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

PLEASE PRINT

CLAIMANT'S STATEMENT

CLAIM NO.

DECEASED INFORMATION

NAME OF DECEASED		POLICY NUMBER	SOCIAL SECURITY #
MARITAL STATUS ❑ Married ❑ Single ❑ Widowed ❑ Divorced	DATE OF BIRTH (mm/dd/yy)	DATE OF DEATH (mm/dd/yy)	LAST DAY WORKED (mm/dd/yy)
CAUSE OF DEATH		IF ILLNESS, STATE DURATION	

MEDICAL INFORMATIO

NAME OF ATTENDING PHYSICIAN		(AREA CODE) TELEPHONE ( )
ADDRESS	CITY STATE ZIP	

INSURED INFORMATION

NAME OF INSURED	SOCIAL SECURITY #
NAME OF LAST EMPLOYER	(AREA CODE) TELEPHONE ( )
ADDRESS	LAST DAY WORKED FOR THIS EMPLOYER (mm/dd/yy)

BENEFICIARY INFORMATION

NAME OF BENEFICIARY	DATE OF BIRTH (mm/dd/yy)	SOCIAL SECURITY #	RELATIONSHIP TO DECEASED
ADDRESS		CITY STATE ZIP	
PHONE NUMBER (WITH AREA CODE) ( )	RELATIONSHIP TO BENEFICIARY	PRINT NAME	

Authorization to Release Information

NAME OF DECEASED (Please Print Full Name) DATE OF BIRTH (mm/dd/yy)

I AUTHORIZE any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, employer, government agency, or other organization, institution, or person HAVING INFORMATION or records available as to diagnosis, treatment and prognosis of any physical or mental condition or treatment of or afforded to the above-named person TO GIVE TO Amalgamated Life Insurance Company or its authorized representative all such medical information.

I AUTHORIZE any of the above organizations or individuals to permit Amalgamated Life Insurance Company or its authorized representative to view, copy or obtain copies of records concerning the employment and/or wage data of the above-named person.

I AGREE that this Authorization shall be valid for one year from the date of my signature as indicated below.

NEW YORK RESIDENTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE STATED VALUE OF THE CLAIM FOR EACH SUCH VIOLATION. FOR RESIDENTS OF ALL OTHER STATES, PLEASE SEE THE LAST PAGE OF THIS FORM.

_____
SIGNATURE OF CLAIMANT

SEAL OF NOTARY

SWORN TO before me this _____ day of _____, 2_____

_____
SIGNATURE OF NOTARY PUBLIC

COUNTY OF _____ STATE OF _____ MY COMMISSION EXPIRES _____

PLEASE COMPLETE AND SIGN THIS FORM. RETURN FORM AND DEATH CERTIFICATE TO THE ADDRESS ABOVE.