

# New York Institute of Technology College of Osteopathic Medicine

## BENEFICIARY DESIGNATION FORM

AMA Insurance  
Policy# 755331

CAMPUS LOCATION

Old Westbury, NY / Jonesboro, AR

DATE COVERAGE BEGINS

/ /

NYITCOM ID

Group Insurance Program For Medical and Health Sciences Students

### SECTION A (STUDENT INFORMATION)

LAST NAME: \_\_\_\_\_ FIRST NAME \_\_\_\_\_ M.I. \_\_\_\_\_

DATE OF BIRTH

/ /

MALE

FEMALE

SOCIAL SECURITY NUMBER

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MAILING ADDRESS

STREET ADDRESS

CITY

STATE

ZIP

PHONE # 1

( ) -

PHONE # 2

( ) -

PERMANENT ADDRESS

STREET ADDRESS

CITY

STATE

ZIP

COVERAGES SELECTED

LIFE  AD&D (COMPLETE SECTION B)  
 DISABILITY

**SECTION B (BENEFICIARY DESIGNATION)** COMPLETE THIS SECTION. IF MORE THAN ONE BENEFICIARY, PLEASE SHOW HOW TO ALLOCATE.

NAME, ADDRESS, DATE OF BIRTH AND RELATIONSHIP OF BENEFICIARY (BENEFICIARIES) RELATIONSHIP = (Mother, Father, Brother, etc.)

I hereby request coverage under the group policy(ies) sponsored by the New York Institute of Technology College of Osteopathic Medicine. I understand that the coverage provided will be subject to the terms and conditions of the group insurance policy(ies).

STUDENT SIGNATURE \_\_\_\_\_ DATE SIGNED \_\_\_\_\_