Amalgamated Life

MONTHLY CHANGE FORM – ADDITIONS

PLEASE RETURN (EITHER BY FAX OR POST OFFICE) THIS FORM WITH COPIES (RETAIN ORIGINALS IN YOUR FILES) OF ENROLLMENT APPLICATIONS TO:

Serafina C. Salera, *Group Plan Administrator*
Tel: 212-539-5279 • Fax: 212-614-9821
e-mail: SSalera@AmalgamatedLife.com

Amalgamated Life Insurance Company
730 Broadway, Group Insurance, 10th Floor
New York, NY 10003-9511

DATE:

NAME OF EMPLOYER / POLICY HOLDER

POLICY NUMBER

Social Security Number	Name	Sex	Date of Birth	Date of Hire	Effective Date	Class / Division	Salary *	Benefit Amount

* Must be completed if salary is related to benefit amount.