Authorization To Obtain and Disclose Information

The Amalgamated Life Insurance Company, its reinsurers, insurance support organizations, and their authorized representative, may obtain medical and other information in order to evaluate my (our) application for life and/or health insurance.

Any physician, practitioner, hospital, clinic, other medical or medically related facility, the Veterans Administration, the Medical Information Bureau, Inc., my employer and consumer reporting agency or insurance company who possesses information of care, treatment, or other medical advice/information of me or my spouse may furnish such information to the Amalgamated Life Insurance Company, its reinsurers or its representatives upon presenting this authorization or a photocopy. This authorization includes information about drugs, alcoholism or medical illness. The Amalgamated Life Insurance Company or its reinsurers may make a brief report regarding me or my children to other companies to whom I have applied or may apply.

This authorization will be valid from the date signed for a period of thirty (30) months.

I (we) authorize the Amalgamated Life Insurance Company to obtain an investigative consumer report on me (us). I (we) have read this authorization and understand I (we) can receive a copy. I (we) have already received copies of the "Notice Regarding MIB" and the "Notice Under the Fair Credit Reporting Act".

[ ] I (we) elect to be interviewed if an investigative consumer report is prepared in connection with this application. Call me (us) during the hours of_____and _____ . My (our) telephone number is _____ .

Applicant's Signature:

X _____

Signed at City: _____State: _____ Zip: _____ Date: _____

Spouse's Signature

X _____

Signed at City: _____State: _____ Zip: _____ Date: _____

Authorization To Obtain Information

Amalgamated Life Insurance Company, may obtain medical information about me in order to evaluate my application for (health) (life) insurance.

I (we) authorize any physician, medical practitioner, hospital, clinic, other medical or medically related facility, the Veterans Administration, the Medical Information Bureau, Inc. other insurance companies, my present and former employers, and other persons who possess information about medical care, treatment, diagnosis or advice rendered to me to furnish such information to Amalgamated Life Insurance or its authorized representatives upon presentation of this authorization or a photocopy thereof.

This authorization includes information about drugs, alcoholism, mental illness, sexually transmitted disease, Human Immuneodeiciency Virus, (HIV) and Acquired Deficiency Syndrome (AIDS).

I (we) authorize Amalgamated Life Insurance Company to obtain an investigative consumer report on me. I (we) elect to be interviewed if an investigative report is conducted.

This authorization is valid for a period of thirty months from the date signed.

I (we) have read this authorization and understand that my authorized representative or I can receive a copy of it.

I (we) have already received a copy of Amalgamated Life's Notice of Information Privacy Practices.

Failure to sign this authorization may impair our ability to process this application and may be a basis for delaying the application.

Date _____ Applicant's Signature: X _____

Date _____ Spouse's Signature: (if needed) X _____

WE (I, MYSELF AND MY SPOUSE IF APPLICABLE) CERTIFY, BY AFFIXING OUR SIGNATURE(S) ABOVE, THAT, TO THE BEST OF MY KNOWLEDGE AND BELIEF, THE STATEMENTS IN THIS APPLICATION ARE COMPLETE AND TRUE. IT IS UNDERSTOOD THAT, IF ANY OF THE ABOVE STATEMENTS IS A MATERIAL MISREPRESENTATION, COVERAGE COULD BE INVALIDATED AS A RESULT.