____________

STUDENT E-MAIL: _____________________________ @nyit.edu TELEPHONE NUMBER: _____________________________
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 and AD&D 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: ________________