



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
ANNUAL SALARY		EMPLOYMENT 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 \_\_\_\_\_