

730 Broadway • New York, NY 10003-9511

**PLEASE TYPE OR PRINT**

EMPLOYER/POLICYHOLDER'S NAME & ADDRESS			POLICY NUMBER		
EMPLOYEE/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 <input type="checkbox"/> MALE <input type="checkbox"/> 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 EMPLOYEE \_\_\_\_\_