

**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**

<b>1. EMPLOYER (complete this section)</b>		<b>POLICY #</b> _____
CHECK <input type="checkbox"/> New Employee	DATE OF EMPLOYMENT/REHIRE _____	_____
<input type="checkbox"/> Retired Employee	COVERAGE CLASS _____	_____
<input type="checkbox"/> Rehired Employee	EFFECTIVE DATE _____	_____
<input type="checkbox"/> Full Time	_____	_____
<input type="checkbox"/> Part Time	_____	_____
_____	_____	_____
_____	_____	_____

 \_\_\_\_\_  
**EMPLOYER'S SIGNATURE**

 \_\_\_\_\_  
**DATE**