AMA-sponsored Group Hospital Indemnity Plan

Underwritten by New York Life Insurance Company

Dependent Enrollment Form

Certificate Owner (Primary Insured) Information:

Name: ____

Certificate Number (If known) ______________________

Address: ____

City: ________________________ State__________ ZIP _________

Email: ____

May AMA Insurance email you regarding products and services for physicians? [ ] YES!

Please change my insurance coverage to: [ ] Physician Plus One [ ] Physician and Family

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I would like to add the following dependent(s) to my coverage:

Dependent Name | Date of Birth | Relationship | [ ] Male [ ] Female

Dependent Name | Date of Birth | Relationship | [ ] Male [ ] Female

Dependent Name | Date of Birth | Relationship | [ ] Male [ ] Female

Dependent Name | Date of Birth | Relationship | [ ] Male [ ] Female

If you have additional dependents, please attach a separate sheet.

I am currently insured under the **AMA-sponsored Group Hospital Income Plan** and wish to enroll the above eligible spouse/domestic partner and/or eligible dependent children.

____ Signature of Primary Insured

__________________ Date

Administered by AMA Insurance Agency, Inc., a subsidiary of the American Medical Association
Questions? Call 1-800-458-5736, weekdays, 8:00 am – 5:00 pm CT

Please complete, sign and date.
Return form to AMA Insurance by fax at 1-312-464-5036
or by mail to 330 N. Wabash Ave. Suite 39300, Chicago, IL 60611-5885

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