NYIT College of Osteopathic Medicine

ENROLLMENT FORM

CAMPUS LOCATION
OLD WESTBURY/ JONESBORO

DATECOVERAGE BEGINS
/ /

STUDENT ID

Group Insurance Program For Medical Students

SECTION A **(STUDENT INFORMATION)**

NAME: LAST FIRST M.I.

DATE OF BIRTH
/ /

❑ MALE ❑ FEMALE

❑ 1ST YR. ❑ 2ND YR. ❑ 3RD YR. ❑ 4TH YR.

MAILING ADDRESS

STREET ADDRESS

CITY STATE ZIP

PERMANENT ADRESS

STREET ADDRESS

CITY STATE ZIP

PHONE # 1
( ) -

PHONE # 2
( ) -

COVERAGES SELECTED
☒ LIFE ☒ AD&D (COMPLETE SECTION C)
❑ MEDICAL ☒ DISABILITY ❑ DENTAL

DO YOU WISH TO COVER YOUR ELIGIBLE DEPENDENTS FOR INSURANCE
❑ YES ❑ NO

SECTION B **(DEPENDENT INFORMATION) LIST ALL PERSONS TO BE COVERED BY THIS ENROLLMENT**

LAST NAME FIRST NAME M.I.	SEX M F	DATE OF BIRTH
SPOUSE _____	❑ ❑	_____
CHILDREN _____	❑ ❑	_____
_____	❑ ❑	_____
_____	❑ ❑	_____
_____	❑ ❑	_____

If you have more than 4 children use additional form.

SECTION C **(BENEFICIARY DESIGNATION)** COMPLETE THIS SECTION ONLY IF YOU HAVE LIFE AND/AD&D INSURANCE. IF MORE THAN ONE BENEFICARY, 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 NYIT 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** _____

NYIT-E

SEE INSTRUCTIONS ON OTHER SIDE

INSTRUCTIONS AND DEFINITIONS

SECTION A - Student

COMPLETE THIS SECTION - Fill in all information.
COVERAGES SELECTED - Availability of coverages determined by the school.
COVERAGES SELECTED - Must include Medical and Dental unless Waiver attached is received and approved.

SECTION B - Student

ELIGIBLE DEPENDENTS include your spouse as well as any eligible children as defined by your group policy.

Complete this section only if you desire coverage for your dependents (spouse and/or children).

SECTION C - Student

BENEFICIARY - The name of the person or persons that you designate to receive Life and/AD&D Insurance proceeds.

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.

Administrator

COVERAGES SELECTED - Must include Medical and Dental unless Waiver attached.
DATE COVERAGE BEGINS - Is the later of:

- The effective date of the Plan;
- The date the student is enrolled and completes an enrollment form;

For Office Use Only:

Add/Term Date: _____

Medical Premium: _____

Dental Premium: _____

Bursar: _____

Guardian: _____

By: _____ Date: _____