



333 Westchester Avenue • White Plains, NY 10604-2910 • 914-367-5000

PLEASE PRINT		CLAIMANT'S STATEMENT		CLAIM NO.
DECEASED INFOR- MATION	NAME OF DECEASED		POLICY NUMBER	SOCIAL SECURITY NUMBER
	MARITAL STATUS ☐ Married ☐ Single ☐ Widowed ☐ Divorced	DATE OF BIRTH (Mo./Day/Yr.)	DATE OF DEATH (Mo./Day/Yr.)	LAST DAY WORKED (Month / Day / Year)
	CAUSE OF DEATH		IF ILLNESS, STATE DURATION	
MEDICAL INFOR- MATION	NAME OF ATTENDING PHYSICIAN			(AREA CODE) TELEPHONE ()
	ADDRESS		CITY	STATE ZIP
INSURED INFOR- MATION	NAME OF INSURED		SOCIAL SECURITY NUMBER	
	NAME OF LAST EMPLOYER		(AREA CODE) TELEPHONE ()	
	ADDRESS		LAST DAY WORKED FOR THIS EMPLOYER (Mo. / Day / Yr.)	
BENE- FICIARY INFOR- MATION	NAME OF BENEFICIARY	DATE OF BIRTH (Mo. / Day / Yr.)	SOCIAL SECURITY NUMBER	RELATIONSHIP TO DECEASED
	ADDRESS		CITY	STATE ZIP
	PHONE NUMBER (WITH AREA CODE) ()			

Authorization to Release Information

NAME OF DECEASED (Please Print Full Name)

DATE OF BIRTH (Mo. / Day / Yr.)

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 The Amalgamated Life Insurance Company or its authorized representative all such medical information.

I AUTHORIZE any of the above organizations or individuals to permit The 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 a photographic copy of this Authorization shall be as valid as the original and 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 AND 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.

SEAL
OF
NOTARY

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

SIGNATURE OF CLAIMANT

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