Amalgamated Life
Life • Accident • Disability
333 Westchester Avenue • White Plains, NY 10604-2910 • 914-367-5000

Group Life Claim

AGD-

NOTICE OF DEATH FORM

Name of Decedent _____ Certificate No. (S.S.#) _____

Name of Insured Group **Hollow Metal Trust Fund** Policy No. **260B58**

Date of Death _____ Date Last Worked_____

Date of Hire_____ Years of Service_____

Date of Birth _____

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

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

_____

_____

_____

_____

Date Reported_____

Claim was reported by: Phone Call ( ) Other ( )

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

_____

_____

Insurance in force on date of death: Yes _____ No _____ If "No" state reason:

_____

Life Insurance Amount_____ Accidental Death & Dismemberment_____ Other_____

As soon as the Policyholder receives notice of death, this form should be forwarded to
AMALGAMATED LIFE INSURANCE COMPANY, INC.
Policy Services Dept. **AGD-Claims**
333 Westchester Avenue, White Plains, NY 10604

_____ _____
Print Name Signature of Policyholder or Representative)

_____ _____
Contact Number Date