Amalgamated Life
730 Broadway • New York, NY 10003-9511

ENROLLMENT FOR LIFE INSURANCE

515 **FORM #3537**

EMPLOYER / POLICY HOLDER:

1. EMPLOYEE'S INFORMATION

NAME _____
(LAST) (FIRST) (MIDDLE INITIAL)

ADDRESS _____
(STREET) (CITY) (STATE) (ZIP CODE)

SOC. SEC. NO. _____ DATE OF BIRTH ____/____/____ SEX ❑ Male ❑ Female

OCCUPATION _____ ANNUAL SALARY $_____ EMPLOYMENT DATE ____/____/____

2. COVERAGE ELECTION

❑ BASIC LIFE ❑ ACCIDENTAL DEATH & DISMEMBERMENT ❑ DEPENDENT LIFE

❑ SUPPLEMENTAL LIFE_____ ❑ DEPENDENT SUPPLEMENTAL LIFE _____

3. DEPENDENT INFORMATION (Only If Eligible For Dependent Life Coverage)

NAME _____ RELATIONSHIP_____ DATE OF BIRTH____/____/____

NAME _____ RELATIONSHIP_____ DATE OF BIRTH____/____/____

NAME _____ RELATIONSHIP_____ DATE OF BIRTH____/____/____

NAME _____ RELATIONSHIP_____ DATE OF BIRTH____/____/____

4. BENEFICIARY DESIGNATION

NAME OF BENEFICIARY RELATIONSHIP ADDRESS

1. _____

2. _____

I UNDERSTAND THAT THIS COVERAGE SHALL BECOME EFFECTIVE ONLY IF THIS APPLICATION IS ACCEPTED BY THE AMALGAMATED LIFE INSURANCE COMPANY.

_____
EMPLOYEE'S SIGNATURE **DATE**

5. NON-PARTICIPATION OPTION

I HAVE BEEN GIVEN THE OPPORTUNITY TO APPLY FOR LIFE INSURANCE OFFERED BY AMALGAMATED LIFE INSURANCE COMPANY. I UNDERSTAND THAT THIS PLAN WAS 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 SUBMISSION OF EVIDENCE OF INSURABILITY. THE INSURANCE COMPANY WILL HAVE THE RIGHT TO ACCEPT OR REJECT MY APPLICATION.

_____
EMPLOYEE'S SIGNATURE **DATE**

1. EMPLOYER (complete this section)

CHECK ❑ New Employee
❑ Retired Employee
❑ Rehired Employee
❑ Full Time
❑ Part Time

POLICY #_____

DATE OF EMPLOYMENT/REHIRE _____

COVERAGE CLASS_____

EFFECTIVE DATE _____

_____
EMPLOYER'S SIGNATURE DATE