Amalgamated Life Insurance Company
Policy Services Department
333 Westchester Avenue
White Plains, NY 10604
1-914-367-5000

ENROLLMENT FOR LIFE INSURANCE

PLEASE TYPE OR PRINT

POLICYHOLDER'S NAME & ADDRESS	POLICY NUMBER

INSURED'S NAME & ADDRESS	(LAST)	(FIRST)	(MIDDLE INITIAL)
STREET			
CITY, STATE, ZIP			
SOCIAL SECURITY #		DATE OF BIRTH	
PLACE OF BIRTH (CITY, STATE)			SEX ❑ MALE ❑ FEMALE

OCCUPATION	ANNUAL SALARY	EMPLOYMENT DATE	EFFECTIVE DATE

BENEFICIARY DESIGNATION

(Please Indicate a Primary and Contingent Beneficiary)

PRIMARY

The proceeds shall be divided equally among those of the following designated person or persons who survive the Insured.

Name	Relationship	Address	Social Security #	Telephone
1.				
2.				

CONTINGENT

The proceeds shall be divided equally among those of the following designated person or persons who survive the Insured, provided no Primary Beneficiary designated above has survived the Insured.

Name	Relationship	Address	Social Security #	Telephone
1.				
2.				

I understand that this coverage shall become effective only if this application is accepted by the Amalgamated Life Insurance Company.

DATE _____, 2_____ SIGNATURE **X** _____

DATE _____, 2_____ _____
WITNESS SIGNATURE OTHER THAN BENEFICIARY

NON-PARTICIPATION OPTION

I have been given an opportunity to apply for life insurance offered by the Amalgamated Life Insurance Company. I understand this plan has been made possible for me through my Employer and I have had its benefits thoroughly explained to me. I choose not to apply at this time, and understand that a later application may require the submission of evidence of insurability. The Insurance Company will have the right to accept or reject my application.

DATE _____, 2_____ SIGNATURE OF INSURED _____