Amalgamated Life

CHANGE FORM - TERMINATIONS

Date:_____

Name of Employer/Policy Holder	Policy Number-Division ID

Social Security Number	Name	Termination Date

Please return a copy of this form, retaining the original in your files, by either fax or post office to:

Amalgamated Life Insurance Co.
Policy Services, 1st Floor
333 Westchester Avenue
White Plains, NY 10644

Fax: 1-914-367-4115