AMALGAMATED LIFE INSURANCE COMPANY

333 Westchester Avenue White Plains, New York 10604

LIFE INSURANCE AND DISABILITY ENROLLMENT FORM

☐ Initial ☐ Change ☐ Termination ☐ Reinstatement

TO BE COMPLETED BY THE EMPLOYEE

Name Last	First	M.I.	Birth Date: MM/DD/YY

Social Security No.	Sex ☐ M ☐ F	Marital Status ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced	Date of Marriage: MM/DD/YY

Employee Home Address Street	City	State	Zip

Indicate type of coverage below. You may only elect coverages reflected in your Employer's contract. (*You will not be covered for coverages not included in your Employer's contract.*) To elect coverage check the box marked "Y". To decline coverage check the box marked "N"

Basic Life ☐ Y ☐ N Amt $_____	Supp Life ☐ Y ☐ N Amt $_____ Basic Income $_____ Other	AD/D ☐ Y ☐ N	Weekly Disability ☐ Y ☐ N Flat Amt $_____	LTD ☐ Y ☐ N Amt $_____

Dependent Life Spouse ☐ Y ☐ N Amt $_____ Child ☐ Y ☐ N Amt $_____	Supplemental Life ☐ Y ☐ N	LTD Buy-Up Option 1 _____% Option 2 _____%

Beneficiary Designation - Please refer to the reverse side for important information regarding beneficiary designation.

	Full Name	Address	SSN	Relationship	DOB
Primary					
Contingent					

X☐	I hereby apply for the coverages I have indicated above on behalf of myself and all dependents listed. I authorize my employer to make the appropriate deductions, if any, from my wages to pay for my share of the cost. I understand that the coverages available to me are in accordance with the provisions of the contract between Amalgamated Life and my Group Plan.
☐	I hereby waive coverages offered to me. I understand that if I desire to apply for any of these coverages at a later date, I will be required to furnish, at my own expense, medical evidence in support of insurability that is satisfactory to Amalgamated Life, before my coverage will become effective.
	INCLUDE THIS PARAGRAPH ONLY IF APPLYING FOR GROUP LIFE THAT IS FULLY OR PARTIALLY PAID FOR BY THE EMPLOYEE The policy permits the group policyholder to change, reduce, restrict or terminate Your rights or benefits under the policy without Your consent and such change, reduction, restriction or termination may occur at a time when Your health status has changed and may affect your ability to procure individual coverage.
	NOTE: For Disability policies only. Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Signature _____ **Date** _____