NYIT College of Osteopathic Medicine

CHANGE FORM

CAMPUS LOCATION
OLD WESTBURY / JONESBORO

PEOPLESOFT ID

Group Insurance Program For Medical Students

LAST NAME | FIRST NAME | M.I.

MAILING ADDRESS | CITY | STATE | ZIP

Change Requested (Check All Applicable Boxes)

- ❑ Add Spouse*-Date to be Added _____
- ❑ Add Dependent(s)-Date Acquired _____

} Complete Section A

- ❑ Delete Spouse-Eff. Date _____
- ❑ Delete Dependent(s)-Eff. Date _____

} Complete Section A

- ❑ Add Medical Coverage (You must show **Proof of loss of other coverage**.)
- ❑ Add Dental Coverage (You must show **Proof of loss of other 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) _____ Effective Date _____

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

Add	Delete	LAST NAME	FIRST	M.I.	SEX M	SEX F	DATE OF BIRTH	SPOUSE SOCIAL SECURITY NUMBER
❑	❑	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: _____

NYITCOM-C

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: _____