GROUP MEMBERSHIP ASSOCIATION REQUEST FOR IDENTIFYING INFORMATION

Name: ____ Social Security Number (last 4 digits): _________________

Group Policyholder Name _American Medical Association Group Insurance Trust_____ Group Policy Number __________________ Certificate Number ___________________

IMPORTANT: In order to expedite claim payments, and in accordance with state insurance regulations, please provide the **Identifying Information** requested below for everyone insured under this Life Insurance Certificate (including dependents, if any), and the beneficiary(ies). **Note:** All states have unclaimed property laws requiring life insurance benefits to be transferred to the state if a beneficiary cannot be located. To avoid having benefits intended for your beneficiary(ies) transferred to the state, please provide the **Identifying Information** to help us locate the beneficiary(ies) at time of claim. **This form should not be used to designate a beneficiary or change a beneficiary.**

INSURED MEMBER INFORMATION:

Full Name ____ Date of Birth ____________ Social Security Number ____-___-_____
(First) (Middle) (Last) (MM-DD-YYYY)

Address____ Phone Number (____)_____________
(Street) (City) (State) (Zip) (Area Code) (Number)

INSURED SPOUSE (IF ANY) INFORMATION: ☐ Address/Phone Number same as Insured Member

Full Name ____ Date of Birth ____________ Social Security Number ____- ___-_____
(First) (Middle) (Last) (MM-DD-YYYY)

Address____ Phone Number (____)_____________
(Street) (City) (State) (Zip) (Area Code) (Number)

INSURED CHILDREN (IF ANY) INFORMATION: ☐ Address/Phone Number same as Insured Member

Child Full Name ____ Date of Birth ____________ Social Security Number ____-___-_____
(First) (Middle) (Last) (MM-DD-YYYY)

Address____ Phone Number (____)____________
(Street) (City) (State) (Zip) (Area Code) (Number)

Child Full Name ____ Date of Birth ____________ Social Security Number ____-___-_____
(First) (Middle) (Last) (MM-DD-YYYY)

Address____ Phone Number (____)____________
(Street) (City) (State) (Zip) (Area Code) (Number)

BENEFICIARY INFORMATION: Please provide the Address, Social Security Number, Date of Birth, and primary Phone Number for the beneficiary(ies) designated on your application for insurance (see enclosed Certificate). If you did not designate a beneficiary or the beneficiary dies before you, death benefits will be paid in accordance with the Group Policy, which typically provides that benefits will be paid to your surviving spouse, children, parents, or siblings, in that order. See the enclosed Certificate which describes how benefits will be paid under the Group Policy.

If there is not enough room on this form, please use the reverse or attach a separate page with your dated signature and the Name, Address, Social Security Number, Date of Birth, and primary Phone Number for your designated beneficiary(ies). **If you wish to change your beneficiary, please call AMA Insurance at 800-458-5736 for the necessary Change of Beneficiary form.**

Beneficiary Name ____ __________ Relationship to Member _____________________
(First) (Middle) (Last)

Address____
(Street) (City) (State) (Zip)

Date of Birth ____/_____/_____ Social Security Number ______-_______-______ Phone Number ______________________
(MM/DD/YYYY) (Area Code) (Number)

☐ Address/Phone Number same as Insured Member

AUTHORIZING SIGNATURE (Insured Member or previously designated non-insured Owner)

Signature____ Date____________________

Name (please print) ____