Amalgamated Life
Group • Stop Loss • Voluntary

amalgamatedbenefits.com

Amalgamated Life Insurance Company
Policy Services Department
333 Westchester Avenue
White Plains, NY 10604
T: 866 975 4089 F: 914 367 4115

Voluntary Benefits Change Form

Please complete the appropriate section(s) and mail or fax to the address or fax number noted above. If you have any questions, please call our Voluntary Service Center at 866-975-4089.

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

FORMER NAME: ______________________________ NEW NAME: ________________________________

REASON FOR CHANGE: ____

☐ ***ADDRESS CHANGE***

NEW RESIDENTIAL ADDRESS: ____

NEW MAILING ADDRESS: ____

☐ ***BENEFICIARY CHANGE***

FORMER BENEFICIARY: _______________________________________ SSN: _______ - _____ - ________

RELATIONSHIP TO INSURED: ____

NEW BENEFICIARY: ____ SSN: _______ - _____ - ________

RELATIONSHIP TO INSURED: _________________________ AGE ________ Date of Birth: _____________

NEW BENEFICIARY ADDRESS: ___________________________________ Telephone Number :__________

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.

☐ ***SOCIAL SECURITY NUMBER CORRECTION*** ***(Requires proof of the corrected SSN)***

OWNER'S NAME: _______________________________ CORRECTED SSN: _______ - _____ - _________

REASON FOR CHANGE: ____

NAME OF INSURED: _______________________________ **PRODUCT TYPE:** _________________________

(Please Print) ***(Disability, Accident, Critical Illness, Workers Life)***

SIGNATURE _____________________________________ **DATE:** ___________________________________

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