The Company You Keep®

GROUP MEMBERSHIP ASSOCIATION REQUEST FOR IDENTIFYING INFORMATION

Group Policyholder
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.

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, call 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) _____