Amalgamated Life Insurance Company
Policy Services Department
333 Westchester Avenue
White Plains, NY 10604
1-914-367-5000

REQUEST FOR CHANGE OF BENEFICIARY / NAME CHANGE / ADDRESS CHANGE

PLEASE TYPE OR PRINT

INSURED'S SOCIAL SECURITY #	POLICYHOLDER'S NAME (EMPLOYER/UNION)	POLICY NO.

Insured's Name	
Street Address	
City, State, Zip	

❑ BENEFICIARY CHANGE

If the beneficiary is a trust, the information provided above should be for the trustee. If you have more than one beneficiary, attach a separate sheet of paper with the name, address, telephone number, date of birth, social security number and relationship (to you) for each beneficiary. Please date and sign.

PRIMARY

Name	Relationship	Address	Social Security #	Telephone
1.				
2.				

CONTINGENT

Name	Relationship	Address	Social Security #	Telephone
1.				
2.				

❑ NAME CHANGE **(Please note: For marriage or divorce you must provide proof of change)**

FROM

TO

❑ ADDRESS CHANGE

Street Address	
City, State, Zip	

NAME OF INSURED: _____
(Please Print)

PRODUCT TYPE: _____
(Group, Individual, Workers Life, Disability, Accident, Critical Illness, Other)

SIGNATURE: _____

DATE: _____

FOR INSURANCE COMPANY'S USE ONLY – ACKNOWLEDGEMENT OF CHANGE

The recording of the change(s) requested above is hereby acknowledged.

Date Recorded	Policy Services Department	Initials