Amalgamated Life
Group • Stop Loss • Voluntary
333 Westchester Avenue • White Plains, NY 10604-2910 • 914-367-5000
Attn: Group Insurance Services

ENROLLMENT FOR LIFE INSURANCE

PLEASE TYPE OR PRINT

POLICYHOLDER'S NAME & ADDRESS	Federal Contract Guards of America (FCGOA) 445 Park Ave, New York, NY 10022	POLICY NUMBER FCGOA

INSURED'S NAME & ADDRESS	(LAST)	(FIRST)	(MIDDLE INITIAL)
STREET			
CITY, STATE, ZIP			

SOCIAL SECURITY NO.		DATE OF BIRTH	(MONTH) (DAY) (YEAR)	SEX q MALE q FEMALE
PLACE OF BIRTH (CITY, STATE)				

OCCUPATION	ANNUAL SALARY	EMPLOYMENT DATE	EFFECTIVE DATE
Security	NA		

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.		

I understand that this coverage shall become effective only if this application is accepted by the Amalgamated Life Insurance Company.

DATE_____, 2_____ SIGNATURE X _____

DATE_____, 2 _____ _____
WITNESS SIGNATURE OTHER THAN BENEFICIARY

NON-PARTICIPATION OPTION

I have been given an opportunity to apply for life insurance offered by Amalgamated Life Insurance Company. I understand this plan has been made possible for me through my Union and I have had its benefits thoroughly explained to me. I choose not to apply at this time, and understand that a later application may require the submission of evidence of insurability. The Insurance Company will have the right to accept or reject my application.

DATE_____, 2_____ SIGNATURE OF INSURED _____