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