Amalgamated Life
Life • Accident • Disability
333 Westchester Avenue • White Plains, NY 10604-2910 • 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 NO. | | DATE OF BIRTH (MONTH) (DAY) (YEAR) | |
| 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 |
|---|---|---|
| 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 |
|---|---|---|
| 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 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 _____