NOTICE OF DEATH FORM

Name of Decedent ____________________ Certificate No. (S.S.) ____________

Name of Policyholder ____________________ Policy No. ____________

Date of Death ____________________ Date last worked ____________

Date of Hire ____________________ Years of Service ____________

Record of Beneficiary Enrollment Form is enclosed: Yes ____ No ____

Beneficiary(ies) Name(s)
and Address(es) ________________________________

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Date Reported ____________

Claim was reported by: Phone Call [ ] Other [ ]

Informant's Name, Address & Telephone No. (if available) ____________________

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Insurance in force on date of death: Yes ________ No ________

If "No" state reason: ________________________________

Life Insurance Amount ________ Accidental Death & Dismemberment Amount ________

As soon as the Policyholder receives notice of death, this form should be forwarded to
THE AMALGAMATED LIFE INSURANCE COMPANY, INC.
333 Westchester Avenue, White Plains NY 10604 (Group Insurance Services)

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(Signature of Policyholder or Representative) (Date)