Amalgamated Life

333 Westchester Avenue • White Plains, NY 10604

ENROLLMENT FOR LIFE INSURANCE

PLEASE TYPE OR PRINT

EMPLOYER/POLICYHOLDER NAME & ADDRESS UFCW 1442			POLICY NUMBER 26CA04
EMPLOYEE / INSURED'S NAME & ADDRESS	(LAST)	(FRST)	MIDDLE INITIAL)
STREET			
CITY, STATE, ZIP			
SOCIAL SECURITY NO.		Date of Birth (MONTH) (DAY) (YEAR)	
PLACE OF BIRTH {CITY, STATE)		SEX ☐ MALE FEMALE	
OCCUPATION		EMPLOYMENT DATE	EFFECTIVE 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.____ %______

DATE ________________2_____ SIGNATURE X ________________________

Complete your Beneficiary Designation Form and return it to our office.