



REQUEST FOR CONVERSION APPLICATION

PLEASE FURNISH ME WITH INFORMATION (APPLICATION & PREMIUM RATES) REGARDING THE CONVERSION OF MY GROUP LIFE INSURANCE TO AN INDIVIDUAL LIFE POLICY.

THIS FORM MUST BE RETURNED WITHIN 45 DAYS OF THIS NOTICE.

Name (Print in full)		Date of Birth - Month	n Day	Year	Age
Address (Street and No. or R.F.D	., City, State, Zip)				
Social Security No. Gro	up Policy No.	Employer, Fund, or Un	ion Name)	
Are you presently actively at worl	? Yes ()	No ()			
If "No," furnish the exact last day	of work (month, day, y	/ear):			
Reason for stopping work:					
State the amount of insurance to	be converted:				
(Signature of Policyholder or Rep	resentative) (Date)	X (Signature of In	sured)	(Date)
	NON-PARTICIP	ATION OPTION			
I have been offered the right to co	onvert my group life in	surance and I choose no	ot to do so	ο.	
Print Name	Sign Nam	е	Date	9	

As soon as the Policyholder receives a request for conversion of insurance, this form should be forwarded to:

AMALGAMATED LIFE INSURANCE COMPANY, INC.

333 Westchester Ave., White Plains, NY 10604 (Group Insurance Services)