

NOTICE OF DEATH FORM

Name of Decedent _____ Certificate No. (S.S.) _____
Name of Policyholder _____ Policy No. _____
Date of Death _____ Date last worked _____

Record of Beneficiary Enrollment Form is enclosed: Yes _____ No _____

Beneficiary(ies) Name(s)
And Address(es)

Date Reported _____

Claim was reported by: Phone Call [] Other []

Informant's Name, Address & Telephone No. (if available)

Insurance in force on date of death: Yes _____ No _____

If "No" state reason: _____

Life Insurance Amount _____ Accidental Death & Dismemberment Amount _____

(Signature of Policyholder or Representative) (Date)

As soon as the Policyholder receives notice of death, this form should be forwarded to
THE AMALGAMATED LIFE INSURANCE COMPANY, INC.
730 Broadway, New York, NY 10003-9511 (Group Insurance Services)