

SERFF Tracking Number: MCHX-G126868655 State: Arkansas  
 Filing Company: Harleysville Life Insurance Company State Tracking Number: 47110  
 Company Tracking Number: IA-006 (Ed. 08-10)  
 TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other  
 Product Name: IA-006 (Ed. 08-10) Individual Life Insurance Appl  
 Project Name/Number: IA-006 (Ed. 08-10) Individual Life Insurance Application - Harleysville Life Insurance Company/IA-006 (Ed. 08-10) Individual Life Insurance Application - Harleysville Life Insurance Company

## Filing at a Glance

Company: Harleysville Life Insurance Company

Product Name: IA-006 (Ed. 08-10) Individual Life Insurance Appl SERFF Tr Num: MCHX-G126868655 State: Arkansas  
 TOI: L08 Life - Other SERFF Status: Closed-Approved-Closed State Tr Num: 47110

Sub-TOI: L08.000 Life - Other Co Tr Num: IA-006 (ED. 08-10) State Status: Approved-Closed  
 Filing Type: Form Reviewer(s): Linda Bird  
 Author: SPI McHughConsulting Disposition Date: 10/26/2010  
 Date Submitted: 10/22/2010 Disposition Status: Approved-Closed

Implementation Date Requested: On Approval Implementation Date:  
 State Filing Description:

## General Information

Project Name: IA-006 (Ed. 08-10) Individual Life Insurance Application - Harleysville Life Insurance Company Status of Filing in Domicile: Pending

Project Number: IA-006 (Ed. 08-10) Individual Life Insurance Application - Harleysville Life Insurance Company Date Approved in Domicile:  
 Requested Filing Mode: Review & Approval Domicile Status Comments:  
 Explanation for Combination/Other: Market Type: Individual  
 Submission Type: New Submission Group Market Size:  
 Overall Rate Impact: Group Market Type:  
 Filing Status Changed: 10/26/2010 Explanation for Other Group Market Type:  
 State Status Changed: 10/26/2010  
 Deemer Date: Created By: SPI McHughConsulting  
 Submitted By: SPI McHughConsulting Corresponding Filing Tracking Number:

Filing Description:  
 Re: HARLEYSVILLE LIFE INSURANCE COMPANY  
 NAIC # 64327, FEIN # 23-1580983

Individual Life Insurance Application Filing  
 Form IA-006 (Ed. 08-10), Application for Individual Life Insurance

SERFF Tracking Number: MCHX-G126868655 State: Arkansas  
Filing Company: Harleysville Life Insurance Company State Tracking Number: 47110  
Company Tracking Number: IA-006 (ED. 08-10)  
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other  
Product Name: IA-006 (Ed. 08-10) Individual Life Insurance Appl  
Project Name/Number: IA-006 (Ed. 08-10) Individual Life Insurance Application - Harleysville Life Insurance Company/IA-006 (Ed. 08-10) Individual Life Insurance Application - Harleysville Life Insurance Company

Form IA-007 (Ed. 08-10), Proposed Other Insured Supplement  
Form IA-008 (Ed. 08-10), Children's Insurance Supplement  
Form IA-009 (Ed. 08-10), Application for Reinstatement  
Form IA-010 (Ed. 08-10), Application for Policy Change  
Form IA-011 (Ed. 08-10), Tobacco Use Application for Policy Change  
Form IA-013 (Ed. 08-10), Payor Benefit Supplement  
Form IQ-001 (Ed. 08-10), Alcohol Use Questionnaire  
Form IQ-002 (Ed. 08-10), Climbing and Mountaineering Questionnaire  
Form IQ-003 (Ed. 08-10), Drug Questionnaire  
Form IQ-004 (Ed. 08-10), Foreign Residence Questionnaire  
Form IQ-005 (Ed. 08-10), Foreign Travel Questionnaire  
Form IQ-006 (Ed. 08-10), Military Status Questionnaire  
Form IQ-007 (Ed. 08-10), Motor Sports Questionnaire  
Form IQ-008 (Ed. 08-10), Occupation Aviation Questionnaire  
Form IQ-009 (Ed. 08-10), Parachuting Questionnaire  
Form IQ-010 (Ed. 08-10), Private Aviation Questionnaire  
Form IQ-011 (Ed. 08-10), Scuba Diving Questionnaire  
Form IQ-012 (Ed. 08-10), Sports Aviation Questionnaire  
Form IQ-013 (Ed. 08-10), Stranger Owned Life Insurance/Life Settlement Questionnaire  
Form IQ-014 (Ed. 08-10), Financial Information Questionnaire  
Form IM-019 (Ed. 08-10), Amendment to the Application  
Form IM-021 (Ed. 08-10), Certificate of Policy Endorsement  
Form IM-028 (Ed. 08-10), Temporary Life Insurance Agreement  
Form IM-030 (Ed. 08-10), Medical Exam Form  
Statement of Variability

Dear Commissioner Bradford:

McHugh Consulting Resources, Inc. has been requested to file the attached forms on behalf of Harleysville Life Insurance Company. We respectfully attach an authorization letter for your files.

We are attaching the above-captioned filing for your review and approval for Harleysville Life Insurance Company. These forms are new and are not intended to your Department. The forms are being submitted in final printed form subject only to changes in font style, margins, page numbers, ink, and paper stock. For example, formatting may change slightly when the document is assembled through an automated document assembly system. Printing standards will never be less than those required by law.

The above forms will be used when applying for Term Life, Whole Life and Universal Life products that have been

SERFF Tracking Number: MCHX-G126868655 State: Arkansas  
Filing Company: Harleysville Life Insurance Company State Tracking Number: 47110  
Company Tracking Number: IA-006 (Ed. 08-10)  
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other  
Product Name: IA-006 (Ed. 08-10) Individual Life Insurance Appl  
Project Name/Number: IA-006 (Ed. 08-10) Individual Life Insurance Application - Harleysville Life Insurance Company/IA-006 (Ed. 08-10) Individual Life Insurance Application - Harleysville Life Insurance Company

previously approved by your Department as listed below and may be used with future products.

" LFCG-027 (Ed. 5-97) approved on August 13, 2001

" IPWL - 200 (Ed. 08-08) approved on December 22, 2008

" IPUL 5 100 (Ed. 08-08) approved on November 18, 2008

" IPUL 6 100 (Ed. 05-09) approved on June 16, 2009

For clarification purposes, Form IA-013 (Ed. 08-10), Payor Benefit Supplement is currently only used with the Whole Life product and Form IA-007 (Ed. 08-10), Proposed Other Insured Supplement is only used with the Term Life and Universal Life products, where applicable.

Currently these application forms will only be used in paper format. If, in the future, Harleysville decides to use them in either an electronic format or telephonic, they will file the procedures and necessary documentation with your Department, if applicable.

Please note this product is currently pending with the Interstate Insurance Product Regulation Commission in which Pennsylvania, Harleysville's state of domicile, has enacted legislation and is a member.

Attached are any required certifications, transmittal forms and/or filing fees.

While every effort is made to submit filings without mistakes, we reserve the right to make corrections to any typographical errors such as misspellings or minor grammatical errors noted after filing and approval.

Harleysville Life Insurance Company will deem these forms approved, if upon the expiration of the initial review period, your Department has not extended the review period or otherwise has not responded to this submission.

We trust the attached is found to be in order and look forward to receiving your favorable reply. Should you have any questions or if we may provide any additional information, please do not hesitate to contact the undersigned. Thank you for your consideration in this matter.

Very truly yours,

Linda Boyce  
Consultant

Attachments

SERFF Tracking Number: MCHX-G126868655 State: Arkansas  
 Filing Company: Harleysville Life Insurance Company State Tracking Number: 47110  
 Company Tracking Number: IA-006 (ED. 08-10)  
 TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other  
 Product Name: IA-006 (Ed. 08-10) Individual Life Insurance Appl  
 Project Name/Number: IA-006 (Ed. 08-10) Individual Life Insurance Application - Harleysville Life Insurance Company/IA-006 (Ed. 08-10) Individual Life Insurance Application - Harleysville Life Insurance Company

## Company and Contact

### Filing Contact Information

Tim Hager, Compliance Project Specialist mcr@mchughconsulting.com  
 McHugh Consulting Resources, Inc. 215-230-7960 [Phone]  
 2005 South Easton Road, Suite 207 215-230-7961 [FAX]  
 Doylestown, PA 18901

### Filing Company Information

(This filing was made by a third party - McHughConsulting)

Harleysville Life Insurance Company	CoCode: 64327	State of Domicile: Pennsylvania
355 Maple Avenue	Group Code: 253	Company Type: Life
Harleysville, PA 19438	Group Name:	State ID Number:
(215) 393-6118 ext. [Phone]	FEIN Number: 23-1580983	

## Filing Fees

Fee Required? Yes  
 Fee Amount: \$1,250.00  
 Retaliatory? No  
 Fee Explanation:  
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Harleysville Life Insurance Company	\$1,250.00	10/22/2010	41051676

SERFF Tracking Number: MCHX-G126868655 State: Arkansas  
Filing Company: Harleysville Life Insurance Company State Tracking Number: 47110  
Company Tracking Number: IA-006 (ED. 08-10)  
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other  
Product Name: IA-006 (Ed. 08-10) Individual Life Insurance Appl  
Project Name/Number: IA-006 (Ed. 08-10) Individual Life Insurance Application - Harleysville Life Insurance Company/IA-006 (Ed. 08-10) Individual Life Insurance Application - Harleysville Life Insurance Company

## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	10/26/2010	10/26/2010

*SERFF Tracking Number:* MCHX-G126868655 *State:* Arkansas  
*Filing Company:* Harleysville Life Insurance Company *State Tracking Number:* 47110  
*Company Tracking Number:* IA-006 (ED. 08-10)  
*TOI:* L08 Life - Other *Sub-TOI:* L08.000 Life - Other  
*Product Name:* IA-006 (Ed. 08-10) Individual Life Insurance Appl  
*Project Name/Number:* IA-006 (Ed. 08-10) Individual Life Insurance Application - Harleysville Life Insurance Company/IA-006 (Ed. 08-10) Individual Life Insurance Application - Harleysville Life Insurance Company

## **Disposition**

Disposition Date: 10/26/2010

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: MCHX-G126868655 State: Arkansas  
 Filing Company: Harleysville Life Insurance Company State Tracking Number: 47110  
 Company Tracking Number: IA-006 (ED. 08-10)  
 TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other  
 Product Name: IA-006 (Ed. 08-10) Individual Life Insurance Appl  
 Project Name/Number: IA-006 (Ed. 08-10) Individual Life Insurance Application - Harleysville Life Insurance Company/IA-006 (Ed. 08-10) Individual Life Insurance Application - Harleysville Life Insurance Company

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		Yes
Supporting Document	Submission Letter		Yes
Supporting Document	Authorization Letter		Yes
Supporting Document	Statement of Variability		Yes
Supporting Document	Guaranty Association Notice		Yes
Supporting Document	Consumer Information Notice		Yes
Form	Application for Individual Life Insurance		Yes
Form	Proposed Other Insured Supplement		Yes
Form	Children's Insurance Supplement		Yes
Form	Application for Reinstatement		Yes
Form	Application for Policy Change		Yes
Form	Tobacco Use Application for Policy Change		Yes
Form	Payor Benefit Supplement		Yes
Form	Alcohol Use Questionnaire		Yes
Form	Climbing and Mountaineering Questionnaire		Yes
Form	Drug Questionnaire		Yes
Form	Foreign Residence Questionnaire		Yes
Form	Foreign Travel Questionnaire		Yes
Form	Military Status Questionnaire		Yes
Form	Motor Sports Questionnaire		Yes
Form	Occupation Aviation Questionnaire		Yes
Form	Parachuting Questionnaire		Yes
Form	Private Aviation Questionnaire		Yes
Form	Scuba Diving Questionnaire		Yes
Form	Sports Aviation Questionnaire		Yes
Form	Stranger Owned Life Insurance/Life Settlement Questionnaire		Yes
Form	Financial Information Questionnaire		Yes
Form	Amendment to the Application		Yes
Form	Certificate of Policy Endorsement		Yes
Form	Temporary Life Insurance Agreement		Yes

SERFF Tracking Number: MCHX-G126868655 State: Arkansas  
Filing Company: Harleysville Life Insurance Company State Tracking Number: 47110  
Company Tracking Number: IA-006 (ED. 08-10)  
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other  
Product Name: IA-006 (Ed. 08-10) Individual Life Insurance Appl  
Project Name/Number: IA-006 (Ed. 08-10) Individual Life Insurance Application - Harleysville Life Insurance Company/IA-006 (Ed. 08-10) Individual Life Insurance Application - Harleysville Life Insurance Company

**Form**

**Medical Exam Form**

**Yes**

SERFF Tracking Number: MCHX-G126868655 State: Arkansas  
 Filing Company: Harleysville Life Insurance Company State Tracking Number: 47110  
 Company Tracking Number: IA-006 (Ed. 08-10)  
 TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other  
 Product Name: IA-006 (Ed. 08-10) Individual Life Insurance Appl  
 Project Name/Number: IA-006 (Ed. 08-10) Individual Life Insurance Application - Harleysville Life Insurance Company/IA-006 (Ed. 08-10) Individual Life Insurance Application - Harleysville Life Insurance Company

## Form Schedule

### Lead Form Number: IA-006 (Ed. 08-10)

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	IA-006 (Ed. 08-10)	Enrollment Form	Application/ Individual Life Insurance	Initial		50.000	IA-006 (Ed_08-10) App for Life Ins-09_30_10.PDF
	IA-007 (Ed. 08-10)	Enrollment Form	Application/ Proposed Other Insured Supplement	Initial		50.000	IA-007 (Ed_08-10) Prop Other Ins Supp-09_30_10.PDF
	IA-008 (Ed. 08-10)	Enrollment Form	Application/ Children's Insurance Supplement	Initial		50.000	IA-008 (Ed_08-10) Child Ins Supp-09_30_10.PDF
	IA-009 (Ed. 08-10)	Enrollment Form	Application/ Application for Reinstatement	Initial		50.000	IA-009 (Ed_08-10) Reinstmt App-09_30_10.PDF
	IA-010 (Ed. 08-10)	Enrollment Form	Application/ Application for Policy Change	Initial		50.000	IA-010 (Ed_08-10) Policy Chge App-09_30_10.PDF
	IA-011 (Ed. 08-10)	Enrollment Form	Application/ Tobacco Use Application for Policy Change	Initial		50.000	IA-011 (Ed_08-10) Tob Pol Chnge App-

SERFF Tracking Number: MCHX-G126868655 State: Arkansas  
 Filing Company: Harleysville Life Insurance Company State Tracking Number: 47110  
 Company Tracking Number: IA-006 (Ed. 08-10)  
 TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other  
 Product Name: IA-006 (Ed. 08-10) Individual Life Insurance Appl  
 Project Name/Number: IA-006 (Ed. 08-10) Individual Life Insurance Application - Harleysville Life Insurance Company/IA-006 (Ed. 08-10) Individual Life Insurance Application - Harleysville Life Insurance Company

Project ID	Description	Initial	Amount	File Name
IA-013 (Ed. 08-10)	Application/ Payor Benefit Enrollment Supplement Form	Initial	50.000	IA-013 (Ed_08-10) Payor Ben Supp-09_30_10.PDF
IQ-001 (Ed. 08-10)	Application/ Alcohol Use Enrollment Questionnaire Form	Initial	50.000	IQ-001 (Ed_08-10) Alcohol Quest-09_30_10.PDF
IQ-002 (Ed. 08-10)	Application/ Climbing and Enrollment Mountaineering Form Questionnaire	Initial	50.000	IQ-002 (Ed_08-10) Climbing-Mount Quest-09_30_10.PDF
IQ-003 (Ed. 08-10)	Application/ Drug Questionnaire Enrollment Form	Initial	50.000	IQ-003 (Ed_08-10) Drug Quest-09_30_10.PDF
IQ-004 (Ed. 08-10)	Application/ Foreign Residence Enrollment Questionnaire Form	Initial	50.000	IQ-004 (Ed_08-10) Foreign Resid Quest-09_30_10.PDF
IQ-005 (Ed. 08-10)	Application/ Foreign Travel Enrollment Questionnaire Form	Initial	50.000	IQ-005 (Ed_08-10) Foreign Travel Quest-09_30_10.PDF
IQ-006 (Ed. 08-10)	Application/ Military Status Enrollment Form	Initial	50.000	IQ-006 (Ed_08-10) Military Status Quest-09_30_10.PDF

<i>SERFF Tracking Number:</i>	<i>MCHX-G126868655</i>	<i>State:</i>	<i>Arkansas</i>	
<i>Filing Company:</i>	<i>Harleysville Life Insurance Company</i>	<i>State Tracking Number:</i>	<i>47110</i>	
<i>Company Tracking Number:</i>	<i>IA-006 (Ed. 08-10)</i>			
<i>TOI:</i>	<i>L08 Life - Other</i>	<i>Sub-TOI:</i>	<i>L08.000 Life - Other</i>	
<i>Product Name:</i>	<i>IA-006 (Ed. 08-10) Individual Life Insurance Appl</i>			
<i>Project Name/Number:</i>	<i>IA-006 (Ed. 08-10) Individual Life Insurance Application - Harleysville Life Insurance Company/IA-006 (Ed. 08-10) Individual Life Insurance Application - Harleysville Life Insurance Company</i>			
08-10)	Enrollment Questionnaire Form		08-10) Military Status Quest-09_30_10.PDF	
08-10)	IQ-007 (Ed. Application/Motor Sports Enrollment Questionnaire Form	Initial	50.000	IQ-007 (Ed_08-10) Motor Sports Quest-09_30_10.PDF
08-10)	IQ-008 (Ed. Application/Occupation Aviation Enrollment Questionnaire Form	Initial	50.000	IQ-008 (Ed_08-10) Occup Aviation Quest-09_30_10.PDF
08-10)	IQ-009 (Ed. Application/Parachuting Enrollment Questionnaire Form	Initial	50.000	IQ-009 (Ed_08-10) Parach Quest-09_30_10.PDF
08-10)	IQ-010 (Ed. Application/Private Aviation Enrollment Questionnaire Form	Initial	50.000	IQ-010 (Ed_08-10) Priv Aviation Quest-09_30_10.PDF
08-10)	IQ-011 (Ed. Application/Scuba Diving Enrollment Questionnaire Form	Initial	50.000	IQ-011 (Ed_08-10) Scuba Div Quest-09_30_10.PDF
08-10)	IQ-012 (Ed. Application/Sports Aviation Enrollment Questionnaire Form	Initial	50.000	IQ-012 (Ed_08-10) Sports Aviation Quest-09_30_10.PDF

SERFF Tracking Number: MCHX-G126868655 State: Arkansas  
 Filing Company: Harleysville Life Insurance Company State Tracking Number: 47110  
 Company Tracking Number: IA-006 (ED. 08-10)  
 TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other  
 Product Name: IA-006 (Ed. 08-10) Individual Life Insurance Appl  
 Project Name/Number: IA-006 (Ed. 08-10) Individual Life Insurance Application - Harleysville Life Insurance Company/IA-006 (Ed. 08-10) Individual Life Insurance Application - Harleysville Life Insurance Company

IQ-013 (Ed. Application/ Stranger Owned Life Initial 08-10) Enrollment Insurance/Life Form Settlement Questionnaire	50.000	IQ-013 (Ed_ 08-10) STOLI Quest- 09_30_10.PD F
IQ-014 (Ed. Application/ Financial Information Initial 08-10) Enrollment Questionnaire Form	50.000	IQ-014 (Ed_ 08-10) Financial Info Quest- 09_30_10.PD F
IM-019 (Ed. Application/ Amendment to the Initial 08-10) Enrollment Application Form	50.000	IM-019 (Ed_ 08-10) Amend of App- 09_30_10.PD F
IM-021 (Ed. Application/ Certificate of Policy Initial 08-10) Enrollment Endorsement Form	50.000	IM-021 (Ed_ 08-10) Cert of Pol Endors- 09_30_10.PD F
IM-028 (Ed. Application/ Temporary Life Initial 08-10) Enrollment Insurance Agreement Form	50.000	IM-028 (Ed_ 08-10) Temp Ins Agree- 09_30_10.PD F
IM-030 (Ed. Application/ Medical Exam Form Initial 08-10) Enrollment Form	50.000	IM-030 (Ed_ 08-10) Med Ex Form- 09_30_10.PD F



Corporate Address:  
**Harleysville Life Insurance Company**  
 [355 Maple Avenue, Harleysville, PA 19438  
 Tel 800.222.1981 www.harleysvillegroup.com]

Please mail forms to the  
 Administrative Address:  
**Harleysville Life Insurance Company**  
 [P.O. Box 253, Harleysville, PA 19438-0253]

**Part I APPLICATION FOR INDIVIDUAL LIFE INSURANCE**

**Section I Proposed Primary Insured**

1. Full Name:

_____	_____	_____	_____ / _____	_____	_____
Last	First	M.I.	Birth Date / Birth State	Sex	Marital Status
Former name if changed in the last 5 years: _____					
_____	_____	_____	_____	_____	_____
Last	First	M.I.	Social Security Number	Driver's License #/State	
Residence: _____					
_____			_____	_____	
Street and Number or Rural Route			Telephone #	Cell Phone #	
_____	_____	_____	_____		
City	State	Zip Code	Email Address		

2. Occupation: \_\_\_\_\_  
 Work Phone Number: \_\_\_\_\_  
 Employer: \_\_\_\_\_  
 Type of Business: \_\_\_\_\_  
 Annual Income: \$ \_\_\_\_\_  
 Total Net Worth: \$ \_\_\_\_\_

3. U. S. Citizen  Yes  No  
 If No, Date of Entry to U.S. \_\_\_\_\_  
 Visa Type \_\_\_\_\_  
 Country of Citizenship \_\_\_\_\_

4. Have you ever used tobacco or nicotine products in any form?  Yes  No

If Yes, please provide details:

Product	Date Last Used (month/year)	Amount/Frequency
Cigarettes	_____	_____
Cigar/Pipe	_____	_____
Chewing Tobacco	_____	_____
Other: _____	_____	_____

**Section II Beneficiary Information**

1. (Name and Relationship, % share of proceeds, age if minor, SS # and/or Date of Birth)

Primary: \_\_\_\_\_ Contingent: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Section III Owner Information (Owner is Proposed Primary Insured, if not otherwise stated.)**

1. Name of Owner: \_\_\_\_\_  
 Owner's Social Security Number or Tax ID # : \_\_\_\_\_  Proposed Primary Insured becomes Owner at age 21. (check if applicable)  
 Owner's Address: \_\_\_\_\_  
 \_\_\_\_\_  
 Street and Number or Rural Route  
 \_\_\_\_\_  
 City State Zip Code

2. Trust Information (Please complete if policy owner is a trust.)  
 Name of Trust: \_\_\_\_\_ Name of Trustee: \_\_\_\_\_  
 Date of Trust: \_\_\_\_\_ Trust Identification Number: \_\_\_\_\_

**Section IV Payment**

1. Payor (If other than the Proposed Primary Insured) \_\_\_\_\_

2. Billing Address:  Residence  Business  Owner  
 \_\_\_\_\_  
 Street and Number or Rural Route City State Zip Code

3. Premiums are to be Paid (choose one) Planned Premium \$ \_\_\_\_\_  
 Annually  Semi-Annually  Quarterly  Single Premium (UL and WL only)  9-Pay (Term only)  
 PAC \* [ Credit Card- except for first premium payment]

\* Pre-Authorized Check; also requires completed PAC form, void check and 2 months premium.

**Section V Plan of Insurance**

1. What plan are you applying for?  Term  Universal Life  Whole Life (If applying for more than one, check all that apply) Complete the section(s) below for each plan(s) that you are applying for.

**a) Term Life**

Level Term: Length of Term  10  15  20  30

Amount of Insurance: \_\_\_\_\_ (Please complete the Financial Information Questionnaire if amount

Riders: (choose all that are applicable) \_\_\_\_\_ is over \$1,500,001 or more)

Children's Benefit, Amount \$ \_\_\_\_\_ ]

Other Insured[\*], Amount \$ \_\_\_\_\_ (Please complete the Proposed Other Insured Supplement) ]

Waiver of Premium]

[\* N/A in New Jersey]

**b) Whole Life**

Amount of Insurance: \_\_\_\_\_ (Please complete the Financial Information Questionnaire if amount

Riders: (choose all that are applicable) \_\_\_\_\_ is \$1,500,001 or more)

Accidental Death Benefit, Amount \$ \_\_\_\_\_ ]

Automatic Premium Loan]

Children's Benefit, Amount \$ \_\_\_\_\_ ]

Guaranteed Insurability Benefit, Amount \$ \_\_\_\_\_ ]

Payor Benefit (Please complete Payor Benefit Supplement)]

Waiver of Premium]

**c) Universal Life**

Plan of Insurance: \_\_\_\_\_

Amount of Insurance \_\_\_\_\_ (Please complete the Financial Information Questionnaire if amount

**Death Benefit Option** (choose one) \_\_\_\_\_ is \$1,500,001 or more)

Option 1: Death Benefit equals Specified Amount

Option 2: Death Benefit equals Specified Amount + Cash Value

**No-Lapse Guarantee Minimum Premium Option** (choose one)

10 Years

20 Years

30 yr NLG]

NLG to 100]

Maturity

Other: \_\_\_\_\_ ]

**Riders:** (choose all that are applicable)

Accidental Death Benefit, Amount \$ \_\_\_\_\_ ]

Children's Term Insurance, Amount \$ \_\_\_\_\_ ]

Other Insured, Amount \$ \_\_\_\_\_  All Years  Number of Years \_\_\_\_\_ (Please complete Proposed Other

[ Accidental Death Benefit - Other Insured, Amount \$ \_\_\_\_\_ Insured Supplement)]

[ Primary Insured, Amount \$ \_\_\_\_\_  All Years  Number of Years \_\_\_\_\_ ]

Scheduled Increase Option, Amount \$ \_\_\_\_\_ ]

Total Disability Premium Payment]

Waiver of Monthly Deductions (not available if Total Disability Premium Rider selected)]

Other \_\_\_\_\_ ]

**Section VI Pending Life Applications**

1. Have you applied for or do you have any other applications or informal inquiries for life insurance pending with any other companies?  Yes  No If Yes, please provide details:

**Name of Company**

**Amount of Coverage**

**Purpose**

\_\_\_\_\_

Which pending applications do you intend to accept? \_\_\_\_\_

2. Have you ever had an application or reinstatement request for life, health or disability insurance declined, postponed, limited, withdrawn or cancelled, or have you been asked to pay a higher premium?  Yes  No

If Yes, please provide details: \_\_\_\_\_

3. Do you intend to sell or permanently assign the policy to another person, entity, life settlement provider or investor, or will it replace a policy that has already been sold to another life settlement company or investor?  Yes  No

If Yes, please complete and submit a **Stranger Owned Life Insurance/Life Settlement Questionnaire**.

**Section VII Other Insurance In Force**

1. Do you have existing life insurance policies or annuity contracts?  Yes  No

Is the insurance applied for intended to replace any life insurance policies or annuity contracts?

If Yes, Please complete the following:

COMPANY	AMOUNT	YEAR ISSUED	PURPOSE
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Yes  No  
 Yes  No  
 Yes  No

2. Harleysville Life Policy to be converted:

Existing policy # \_\_\_\_\_ Conversion Amount  Full  Partial \$ \_\_\_\_\_

If partial conversion, status of remaining coverage  
 Retain: Amount: \$ \_\_\_\_\_  
 Terminate Balance of Term Coverage

**Section VIII General Information**

1. In the past/next 2 years have you or do you intend to travel to a foreign country? <b>If Yes, complete Foreign Travel Questionnaire</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. In the past/next 2 years, have you or do you have plans to reside in a foreign country for 90 days or longer? <b>If Yes, Please complete Foreign Residence Questionnaire</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. In the past/next 2 years have you engaged in or do you intend to engage in any of the following: (check all that apply) ___ skin/scuba diving ___ mountain, ice or rock climbing ___ aviation sports ___ parachuting ___ motor sports <b>If Yes, Please complete the appropriate questionnaire(s)</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. In the past 5 years have you flown or do you intend to fly within the next 2 years as a pilot, copilot or crew member for other than a scheduled commercial airline, or do you hold a current pilot's license? <b>If Yes, Please complete an appropriate Aviation Questionnaire</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. In the past 5 years have you pled guilty to or been convicted of driving while impaired or under the influence of drugs or alcohol? <b>If Yes, complete the appropriate Alcohol or Drug Questionnaire</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. In the past 7 years, have you filed for bankruptcy? <b>If Yes, please provide details including chapter filed, date, reason and if discharged</b> _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. Have you been placed on current active status in the Armed Forces, or entered into a written agreement to have active status in the near future? <b>If Yes, complete the Military Status Questionnaire</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
8. In the past 5 years have you pled guilty to or been convicted of any moving violations, or had your license suspended or revoked? <b>If Yes, please provide details:</b> _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
9. Have you ever been convicted of, or are you currently charged with, a felony or misdemeanor, or are you currently on probation or parole? <b>If Yes, please provide details:</b> _____	<input type="checkbox"/> Yes <input type="checkbox"/> No

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

New Jersey: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

**APPLICANT'S STATEMENT**

I (We) have read the preceding questions and answers, and hereby represent to the best of my (our) knowledge and belief that the statements and answers are complete and true, and that Harleysville Life Insurance Company may rely on the answers in the issuance of a policy. I (We) understand and agree that this application and other required parts will be the basis for, and an integral part of, any policy issued; that no waiver or modification will bind the Company unless in writing and signed by the President, a Vice President or the Secretary of Harleysville Life Insurance Company. I (We) understand and agree that a sales representative does not have the company's authorization to accept risk, pass on insurability, or make, void, waive, or change any conditions or provisions of the application, policy or receipt. I (We) further understand and agree that **no insurance will take effect until the policy has been manually delivered to and received and accepted by me (us), and the full first premium is paid during the lifetime of each person on whom insurance is requested and while the proposed insured is alive.**

**AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION**

I (We) authorize any licensed physician, medical practitioner, hospital, clinic, dispensary, sanitarium, or other medically related facility, governmental motor vehicle agencies, insurance companies, the Veteran's Administration, Medical Information Bureau (MIB, Inc.), [pharmaceutical data bases], consumer reporting agency or employer to release to the Harleysville Life Insurance Company and its reinsurers any of the following pertaining to me (us) or my children if they are to be insured: information relating to physical and mental condition; medical care, diagnosis or treatment; and avocation, insurance, aviation activity, criminal activity, financial information, occupation, habits, driving record and general character. This information will be used by Harleysville Life Insurance Company and its reinsurers to determine eligibility for insurance. In addition to this Authorization, and to facilitate rapid transmission of information to an appropriate Harleysville representative(s), I (We) will execute Authorizations for Release of Medical Records for any sources requiring an authorization.

I (We) understand that Harleysville Life Insurance Company will not disclose this information to any person or organization except its reinsurer(s); the Medical Information Bureau (MIB, Inc.); other persons or organizations performing business or legal services in connection with my/our application, including employees of Harleysville Insurance, or as may be otherwise lawfully required, or as I (We) further authorize.

I (We) authorize;  I (We) do not authorize: Harleysville Life Insurance Company to disclose, at its discretion, information obtained during the application/underwriting process to my/our agent of record or representative of agent of record.

I (We) understand that I (we) or my (our) authorized representative have the right to receive a copy of this authorization and agree that a photographic copy will be as valid as the original. I (We) also understand that this authorization will be valid for 24 months from the date shown below.

I (We) certify that the Social Security Number(s) provided above is/are true, correct and complete.

I (We) acknowledge receiving the Notice of Information Practices and authorize Harleysville Life Insurance Company to obtain an investigative or other consumer report as described, and

I (We) request;  I (We) do not request, a personal interview in connection with such report.

I (We) understand and acknowledge that this application and all supplementary documentation, in the aggregate, constitute the entire application, including all information provided in the application, the medical exam, questionnaires and supplements to the application, and amendments issued by Harleysville Life Insurance Company, and that they will be attached to and made a part of the policy and delivered to the policy owner.

I (We) have paid \$\_\_\_\_\_ with this application in consideration of the [Temporary Insurance Agreement]. I (We) have read, understood, and agreed to the terms of the [Temporary Insurance Agreement].

SIGNED AT: \_\_\_\_\_  
**City and State**

P \_\_\_\_\_  
**Signature of Insured**

DATED ON: \_\_\_\_\_  
**Month/Day/Year**

Ü \_\_\_\_\_  
**Signature of Parent or Legal Guardian**  
 (If Insured is under the age of majority required by the state where the policy is issued for delivery)

P \_\_\_\_\_  
**Signature of Owner** (if other than Insured)

P \_\_\_\_\_  
**Signature of Applicant** (if other than Insured)

**AGENT CERTIFICATION**

I certify that I personally completed this application in the company of all proposed insureds.  Yes  No  
 I certify that I have no knowledge of anything which might affect the insurability of any person proposed for insurance which is not fully set forth herein.  Yes  No

Does the proposed insured have existing life insurance policies or annuity contracts?  Yes  No  
 Is this insurance applied for intended to replace any existing life insurance policies or annuity contracts?  Yes  No  
 If either question is answered Yes, please complete a replacement form as prescribed by your state's regulations.  
 Is this a 1035 Exchange?  Yes  No      Is this an internal term conversion?  Yes  No

Signed at: \_\_\_\_\_

P \_\_\_\_\_  
**Signature of Licensed Agent**

Dated on: \_\_\_\_\_

\_\_\_\_\_  
**Print Name of Licensed Agent**



Corporate Address:  
**Harleysville Life Insurance Company**  
 [355 Maple Avenue, Harleysville, PA 19438  
 Tel 800.222.1981 www.harleysvillegroup.com]

Please mail forms to the  
 Administrative Address:  
**Harleysville Life Insurance Company**  
 [P.O. Box 253, Harleysville, PA 19438-0253]

## Part II Medical Information

1. Name of Proposed Insured \_\_\_\_\_ Date of Birth \_\_\_\_\_  
 Height \_\_\_\_\_ Weight \_\_\_\_\_ Weight change ( > 10 lbs) in last 12 months \_\_\_\_\_ Reason for weight change \_\_\_\_\_  
 Personal Primary Physician: Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 \_\_\_\_\_  
 Telephone Number: \_\_\_\_\_

**2. To the best of your knowledge and belief, has a parent or sibling died of coronary artery disease, cerebrovascular disease, diabetes mellitus, or cancer?**

Relationship	Age at Death	Cause of Death
Father		
Mother		
Brothers and Sisters		

**3. Have you ever been diagnosed with, been treated for or consulted a physician for:  
 (If Yes, please provide full details)**

a. depression, anxiety, psychosis, anorexia, bulimia, or other mental, nervous or emotional disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No
b. seizures, tremors, headaches, paralysis, stroke, transient ischemic attack, multiple sclerosis, Parkinson's, Alzheimer's, or other disorder of the brain, spinal cord, nerves or muscles?	<input type="checkbox"/> Yes <input type="checkbox"/> No
c. cancer, tumor, or any other malignant disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No
d. diabetes or elevated blood sugar, or any other disorder of the thyroid, pituitary, endocrine glands?	<input type="checkbox"/> Yes <input type="checkbox"/> No
e. chest pain, angina, high blood pressure, high cholesterol/triglycerides, palpitations, irregular heartbeat, heart murmur, heart attack, peripheral vascular disease, phlebitis or any other disorder of the heart or blood vessels?	<input type="checkbox"/> Yes <input type="checkbox"/> No
f. anemia, blood clots, leukemia, lymphoma, immune deficiency or any other disorder of the blood, lymph glands or immune system (excluding HIV or AIDS)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
g. hepatitis, ulcer, acid reflux, colitis, or any other disorder of the stomach, liver, intestines, colon, rectum, pancreas, spleen, gallbladder, esophagus?	<input type="checkbox"/> Yes <input type="checkbox"/> No
h. asthma, bronchitis, emphysema, chronic obstructive lung/pulmonary disease, shortness of breath, persistent cough or hoarseness, sarcoidosis, tuberculosis, sleep apnea or any other disorder of the respiratory system?	<input type="checkbox"/> Yes <input type="checkbox"/> No
i. albumin, blood, protein in the urine or any other disorder of the kidney or bladder?	<input type="checkbox"/> Yes <input type="checkbox"/> No
j. sexually transmitted disease or any other disorder of the uterus, cervix, ovaries, breast, prostate or reproductive system?	<input type="checkbox"/> Yes <input type="checkbox"/> No
k. arthritis or any other disorder of the bones, joints or muscles?	<input type="checkbox"/> Yes <input type="checkbox"/> No
l. any disorder of the eyes, ears, nose, throat?	<input type="checkbox"/> Yes <input type="checkbox"/> No
m. any disease or disorder other than what is mentioned above?	<input type="checkbox"/> Yes <input type="checkbox"/> No



Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

New Jersey: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

### APPLICANT'S STATEMENT

I (We) have read the preceding questions and answers, and hereby represent to the best of my (our) knowledge and belief that the statements and answers are complete and true, and that Harleysville Life Insurance Company may rely on the answers in the issuance of a policy. I (We) understand and agree that this application and other required parts will be the basis for, and an integral part of, any policy issued; that no waiver or modification will bind the Company unless in writing and signed by the President, a Vice President or the Secretary of Harleysville Life Insurance Company. I (We) understand and agree that a sales representative does not have the company's authorization to accept risk, pass on insurability, or make, void, waive, or change any conditions or provisions of the application, policy or receipt. I (We) further understand and agree that **no insurance will take effect until the policy has been manually delivered to and received and accepted by me (us), and the full first premium is paid during the lifetime of each person on whom insurance is requested and while the proposed insured is alive.**

### AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

I (We) authorize any licensed physician, medical practitioner, hospital, clinic, dispensary, sanitarium, or other medically related facility, governmental motor vehicle agencies, insurance companies, the Veteran's Administration, Medical Information Bureau (MIB, Inc.), [pharmaceutical data bases], consumer reporting agency or employer to release to the Harleysville Life Insurance Company and its reinsurers any of the following pertaining to me (us) or my children if they are to be insured: information relating to physical and mental condition; medical care, diagnosis or treatment; and avocation, insurance, aviation activity, criminal activity, financial information, occupation, habits, driving record and general character. This information will be used by Harleysville Life Insurance Company and its reinsurers to determine eligibility for insurance. In addition to this Authorization, and to facilitate rapid transmission of information to an appropriate Harleysville representative(s), I (We) will execute Authorizations for Release of Medical Records for any sources requiring an authorization.

I (We) understand that Harleysville Life Insurance Company will not disclose this information to any person or organization except its reinsurer(s); the Medical Information Bureau (MIB, Inc.); other persons or organizations performing business or legal services in connection with my/our application, including employees of Harleysville Insurance, or as may be otherwise lawfully required, or as I (We) further authorize.

I (We) authorize;  I (We) do not authorize: Harleysville Life Insurance Company to disclose, at its discretion, information obtained during the application/underwriting process to my/our agent of record or representative of agent of record.

I (We) understand that I (we) or my (our) authorized representative have the right to receive a copy of this authorization and agree that a photographic copy will be as valid as the original. I (We) also understand that this authorization will be valid for 24 months from the date shown below.

I (We) certify that the Social Security Number(s) provided above is/are true, correct and complete.

I (We) acknowledge receiving the Notice of Information Practices and authorize Harleysville Life Insurance Company to obtain an investigative or other consumer report as described, and

I (We) request;  I (We) do not request, a personal interview in connection with such report.

I (We) understand and acknowledge that this application and all supplementary documentation, in the aggregate, constitute the entire application, including all information provided in the application, the medical exam, questionnaires and supplements to the application, and amendments issued by Harleysville Life Insurance Company, and that they will be attached to and made a part of the policy and delivered to the policy owner.

I (We) have paid \$\_\_\_\_\_ with this application in consideration of the [Temporary Insurance Agreement]. I (We) have read, understood, and agreed to the terms of the [Temporary Insurance Agreement].

SIGNED AT: \_\_\_\_\_  
City and State

DATED ON: \_\_\_\_\_  
Month/Day/Year

P \_\_\_\_\_  
Signature of Owner (if other than Insured)

P \_\_\_\_\_  
Signature of Insured

Ü \_\_\_\_\_  
Signature of Parent or Legal Guardian  
(If Insured is under the age of majority required by the state where the policy is issued for delivery)

P \_\_\_\_\_  
Signature of Applicant (if other than Insured)

**AGENT CERTIFICATION**

I certify that I personally completed this application in the company of all proposed insureds.  Yes  No  
I certify that I have no knowledge of anything which might affect the insurability of any person proposed for insurance which is not fully set forth herein.  Yes  No

Signed at: \_\_\_\_\_

P

\_\_\_\_\_  
**Signature of Licensed Agent**

Dated on:

\_\_\_\_\_  
**Print Name of Licensed Agent**

**Section I Proposed Other Insured**

1. Relationship to Proposed Insured: \_\_\_\_\_

Full Name: \_\_\_\_\_

\_\_\_\_\_/\_\_\_\_\_  
 Last First M.I. Birth Date Birth State Sex Marital Status

Former name if changed in the last 5 years: \_\_\_\_\_

\_\_\_\_\_  
 Last First M.I. Social Security Number Driver's License#/State

Residence:  Same as Primary Insured

\_\_\_\_\_  
 Street and Number or Rural Route Telephone # Cell Phone #

\_\_\_\_\_  
 City State Zip Code Email Address

2. Occupation: \_\_\_\_\_

Work Phone Number: \_\_\_\_\_

Employer: \_\_\_\_\_

Type of Business: \_\_\_\_\_

Annual Income: \$ \_\_\_\_\_

Net Worth \$ \_\_\_\_\_

3. U. S. Citizen  Yes  No  
 If No, Date of Entry to U.S. \_\_\_\_\_  
 Visa Type \_\_\_\_\_  
 Country of Citizenship \_\_\_\_\_

4. Have you ever used tobacco or nicotine products in any form?  Yes  No

If Yes, please provide details:

Product	Date last used (month/year)	Amount/Frequency
Cigarettes	_____	_____
Cigars/Pipe	_____	_____
Chewing Tobacco	_____	_____
Other: _____	_____	_____

**Section II Beneficiary Information**

1. (Name and Relationship, % share of proceeds, age if minor, SS # and/or Date of Birth)

Primary: \_\_\_\_\_ Contingent: \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_

**Section III Other Insurance In Force**

1. Have you applied for or do you have any other applications or informal inquiry for life insurance pending with any other companies?  Yes  No If Yes, please provide details:

Name of Company	Amount of Coverage	Purpose
_____	_____	_____
_____	_____	_____

Which pending applications do you intend to accept? \_\_\_\_\_

2. Have you ever had an application or reinstatement request for life, health or disability insurance declined, postponed, limited, withdrawn or cancelled, or have you been asked to pay a higher premium?  Yes  No

If Yes, please provide details \_\_\_\_\_

3. Do you have existing life insurance policies or annuity contracts?  Yes  No

If Yes, please complete the following:

Is the insurance applied for intended to replace any life Insurance policies or annuity contracts?

COMPANY	AMOUNT	POLICY #	YEAR ISSUED	PURPOSE	
_____	_____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No

4. Do you intend to sell or permanently assign the policy to another person, entity, life settlement provider or investor, or will it replace a policy that has already been sold to another life settlement company or investor?  Yes  No

If Yes, please complete and submit a **Stranger Owned Life Insurance/Life Settlement Questionnaire**.

<b>Section IV General Information</b>	
1. In the past/next 2 years have you or do you intend to travel to a foreign country? <b>If Yes, complete Foreign Travel Questionnaire</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. In the past/next 2 years, have you or do you have plans to reside in a foreign country for 90 days or longer? <b>If Yes, Please complete Foreign Residence Questionnaire</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. In the past/next 2 years have you engaged in or do you intend to engage in any of the following: (check all that apply) ___ skin/scuba diving ___ mountain, ice or rock climbing ___ aviation sports ___ parachuting ___ motor sports <b>If Yes, Please complete the appropriate questionnaire</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. In the past 5 years have you flown or do you intend to fly within the next 2 years as a pilot, copilot or crew member for other than a scheduled commercial airline, or do you hold a current pilot's license? <b>If Yes, Please complete an appropriate Aviation Questionnaire</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. In the past 5 years have you pled guilty to or been convicted of driving while impaired or under the influence of drugs or alcohol? <b>If Yes, complete the appropriate Alcohol or Drug Questionnaire</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. In the past 7 years, have you filed for bankruptcy? <b>If Yes, please provide details including chapter filed, date, reason and if discharged</b> _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. Have you been placed on current active status in the Armed Forces, or entered into a written agreement to have active status in the near future? <b>If Yes, complete the Military Status Questionnaire</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
8. In the past 5 years have you pled guilty to or been convicted of any moving violations, or had your license suspended or revoked? <b>If Yes, please provide details:</b> _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
9. Have you ever been convicted of, or currently charged with, a felony or misdemeanor, or are you currently on probation or parole? <b>If Yes, please provide details:</b> _____	<input type="checkbox"/> Yes <input type="checkbox"/> No

<b>Section V Medical Information</b>
1. Name of Proposed Other Insured _____ Date of Birth _____ Height _____ Weight _____ Weight change (> 10 lbs) in last 12 months _____ Reason for weight change _____ Personal Primary Physician: Name: _____ Address: _____ Telephone Number: _____

<b>2. To the best of your knowledge and belief, has a parent or sibling died of coronary artery disease, cerebrovascular disease, diabetes, mellitus or cancer?</b>		
Relationship	Age at Death	Cause of Death
Father		
Mother		
Brothers and Sisters		

<b>3. Have you ever been diagnosed with, been treated for, or consulted a physician for: (If Yes, please provide full details)</b>	
a. depression, anxiety, psychosis, anorexia, bulimia, or other mental, nervous or emotional disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No
b. seizures, tremors, headaches, paralysis, stroke, transient ischemic attack, multiple sclerosis, Parkinson's, Alzheimer's, or other disorder of the brain, spinal cord, nerves or muscles?	<input type="checkbox"/> Yes <input type="checkbox"/> No
c. cancer, tumor, or any other malignant disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No
d. diabetes or elevated blood sugar, or any other disorder of the thyroid, pituitary, endocrine glands?	<input type="checkbox"/> Yes <input type="checkbox"/> No
e. chest pain, angina, high blood pressure, high cholesterol/triglycerides, palpitations, irregular heartbeat, heart murmur, heart attack, peripheral vascular disease, phlebitis or any other disorder of the heart or blood vessels?	<input type="checkbox"/> Yes <input type="checkbox"/> No

f. anemia, blood clots, leukemia, lymphoma, immune deficiency or any other disorder of the blood, lymph glands or immune system (excluding HIV or AIDS)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
g. hepatitis, ulcer, acid reflux, colitis, or any other disorder of the stomach, liver, intestines, colon, rectum, pancreas, spleen, gallbladder, esophagus?	<input type="checkbox"/> Yes <input type="checkbox"/> No
h. asthma, bronchitis, emphysema, chronic obstructive lung/pulmonary disease, shortness of breath, persistent cough or hoarseness, sarcoidosis, tuberculosis, sleep apnea or any other disorder of the respiratory system?	<input type="checkbox"/> Yes <input type="checkbox"/> No
i. albumin, blood, protein in the urine or any other disorder of the kidney or bladder?	<input type="checkbox"/> Yes <input type="checkbox"/> No
j. sexually transmitted disease or any other disorder of the uterus, cervix, ovaries, breast, prostate or reproductive system?	<input type="checkbox"/> Yes <input type="checkbox"/> No
k. arthritis or any other disorder of the bones, joints or muscles?	<input type="checkbox"/> Yes <input type="checkbox"/> No
l. any disorder of the eyes, ears, nose or throat?	<input type="checkbox"/> Yes <input type="checkbox"/> No
m. any disease or disorder other than what is mentioned above?	<input type="checkbox"/> Yes <input type="checkbox"/> No

<b>4. In the past 5 years have you:</b>	
a. had a complete physical exam, or checkup, electrocardiogram, x-ray, blood test, or other diagnostic test (excluding an HIV or AIDS test)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
b. been treated, examined or consulted a physician for a condition other than what has already been provided?	<input type="checkbox"/> Yes <input type="checkbox"/> No
c. been advised by a medical professional to have hospitalization, surgery, biopsy, medical treatment or any other diagnostic test (excluding an HIV or AIDS test), which has not been completed?	<input type="checkbox"/> Yes <input type="checkbox"/> No
d. taken or been advised by a medical professional to take a prescription medication, or any herbal or non prescription medication?	<input type="checkbox"/> Yes <input type="checkbox"/> No
e. lost time from work, school, received disability benefits, been unable to perform routine activities of daily living, or confined to a home?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Have you had a member of the medical profession diagnose or prescribe treatment for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) or advise that you tested Human Immunodeficiency Virus (HIV) positive?	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Have you ever been advised by a medical professional to reduce or discontinue the use of alcohol, joined an organization or received medical treatment or counseling for the use of alcohol? <b>If Yes, complete an Alcohol Questionnaire</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. Have you ever used barbiturates, amphetamines, cocaine, marijuana or other illegal or controlled substances, except as prescribed by a physician, or joined an organization or received medical treatment or counseling for the use of drugs? <b>If Yes, complete a Drug Questionnaire</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
8. Have you ever been advised by a medical professional to reduce or discontinue the use of, or been addicted to, prescription medication? <b>If Yes, complete a Drug Questionnaire</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No

**Details to any above questions answered Yes.**

Question #	Date(s)	Physician(s)	Details

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

New Jersey: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

**APPLICANT’S STATEMENT**

I (We) have read the preceding questions and answers, and hereby represent that to the best of my (our) knowledge and belief, that the statements and answers are complete and true, and that Harleysville Life Insurance the Company may rely on the answers in the issuance of a policy. I (We) understand and agree that this application and other required parts will be the basis for, and an integral part of, any policy issued; that no waiver or modification will bind the Company unless in writing and signed by the President, or a Vice President or the Secretary of Harleysville Life Insurance Company. I (We) understand and agree that a sales representative does not have the company’s authorization to accept risk, pass on insurability, or make, void, waive, or change any conditions or provisions of the application, policy or receipt. I (We) further understand and agree; and that **no insurance will take effect unless and until the policy has been manually delivered to and received and accepted by me (us), and the full first premium is paid during the lifetime and of each person on whom insurance is requested and while the proposed other insured is alive.**

**AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION**

I (We) authorize any licensed physician, medical practitioner, hospital, clinic, dispensary, sanitarium, or other medically related facility, governmental motor vehicle agencies, insurance companies, the Veteran’s Administration, or Medical Information Bureau (MIB, Inc.), [pharmaceutical data bases], consumer reporting agency or employer to release to the Harleysville Life Insurance Company and its reinsurers any of the following pertaining to me (us) or my children if they are to be insured: information relating to physical and mental condition; medical care, diagnosis or treatment; and avocation, insurance, aviation activity, criminal activity, financial information, occupation, habits, driving record and general character. This information will be used by Harleysville Life Insurance Company and its reinsurers to determine eligibility for insurance. In addition to this Authorization, and to facilitate rapid transmission of such information to an appropriate Harleysville representative(s), I (We) will execute the required Authorizations for Release of Medical Records for any such sources requiring an authorization., except Medical Information Bureau (MIB, Inc.), to provide such records of information to any appropriate Harleysville representative(s).

I (We) understand that Harleysville Life Insurance Company will not disclose this information to any person or organization except its reinsurer(s); the Medical Information Bureau (MIB, Inc.); other life insurance companies with which I have policies or to whom I may apply, or to whom a claim for benefits may be submitted; other persons or organizations performing business or legal services in connection with my/our application, including employees of Harleysville Insurance, or as may be otherwise lawfully required, or as I (We) further authorize.

I (We) authorize;  I (We) do not authorize: Harleysville Life Insurance Company to disclose, at its discretion, information obtained during the application/underwriting process to my/our agent of record or representative of agent of record.

I (We) understand that I (we) or my (our) authorized representative have the right to receive a copy of this authorization and agree that a photographic copy will be as valid as the original. I (We) also understand that this authorization will be valid for 24 months from the date shown below.

I (We) certify that the Social Security Number(s) provided above is/are true, correct and complete.

I (We) acknowledge receiving the Notice of Information Practices and authorize Harleysville Life Insurance Company to obtain an investigative or other consumer report as described, and

I (We) request;  
 I (We) do not request, a personal interview in connection with such report.

I (We) understand and acknowledge that this application, and all supplementary documentation, in the aggregate, constitute the entire application, including all information provided in the application, the medical exam, questionnaires and supplements to the application, and amendments issued by the Harleysville Life Insurance Company, and that they will be attached to and made a part of the policy and delivered to the policy owner.

I (We) have paid \$\_\_\_\_\_ with this application in consideration of the [Temporary Insurance Agreement].  
I (We) have read, understood, and agreed to the terms of the [Temporary Insurance Agreement].

SIGNED AT: \_\_\_\_\_  
City and State

P \_\_\_\_\_  
Signature of Insured

DATED ON: \_\_\_\_\_  
Month/Day/Year

Ü \_\_\_\_\_  
Signature of Parent or Legal Guardian  
(If Insured is under the age of majority required by the state where the policy is issued for delivery)

P \_\_\_\_\_  
**Signature of Owner** (if other than Insured)

P \_\_\_\_\_  
**Signature of Applicant** (if other than Insured)

**AGENT CERTIFICATION**

I certify that I personally completed this application in the company of all proposed insureds.  Yes  No  
I certify that I have no knowledge of anything which might affect the insurability of any person proposed for insurance which is not fully set forth herein.  Yes  No

Does the proposed insured have existing life insurance policies or annuity contracts?  Yes  No  
Is this insurance applied for intended to replace any existing life insurance policies or annuity contracts?  Yes  No  
If either question is answered Yes, please complete a replacement form as prescribed by your state's regulations.  
Is this a 1035 Exchange?  Yes  No      Is this an internal term conversion?  Yes  No

Signed at: \_\_\_\_\_

P \_\_\_\_\_  
**Signature of Licensed Agent**

Dated on: \_\_\_\_\_

\_\_\_\_\_  
**Print Name of Licensed Agent**



Corporate Address:  
**Harleysville Life Insurance Company**  
 [355 Maple Avenue, Harleysville, PA 19438  
 Tel 800.222.1981 www.harleysvillegroup.com]

Please mail forms to the  
 Administrative Address:  
**Harleysville Life Insurance Company**  
 [P.O. Box 253, Harleysville, PA 19438-0253]

**Children's Insurance Supplement**

**Section I**

1. List all children to be covered:

Name	Sex	Date of Birth	Height	Weight

**Section II**

1. Is there currently other life insurance policies or annuity contracts in force on any child?  Yes  No  
 If Yes, please provide details: \_\_\_\_\_
2. Is the insurance applied for intended to replace any existing life insurance policies or annuity contracts?  Yes  No
3. Have you ever had an application or reinstatement request for life, health, disability insurance declined, postponed, limited, withdrawn or cancelled, or been asked to pay a higher premium for any child?  Yes  No  
 If yes, please provide details \_\_\_\_\_
4. Amount of life insurance on parents? Father \_\_\_\_\_ Mother \_\_\_\_\_

**Section III General Information**

1. In the past/next 2 years have you or do you intend to travel to a foreign country? <b>If Yes, complete Foreign Travel Questionnaire</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. In the past/next 2 years, have you or do you have plans to reside in a foreign country for 90 days or longer? <b>If Yes, Please complete Foreign Residence Questionnaire</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. In the past/next 2 years have you engaged in or do you intend to engage in any of the following: (check all that apply) ___ skin/scuba diving ___ mountain, ice or rock climbing ___ aviation sports ___ parachuting ___ motor sports <b>If Yes, Please complete the appropriate questionnaire(s)</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. In the past 5 years have you flown or do you intend to fly within the next 2 years as a pilot, copilot or crew member for other than a scheduled commercial airline, or do you hold a current pilot's license? <b>If Yes, Please complete an appropriate Aviation Questionnaire</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. In the past 5 years have you pled guilty to or been convicted of driving while impaired or under the influence of drugs or alcohol? <b>If Yes, complete the appropriate Alcohol or Drug Questionnaire</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Have you been placed on current active status in the Armed Forces, or entered into a written agreement to have active status in the near future? <b>If Yes, complete the Military Questionnaire</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. In the past 5 years have you pled guilty to or been convicted of any moving violations, or had your license suspended or revoked? If Yes, please provide details: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
8. Have you ever been convicted of, or currently charged with, a felony or misdemeanor, or are you currently on probation or parole? If Yes, please provide details: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No

**Section IV Medical Information**

1. Child's Personal Primary Physician: Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Telephone Number: \_\_\_\_\_

<b>2. Has any child ever been diagnosed with, been treated for or consulted a physician for: (If Yes, please provide full details)</b>	
a. depression, anxiety, psychosis, anorexia, bulimia, or other mental, nervous or emotional disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No
b. seizures, tremors, headaches, paralysis, stroke, transient ischemic attack, multiple sclerosis, Parkinson's, Alzheimer's, or other disorder of the brain, spinal cord, nerves or muscles?	<input type="checkbox"/> Yes <input type="checkbox"/> No
c. cancer, tumor, or any other malignant disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No
d. diabetes or elevated blood sugar, or any other disorder of the thyroid, pituitary, endocrine glands?	<input type="checkbox"/> Yes <input type="checkbox"/> No
e. chest pain, angina, high blood pressure, high cholesterol/triglycerides, palpitations, irregular heartbeat, heart murmur, heart attack, peripheral vascular disease, phlebitis or any other disorder of the heart or blood vessels?	<input type="checkbox"/> Yes <input type="checkbox"/> No
f. anemia, blood clots, leukemia, lymphoma, immune deficiency or any other disorder of the blood, lymph glands or immune system (excluding HIV or AIDS)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
g. hepatitis, ulcer, acid reflux, colitis, or any other disorder of the stomach, liver, intestines, colon, rectum, pancreas, spleen, gallbladder, esophagus?	<input type="checkbox"/> Yes <input type="checkbox"/> No
h. asthma, bronchitis, emphysema, chronic obstructive lung/pulmonary disease, shortness of breath, persistent cough or hoarseness, sarcoidosis, tuberculosis, sleep apnea or any other disorder of the respiratory system?	<input type="checkbox"/> Yes <input type="checkbox"/> No
i. albumin, blood, protein in the urine or any other disorder of the kidney or bladder?	<input type="checkbox"/> Yes <input type="checkbox"/> No
j. sexually transmitted disease or any other disorder of the uterus, cervix, ovaries, breast, prostate or reproductive system?	<input type="checkbox"/> Yes <input type="checkbox"/> No
k. arthritis or any other disorder of the bones, joints or muscles?	<input type="checkbox"/> Yes <input type="checkbox"/> No
l. any disorder of the eyes, ears, nose, throat?	<input type="checkbox"/> Yes <input type="checkbox"/> No
m. any disease or disorder other than what is mentioned above?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>3. In the past 5 years has any child:</b>	
a. had a complete physical exam, or checkup, electrocardiogram, x-ray, blood test, or other diagnostic test (excluding an HIV or AIDS test)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
b. been treated, examined or consulted a physician for a condition other than what has already been provided?	<input type="checkbox"/> Yes <input type="checkbox"/> No
c. been advised by a medical professional to have hospitalization, surgery, biopsy, medical treatment or any diagnostic test (excluding an HIV or AIDS test), which has not been completed?	<input type="checkbox"/> Yes <input type="checkbox"/> No
d. taken or been advised by a medical professional to take prescription medication, or any herbal or non prescription medication?	<input type="checkbox"/> Yes <input type="checkbox"/> No
e. lost time from work, school, been unable to perform routine activities of daily living, or confined to a home?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Has any child, had a member of the medical profession diagnose or prescribe treatment for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) or advise that they tested Human Immunodeficiency Virus (HIV) positive?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Has any child ever been advised by a medical professional to reduce or discontinue the use of alcohol, joined an organization or received medical treatment for the use of alcohol? <b>If Yes, complete an Alcohol Questionnaire</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Has any child ever used barbiturates, amphetamines, cocaine, marijuana or other illegal or controlled substances, except as prescribed by a physician, or joined an organization or received medical treatment or counseling for the use of drugs? <b>If Yes, complete a Drug Questionnaire</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. Has any child ever been advised by a medical professional to reduce or discontinue the use of, or been addicted to, prescription medication? <b>If Yes, complete a Drug Questionnaire</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No



I (We) understand and acknowledge that this application and all supplementary documentation, in the aggregate, constitute the entire application, including all information provided in the application, the medical exam, questionnaires and supplements to the application, and amendments issued by Harleysville Life Insurance Company, and that they will be attached to and made a part of the policy and delivered to the policy owner.

I (We) have paid \$ \_\_\_\_\_ with this application in consideration of the [Temporary Insurance Agreement]. I (We) have read, understood, and agreed to the terms of the [Temporary Insurance Agreement].

SIGNED AT: \_\_\_\_\_  
**City and State**

P \_\_\_\_\_  
**Signature of Insured**

DATED ON: \_\_\_\_\_  
**Month/Day/Year**

Ü \_\_\_\_\_  
**Signature of Parent or Legal Guardian**  
(If Insured is under the age of majority required by the state where the policy is issued for delivery)

P \_\_\_\_\_  
**Signature of Owner** (if other than Insured)

P \_\_\_\_\_  
**Signature of Applicant** (if other than Insured)

**AGENT CERTIFICATION**

I certify that I personally completed this application in the company of all proposed insureds.  Yes  No

I certify that I have no knowledge of anything which might affect the insurability of any person proposed for insurance which is not fully set forth herein.  Yes  No

Does the proposed insured have existing life insurance policies or annuity contracts?  Yes  No

Is this insurance applied for intended to replace any existing life insurance policies or annuity contracts?  Yes  No

If either question is answered Yes, please complete a replacement form as prescribed by your state's regulations.

Is this a 1035 Exchange?  Yes  No      Is this an internal term conversion?  Yes  No

SIGNED AT: \_\_\_\_\_

P \_\_\_\_\_  
**Signature of Licensed Agent**

DATED ON: \_\_\_\_\_

\_\_\_\_\_  
**Print Name of Licensed Agent**



Corporate Address:  
**Harleysville Life Insurance Company**  
 [355 Maple Avenue, Harleysville, PA 19438  
 Tel 800.222.1981 www.harleysvillegroup.com]

Please mail forms to the  
 Administrative Address:  
**Harleysville Life Insurance Company**  
 [P.O. Box 253, Harleysville, PA 19438-0253]

**APPLICATION FOR REINSTATEMENT**  
 which lapsed for non-payment of the premium  
 with DUE DATE \_\_\_\_\_.

Policy Number \_\_\_\_\_

**\*\* Do not send money**

**PLEASE COMPLETE THE FOLLOWING QUESTIONS AS THEY  
 PERTAIN TO EACH PERSON INSURED UNDER THIS POLICY.**

Name of Each Insured	Sex	Date of Birth	Height	Weight	Weight Change Past Year	Name and Address of Personal Physician

Has any person applying for reinstatement:	Primary Insured		Other Insured		Children	
	Yes	No	Yes	No	Yes	No
1. In the past 5 years, ever use tobacco or nicotine products in any form? If Yes, please provide details: <u>Product</u> <u>Date Last Used (month/year)</u> <u>Amount/Frequency</u> Cigarettes                      _____                      _____ Cigar/Pipe                      _____                      _____ Chewing Tobacco                      _____                      _____ Other: _____	<input type="checkbox"/>					
2. Had any application or policy for life or health insurance declined, rated, restricted, postponed, canceled, modified, or reinstatement denied? Please provide details below.	<input type="checkbox"/>					
3. In the past 90 days, have you applied for or do you have any other applications or informal inquiry for life insurance pending with any other companies? If Yes, provide details. <u>Name of Company</u> <u>Amount of Coverage</u> <u>Purpose</u> _____ _____ Which pending applications do you intend to accept? _____	<input type="checkbox"/>					

**General Information**

1. In the past/next 2 years have you or do you intend to travel to a foreign country?	<input type="checkbox"/>					
2. In the past/next 2 years, have you or do you have plans to reside in a foreign country for 90 days or longer?	<input type="checkbox"/>					
3. In the past 2 years have you engaged in or do you intend to engage in any of the following: (check all that apply) ___ skin/scuba diving ___ mountain, ice or rock climbing ___ aviation sports ___ parachuting ___ motor sports	<input type="checkbox"/>					
4. In the past 5 years have you flown or do you intend to fly within the next 2 years as a pilot, copilot or crew member for other than a scheduled commercial airline, or do you hold a current pilot's license?	<input type="checkbox"/>					
5. In the past 7 years, have you filed for bankruptcy? If Yes, Indicate chapter filed, date, reason and if discharged. <b>If Yes, please provide details:</b> _____	<input type="checkbox"/>					
6. Have you been placed on current active status in the Armed Forces, or entered into a written agreement to have active status in the near future?	<input type="checkbox"/>					

7. In the past 5 years have you pled guilty to or been convicted of any moving violations, or had your license suspended or revoked? <b>If Yes, please provide details:</b> _____	<input type="checkbox"/>					
8. Have you ever been convicted of, or currently charged with, a felony or misdemeanor, or are you currently on probation or parole? <b>If Yes, please provide details:</b> _____	<input type="checkbox"/>					

**Medical Information**

1. Has any person applying for reinstatement been diagnosed with, been treated for or consulted a physician for: (If Yes, please provide full details)	Primary Insured		Other Insured		Children	
	Yes	No	Yes	No	Yes	No
a. depression, anxiety, psychosis, anorexia, bulimia, or other mental, nervous or emotional disorder?	<input type="checkbox"/>					
b. seizures, tremors, headaches, paralysis, stroke, transient ischemic attack, Multiple sclerosis, Parkinson's, Alzheimer's, or other disorder of the brain, spinal cord, nerves or muscles?	<input type="checkbox"/>					
c. cancer, tumor, or any other malignant disorder?	<input type="checkbox"/>					
d. cyst, polyp, lump or any disorder of the skin or lymph nodes?	<input type="checkbox"/>					
e. diabetes or elevated blood sugar, or any other disorder of the thyroid, pituitary, endocrine glands?	<input type="checkbox"/>					
f. chest pain, angina, high blood pressure, high cholesterol/triglycerides, palpitations, irregular heartbeat, heart murmur, heart attack, peripheral vascular disease, phlebitis or any other disorder of the heart or blood vessels?	<input type="checkbox"/>					
g. anemia, blood clots, leukemia, lymphoma, immune deficiency or any other disorder of the blood, lymph glands or immune system (excluding HIV or AIDS)?	<input type="checkbox"/>					
h. hepatitis, ulcer, acid reflux, colitis, or any other disorder of the stomach, liver, intestines, colon, rectum, pancreas, spleen, gallbladder, esophagus?	<input type="checkbox"/>					
i. asthma, bronchitis, emphysema, chronic obstructive lung/pulmonary disease, shortness of breath, persistent cough or hoarseness, sarcoidosis, tuberculosis, sleep apnea or any other disorder of the respiratory system?	<input type="checkbox"/>					
j. albumin, blood, protein in the urine or any other disorder of the kidney or bladder?	<input type="checkbox"/>					
k. sexually transmitted disease or any other disorder of the uterus, cervix, ovaries, breast, prostate or reproductive system?	<input type="checkbox"/>					
l. arthritis or any other disorder of the bones, joints or muscles?	<input type="checkbox"/>					
m. any disorder of the eyes, ears, nose, throat?	<input type="checkbox"/>					
<b>2. In the past 5 years have you:</b>						
a. had a complete physical exam, or checkup, electrocardiogram, x-ray, blood test, or other diagnostic test (excluding an HIV or AIDS test)?	<input type="checkbox"/>					
b. been treated, examined or consulted a physician for a condition other than what has already been provided?	<input type="checkbox"/>					
c. been advised by a medical professional to have hospitalization, surgery, biopsy, medical treatment or any other diagnostic test (excluding an HIV or AIDS test), which has not been completed?	<input type="checkbox"/>					
d. taken or been advised by a medical professional to take prescription medication, or any herbal or non prescription medication?	<input type="checkbox"/>					
e. lost time from work, school, received disability benefits, been unable to perform routine activities of daily living, or confined to a home?	<input type="checkbox"/>					



I (We) understand that Harleysville Life Insurance Company will not disclose this information to any person or organization except its reinsurer(s); the Medical Information Bureau (MIB, Inc.); other persons or organizations performing business or legal services in connection with my/our application, including employees of Harleysville Insurance, or as may be otherwise lawfully required, or as I (We) further authorize.

I (We) authorize;  I (We) do not authorize: Harleysville Life Insurance Company to disclose, at its discretion, information obtained during the application/underwriting process to my/our agent of record or representative of agent of record.

I (We) understand that I (we) or my (our) authorized representative have the right to receive a copy of this authorization and agree that a photographic copy will be as valid as the original. I (We) also understand that this authorization will be valid for 24 months from the date shown below.

I (We) acknowledge receiving the Notice of Information Practices and authorize Harleysville Life Insurance Company to obtain an investigative or other consumer report as described, and

I (We) request;  I (We) do not request, a personal interview in connection with such report.

I (We) understand and acknowledge that this Application for Reinstatement and all supplementary documentation, in the aggregate, constitute the entire Application for Reinstatement, including all information provided in the Application for Reinstatement, the medical exam, questionnaires and supplements to the Application for Reinstatement, and amendments issued by Harleysville Life Insurance Company, and that they will be attached to and made a part of the policy.

SIGNED AT: \_\_\_\_\_  
**City and State**

DATED ON: \_\_\_\_\_  
**Month/Day/Year**

SIGNED AT: \_\_\_\_\_  
**City and State**

DATED ON: \_\_\_\_\_  
**Month/Day/Year**

P \_\_\_\_\_  
**Signature of Insured**

Ü \_\_\_\_\_  
**Signature of Parent or Legal Guardian**  
(If Insured is under the age of majority required by the state where the policy is issued for delivery)

P \_\_\_\_\_  
**Signature of Other Insured**

Ü \_\_\_\_\_  
**Signature of Parent or Legal Guardian**  
(If Other Insured is under the age of majority required by the state where the policy is issued for delivery)

P \_\_\_\_\_  
**Signature of Owner (if other than Insured)**

H.O. Use Only	
Approved for Reinstatement	Underwriting Comments



APPLICATION FOR POLICY CHANGE

Corporate Address:
Harleysville Life Insurance Company
[355 Maple Avenue, Harleysville, PA 19438
Tel 800.222.1981 www.harleysvillegroup.com]

Please mail forms to the
Administrative Address:
Harleysville Life Insurance Company
[P.O. Box 253, Harleysville, PA 19438-0253]

Section I
Insured Name Policy Number

1. Change Request:

All rights, title and interest as owner of this policy is transferred to:
2. Owner: Daytime Phone:
Social Security or Owner Tax ID Number:
Address:

All previous beneficiary designations and settlement options are hereby revoked and the following designation is made:
Please avoid naming a minor as primary beneficiary unless a trust has been established. If there is a trust, we will need the name of the trustee and the trust date and tax identification number. Also, if naming more than one primary beneficiary, please state the desired distribution if other than equal shares.
3. Beneficiary for Base Insured: (Include age, if minor) Beneficiary for Other Insured: (Include age, if minor)
Primary Relationship Contingent Relationship

If additional coverage is being requested, please complete sections III and IV. Also, applicable for reduction or removal of Special Premium Classification. Please complete the following section for increase in coverage amount, addition of rider or rate class change.

Section II
5. TERM LIFE AND WHOLE LIFE
Riders: (choose all that are applicable)
[Accidental Death Benefit Delete Add - Amount \$
[Children's Benefit Delete Add - Amount \$
[Guaranteed Insurability Benefit/Scheduled Increase Option Delete Add - Amount \$
[Other Insured[\*] Delete Add - Amount \$ [\* N/A in New Jersey]
[Accidental Death Benefit - Other Insured Delete Add - Amount \$
[Waiver of Premium Delete Add]
[Other Delete Add]

6. UNIVERSAL LIFE
Riders: (choose all that are applicable)
[Accidental Death Benefit Delete Add - Amount \$
[Children's Term Insurance Delete Add - Amount \$
[Cost of Living Delete]
[Accelerated Benefit Rider Delete]
[Maturity Extension Delete Add]
[Other Insured Delete Add - Amount \$ All Years Number of Years
[Accidental Death Benefit - Other Insured Delete Add - Amount \$
[Accelerated Benefit Rider- Other Insured Delete]
[Primary Insured Delete Add - Amount \$ All Years Number of Years
[Scheduled Increase Option Delete Add - Amount \$
[Total Disability Premium Payment Delete Add]

(Universal Life continued)

[Waiver of Monthly Deductions  Delete  Add (Primary Insured only)]

[Other \_\_\_\_\_  Delete  Add]

Change Planned Periodic Premium to \$ \_\_\_\_\_

Change Death Benefit Option:  Option 1 to Option 2 \*

Option 2 to Option 1

Option 3 to Option 1

\*If changing Option 1 to Option 2, do you want the Specified Amount reduced by the current cash value?  Yes  No

7. Have you applied for or do you have any other applications or informal inquiry for life insurance pending with any other companies?

Yes  No If Yes, please provide details:

Name of Company	Amount of Coverage	Purpose
_____	_____	_____
_____	_____	_____

Which pending applications do you intend to accept? \_\_\_\_\_

Have you ever had an application or reinstatement request for life, health or disability insurance declined, postponed, limited, withdrawn or cancelled, or have you been asked to pay a higher premium?  Yes  No

Do you have existing life insurance policies or annuity contracts?  Yes  No If Yes, please complete the following:

PERSON	COMPANY	AMOUNT	POLICY #	YEAR ISSUED	PURPOSE	intended to replace any life insurance policies or annuity contracts?
_____	_____	_____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	_____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	_____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No

Do you intend to sell or permanently assign the policy to another person, entity, life settlement provider or investor, or will it replace a policy that has already been sold to another life settlement company or investor?  Yes  No

If Yes, please complete and submit a **Stranger Owned Life Insurance/Life Settlement Questionnaire**.

Details: \_\_\_\_\_

Section III General Information	Primary Insured		Other Insured		Children	
	Yes	No	Yes	No	Yes	No
1. In the past/next 2 years have you or do you intend to travel to a foreign country?	<input type="checkbox"/>					
2. In the past/next 2 years, have you or do you have plans to reside in a foreign country for 90 days or longer?	<input type="checkbox"/>					
3. In the past/next 2 years have you engaged in or do you intend to engage in any of the following: check all that apply) ___ skin/scuba diving ___ mountain, ice or rock climbing ___ aviation sports ___ parachuting ___ motor sports	<input type="checkbox"/>					
4. In the past 5 years have you flown or do you intend to fly within the next 2 years as a pilot, copilot or crew member for other than a scheduled commercial airline, or do you hold a current pilot's license?	<input type="checkbox"/>					
5. In the past 5 years have you pled guilty to or been convicted of driving while impaired or under the influence of drugs or alcohol?	<input type="checkbox"/>					
6. In the past 7 years, have you filed for bankruptcy? <b>If Yes, Indicate chapter filed, date, reason and if discharged.</b> If Yes, please provide details:	<input type="checkbox"/>					

	Primary Insured		Other Insured		Children	
	Yes	No	Yes	No	Yes	No
7. Have you been placed on current active status in the Armed Forces, or entered into a written agreement to have active status in the near future?	<input type="checkbox"/>					
8. In the past 5 years have you pled guilty to or been convicted of any moving violations, or had your license suspended or revoked? If Yes, please provide details: _____	<input type="checkbox"/>					
9. Have you ever been convicted of, or currently charged with, a felony or misdemeanor, or are you currently on probation or parole? If Yes, please provide details: _____	<input type="checkbox"/>					

**Section IV**

INFORMATION BELOW RELATES TO:  Proposed Insured  Other Insured  Children

Name of Each Person to be Insured	Sex	Date of Birth	Height	Weight	Weight Change in the Past Year	Name and Address of Personal Physician

	Primary Insured		Other Insured		Children	
	Yes	No	Yes	No	Yes	No
1. Have you ever used tobacco or nicotine products in any form? If Yes, please provide details: Product _____ Date Last Used (month/year) _____ Amount/Frequency _____ Cigarettes _____ Cigar/Pipe _____ Chewing Tobacco _____ Other: _____	<input type="checkbox"/>					
<b>2. Have you ever been diagnosed with, been treated for or consulted a physician for: (If Yes, please provide full details)</b>						
a. depression, anxiety, psychosis, anorexia, bulimia, or other mental, nervous or emotional disorder?	<input type="checkbox"/>					
b. seizures, tremors, headaches, paralysis, stroke, transient ischemic attack, multiple sclerosis, Parkinson's, Alzheimer's, or other disorder of the brain, spinal cord, nerves or muscles?	<input type="checkbox"/>					
c. cancer, tumor, or any other malignant disorder?	<input type="checkbox"/>					
d. cyst, polyp, lump or any disorder of the skin or lymph nodes?	<input type="checkbox"/>					
e. diabetes or elevated blood sugar, or any other disorder of the thyroid, pituitary, endocrine glands?	<input type="checkbox"/>					
f. chest pain, angina, high blood pressure, high cholesterol/triglycerides, palpitations, irregular heartbeat, abnormal electrocardiogram, heart murmur, heart attack, peripheral vascular disease, phlebitis or any other disorder of the heart or blood vessels?	<input type="checkbox"/>					
g. anemia, blood clots, leukemia, lymphoma, immune deficiency or any other disorder of the blood, lymph glands or immune system (excluding HIV or AIDS)?	<input type="checkbox"/>					
h. hepatitis, ulcer, acid reflux, colitis, or any other disorder of the stomach, liver, intestines, colon, rectum, pancreas, spleen, gallbladder, esophagus?	<input type="checkbox"/>					
i. asthma, bronchitis, emphysema, chronic obstructive lung/pulmonary disease, shortness of breath, persistent cough or hoarseness, sarcoidosis, tuberculosis, sleep apnea or any other disorder of the respiratory system?	<input type="checkbox"/>					



Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

New Jersey: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

### APPLICANT'S STATEMENT

I (We) have read the preceding questions and answers, and hereby represent to the best of my (our) knowledge and belief that the statements and answers are complete and true, and that Harleysville Life Insurance Company may rely on the answers in the granting of an Application for Policy Change. I (We) understand and agree that this application and other required parts will be the basis for granting the policy change and an integral part of the policy; that no waiver or modification will bind the Company unless in writing and signed by the President, a Vice President or the Secretary of Harleysville Life Insurance Company. I (We) understand and agree that a sales representative does not have the company's authorization to accept risk, pass on insurability, or make, void, waive, or change any conditions or provisions of the application, policy or receipt. I (We) further understand and agree that **no insurance will take effect until the policy has been manually delivered to and received and accepted by me (us), and the full first premium is paid during the lifetime of each person on whom insurance is requested and while the proposed insured is alive.**

### AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

I (We) authorize any licensed physician, medical practitioner, hospital, clinic, dispensary, sanitarium, or other medically related facility, governmental motor vehicle agencies, insurance companies, the Veteran's Administration, Medical Information Bureau (MIB, Inc.), [pharmaceutical data bases], consumer reporting agency or employer to release to the Harleysville Life Insurance Company and its reinsurers any of the following pertaining to me (us) or my children if they are to be insured: information relating to physical and mental condition; medical care, diagnosis or treatment; and avocation, insurance, aviation activity, criminal activity, financial information, occupation, habits, driving record and general character. This information will be used by Harleysville Life Insurance Company and its reinsurers to determine eligibility for insurance. In addition to this Authorization, and to facilitate rapid transmission of information to an appropriate Harleysville representative(s), I (We) will execute Authorizations for Release of Medical Records for any sources requiring an authorization.

I (We) understand that Harleysville Life Insurance Company will not disclose this information to any person or organization except its reinsurer(s); the Medical Information Bureau (MIB, Inc.); other persons or organizations performing business or legal services in connection with my/our application, including employees of Harleysville Insurance, or as may be otherwise lawfully required, or as I (We) further authorize.

I (We) authorize;  I (We) do not authorize: Harleysville Life Insurance Company to disclose, at its discretion, information obtained during the application/underwriting process to my/our agent of record or representative of agent of record.

I (We) understand that I (we) or my (our) authorized representative have the right to receive a copy of this authorization and agree that a photographic copy will be as valid as the original. I (We) also understand that this authorization will be valid for 24 months from the date shown below.

I (We) acknowledge receiving the Notice of Information Practices and authorize Harleysville Life Insurance Company to obtain an investigative or other consumer report as described, and

I (We) request;  I (We) do not request, a personal interview in connection with such report.

I (We) understand and acknowledge that this Application for Policy Change and all supplementary documentation, in the aggregate, constitute the entire Application for Policy Change, including all information provided in the Application for Policy Change, the medical exam, questionnaires and supplements to the Application for Policy Change, and amendments issued by Harleysville Life Insurance Company, and that they will be attached to and made a part of the policy.

SIGNED AT: \_\_\_\_\_  
City and State

DATED ON: \_\_\_\_\_  
Month/Day/Year

P \_\_\_\_\_  
Signature of Owner (if other than Insured)

P \_\_\_\_\_  
Signature of Insured

Ü \_\_\_\_\_  
Signature of Parent or Legal Guardian  
(If Insured is under the age of majority required by the state where the policy is issued for delivery)



Corporate Address:  
**Harleysville Life Insurance Company**  
 [355 Maple Avenue, Harleysville, PA 19438  
 Tel 800.222.1981 www.harleysvillegroup.com]

Please mail forms to the  
 Administrative Address:  
**Harleysville Life Insurance Company**  
 [P.O. Box 253, Harleysville, PA 19438-0253]

## Tobacco Use Application for Policy Change

**Insured Name:** \_\_\_\_\_

**Policy #:** \_\_\_\_\_

I hereby request the underwriting rate class to be changed to:

- Non-Tobacco  
 Alternative Tobacco [Pro Provider]

1. Has the insured smoked cigarettes in the past 12 months:  Yes  No  
 If No, please provide approximate date cigarettes last used \_\_\_\_\_
2. Does the insured currently use any other form of tobacco or nicotine product?  Yes  No  
 If Yes, please describe amount and type used \_\_\_\_\_  
 If No, please provide approximate date tobacco or nicotine product last used \_\_\_\_\_
3. Was the insured given medication to aid in the cessation of tobacco or nicotine products?  Yes  No  
 If Yes, please provide details \_\_\_\_\_

### In order to process this request a urinalysis test will need to be ordered.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.  
 New Jersey: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

### APPLICANT'S STATEMENT

I have read the preceding questions and answers, and hereby represent to the best of my knowledge and belief that the statements and answers are complete and true, and that Harleysville Life Insurance Company may rely on the answers in the granting of an Application for Policy Change. I understand and agree that this application and other required parts will be the basis for granting the policy change, and an integral part of, the policy; and that no waiver or modification will bind the Company unless in writing and signed by the President, a Vice President or the Secretary of Harleysville Life Insurance Company. I understand and agree that a sales representative does not have the company's authorization to accept risk, pass on insurability, or make, void, waive, or change any conditions or provisions of the application, policy or receipt.

I understand that Harleysville Life Insurance Company will not disclose this information to any person or organization except its reinsurer(s); the Medical Information Bureau (MIB, Inc.); other persons or organizations performing business or legal services in connection with my/our application, including employees of Harleysville Insurance, or as may be otherwise lawfully required, or as I further authorize.

I authorize;  I do not authorize: Harleysville Life Insurance Company to disclose, at its discretion, information obtained during the application/underwriting process to my/our agent of record or representative of agent of record. I (We) understand that I (we) or my (our) authorized representative have the right to receive a copy of this authorization and agree that a photographic copy will be as valid as the original. I (We) also understand that this authorization will be valid for 24 months from the date shown below.

I acknowledge receiving the Notice of Information Practices and authorize Harleysville Life Insurance Company to obtain an investigative or other consumer report as described, and

I understand and acknowledge that this Application for Policy Change and any supplementary documentation will be made a part of the policy.

SIGNED AT: \_\_\_\_\_  
**City and State**

P \_\_\_\_\_  
**Signature of Insured**

DATED ON: \_\_\_\_\_  
**Month/Day/Year**

Ü \_\_\_\_\_  
**Signature of Parent or Legal Guardian**  
 (If Insured is under the age of majority required by the state where the policy is issued for delivery)

P \_\_\_\_\_  
**Signature of Owner** (if other than Insured)



Corporate Address:  
**Harleysville Life Insurance Company**  
 [355 Maple Avenue, Harleysville, PA 19438  
 Tel 800.222.1981 www.harleysvillegroup.com]

Please mail forms to the  
 Administrative Address:  
**Harleysville Life Insurance Company**  
 [P.O. Box 253, Harleysville, PA 19438-0253]

**Payor Benefit Supplement**  
 [(For use with Whole Life only)]

**Section I**

**1. Relationship to Proposed Insured:** \_\_\_\_\_  
 Full Name: \_\_\_\_\_  
 \_\_\_\_\_ / \_\_\_\_\_  
 Last First M.I. Birth Date Birth State Sex Marital Status  
 Former name if changed in the last 5 years: \_\_\_\_\_  
 \_\_\_\_\_  
 Last First M.I. Social Security Number Driver's License#/State  
 Residence:  Same as Primary Insured  
 \_\_\_\_\_  
 Street and Number or Rural Route Telephone # Cell Phone #  
 \_\_\_\_\_  
 City State Zip Code Email Address

**2. Occupation:** \_\_\_\_\_  
 Work Phone Number: \_\_\_\_\_  
 Employer: \_\_\_\_\_  
 Type of Business: \_\_\_\_\_  
 Annual Income: \$ \_\_\_\_\_  
 Net Worth \$ \_\_\_\_\_

**3. U. S. Citizen**  Yes  No  
 If No, Date of Entry to U.S. \_\_\_\_\_  
 Visa Type \_\_\_\_\_  
 Country of Citizenship \_\_\_\_\_

**Section II General Information (If Yes, Provide Details)**

<b>1.</b> In the past/next 2 years have you or do you intend to travel to a foreign country?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>2.</b> In the past/next 2 years, have you or do you have plans to reside in a foreign country for 90 days or longer?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>3.</b> In the past/next 2 years have you engaged in or do you intend to engage in any of the following: (check all that apply) ___ skin/scuba diving ___ mountain, ice or rock climbing ___ aviation sports ___ parachuting ___ motor sports	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>4.</b> In the past 5 years have you flown or do you intend to within the next 2 years fly as a pilot, copilot or crew member for other than a scheduled commercial airline, or do you hold a current pilot's license?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>5.</b> In the past 5 years have you pled guilty to or been convicted of driving while impaired or under the influence of drugs or alcohol?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>6.</b> In the past 7 years, have you filed for bankruptcy?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>7.</b> Have you been placed on current active status in the Armed Forces, or entered into a written agreement to have active status in the near future?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>8.</b> In the past 5 years have you pled guilty to or been convicted of any moving violations, or had your license suspended or revoked?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>9.</b> Have you ever been convicted of, or currently charged with, a felony or misdemeanor, or are you currently on probation or parole?	<input type="checkbox"/> Yes <input type="checkbox"/> No

**Section III Medical Information**

**1.** Name of Payor \_\_\_\_\_ Date of Birth \_\_\_\_\_  
 Height \_\_\_\_\_ Weight \_\_\_\_\_ Weight change (> 10 lbs) in last 12 months \_\_\_\_\_ Reason for weight change \_\_\_\_\_  
 Personal Primary Physician: Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Telephone Number: \_\_\_\_\_

<b>2. Have you ever been diagnosed with, been treated for or consulted a physician for: (If Yes, please provide full details)</b>	
a. depression, anxiety, psychosis, anorexia, bulimia, or other mental, nervous or emotional disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No
b. seizures, tremors, headaches, paralysis, stroke, transient ischemic attack, multiple sclerosis, Parkinson's, Alzheimer's, or other disorder of the brain, spinal cord, nerves or muscles?	<input type="checkbox"/> Yes <input type="checkbox"/> No
c. cancer, tumor, or any other malignant disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No
d. diabetes or elevated blood sugar, or any other disorder of the thyroid, pituitary, endocrine glands?	<input type="checkbox"/> Yes <input type="checkbox"/> No
e. chest pain, angina, high blood pressure, high cholesterol/triglycerides, palpitations, irregular heartbeat, heart murmur, heart attack, peripheral vascular disease, phlebitis or any other disorder of the heart or blood vessels?	<input type="checkbox"/> Yes <input type="checkbox"/> No
f. anemia, blood clots, leukemia, lymphoma, immune deficiency or any other disorder of the blood, lymph glands or immune system (excluding HIV or AIDS)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
g. hepatitis, ulcer, acid reflux, colitis, or any other disorder of the stomach, liver, intestines, colon, rectum, pancreas, spleen, gallbladder, esophagus?	<input type="checkbox"/> Yes <input type="checkbox"/> No
h. asthma, bronchitis, emphysema, chronic obstructive lung/pulmonary disease, shortness of breath, persistent cough or hoarseness, sarcoidosis, tuberculosis, sleep apnea or any other disorder of the respiratory system?	<input type="checkbox"/> Yes <input type="checkbox"/> No
i. albumin, blood, protein in the urine or any other disorder of the kidney or bladder?	<input type="checkbox"/> Yes <input type="checkbox"/> No
j. sexually transmitted disease or any other disorder of the uterus, cervix, ovaries, breast, prostate or reproductive system?	<input type="checkbox"/> Yes <input type="checkbox"/> No
k. arthritis or any other disorder of the bones, joints or muscles?	<input type="checkbox"/> Yes <input type="checkbox"/> No
l. any disorder of the eyes, ears, nose or throat?	<input type="checkbox"/> Yes <input type="checkbox"/> No
m. any disease or disorder other than what is mentioned above?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>3. In the past 5 years have you:</b>	
a. had a complete physical exam, or checkup, electrocardiogram, x-ray, blood test, or other diagnostic test (excluding an HIV or AIDS test)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
b. been treated, examined or consulted a physician for a condition other than what has already been provided?	<input type="checkbox"/> Yes <input type="checkbox"/> No
c. been advised by a medical professional to have hospitalization, surgery, biopsy, medical treatment or any other diagnostic test (excluding an HIV or AIDS test), which has not been completed?	<input type="checkbox"/> Yes <input type="checkbox"/> No
d. taken or been advised by a medical professional to take prescription medication, or any herbal or non prescription medication?	<input type="checkbox"/> Yes <input type="checkbox"/> No
e. lost time from work, school, received disability benefits, been unable to perform routine activities of daily living, or confined to a home?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Have you had a member of the medical profession diagnose or prescribe treatment for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) or advise that you tested Human Immunodeficiency Virus (HIV) positive?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Have you ever been advised by a medical professional to reduce or discontinue the use of alcohol, joined an organization or received medical treatment or counseling for the use of alcohol?	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Have you ever used barbiturates, amphetamines, cocaine, marijuana or other illegal or controlled substances, except as prescribed by a physician, or joined an organization or received medical treatment or counseling for the use of drugs?	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. Have you ever been advised by a medical professional to reduce or discontinue the use of, or been addicted to, prescription medication?	<input type="checkbox"/> Yes <input type="checkbox"/> No

**Details to any above questions answered Yes.**

Question #	Date(s)	Physician(s)	Details

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

New Jersey: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

**APPLICANT’S STATEMENT**

I (We) have read the preceding questions and answers, and hereby represent that to the best of my (our) knowledge and belief, that the statements and answers are complete and true, and that Harleysville Life Insurance the Company may rely on the answers statements in the issuance of a policy. I (We) understand and agree that this application and other required parts will be the basis for, and an integral part of, any policy issued; that no waiver or modification will bind the Company unless in writing and signed by the President, or a Vice President or the Secretary of Harleysville Life Insurance Company. I (We) understand and agree that a sales representative does not have the company’s authorization to accept risk, pass on insurability, or make, void, waive, or change any conditions or provisions of the application, policy or receipt. I (We) further understand and agree; and that **no insurance will take effect unless and until the policy has been manually delivered to and received and accepted by me (us), and the full first premium is paid during the lifetime and of each person on whom insurance is requested and while the proposed insured is alive.**

**AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION**

I (We) authorize any licensed physician, medical practitioner, hospital, clinic, dispensary, sanitarium, or other medically related facility, governmental motor vehicle agencies, insurance companies, the Veteran’s Administration, or Medical Information Bureau (MIB, Inc.), [pharmaceutical data bases], consumer reporting agency or employer to release to the Harleysville Life Insurance Company and its reinsurers any of the following pertaining to me (us) or my children if they are to be insured: information relating to physical and mental condition; medical care, diagnosis or treatment; and avocation, insurance, aviation activity, criminal activity, financial information, occupation, habits, driving record and general character. This information will be used by Harleysville Life Insurance Company and its reinsurers to determine eligibility for insurance. In addition to this Authorization, and to facilitate rapid transmission of such information to an appropriate Harleysville representative(s), I (We) will execute the required Authorizations for Release of Medical Records for any such sources requiring an authorization., except Medical Information Bureau (MIB, Inc.), to provide such records of information to any appropriate Harleysville representative(s).

I (We) understand that Harleysville Life Insurance Company will not disclose this information to any person or organization except its reinsurer(s); the Medical Information Bureau (MIB, Inc.); other life insurance companies with which I have policies or to whom I may apply, or to whom a claim for benefits may be submitted; other persons or organizations performing business or legal services in connection with my/our application, including employees of Harleysville Insurance, or as may be otherwise lawfully required, or as I (We) further authorize.

I (We) authorize;  I (We) do not authorize: Harleysville Life Insurance Company to disclose, at its discretion, information obtained during the application/underwriting process to my/our agent of record or representative of agent of record.

I (We) understand that I (we) or my (our) authorized representative have the right to receive a copy of this authorization and agree that a photographic copy will be as valid as the original. I (We) also understand that this authorization will be valid for 24 months from the date shown below.

I (We) certify that the Social Security Number(s) provided above is/are true, correct and complete.

I (We) acknowledge receiving the Notice of Information Practices and authorize Harleysville Life Insurance Company to obtain an investigative or other consumer report as described, and

- I (We) request;
- I (We) do not request, a personal interview in connection with such report.

I (We) understand and acknowledge that this application, and all supplementary documentation, in the aggregate, constitute the entire application, including all information provided in the application, the medical exam, questionnaires and supplements to the application, and amendments issued by the Harleysville Life Insurance Company, and that they will be attached to and made a part of the policy and delivered to the policy owner.

I (We) have paid \$\_\_\_\_\_ with this application in consideration of the [Temporary Insurance Agreement]. I (We) have read, understood, and agreed to the terms of the [Temporary Insurance Agreement].

SIGNED AT: \_\_\_\_\_  
**City and State**

P \_\_\_\_\_  
**Signature of Payor**

DATED ON: \_\_\_\_\_  
**Month/Day/Year**

Ü \_\_\_\_\_  
**Signature of Owner (if other than Payor)**

**AGENT CERTIFICATION**

I certify that I personally completed this application in the company of all proposed insureds.  Yes  No

I certify that I have no knowledge of anything which might affect the insurability of any person proposed for insurance which is not fully set forth herein.  Yes  No

Signed at: \_\_\_\_\_

P \_\_\_\_\_  
**Signature of Licensed Agent**

Dated on: \_\_\_\_\_

\_\_\_\_\_  
**Print Name of Licensed Agent**



Corporate Address:  
**Harleysville Life Insurance Company**  
 [355 Maple Avenue, Harleysville, PA 19438  
 Tel 800.222.1981 www.harleysvillegroup.com]

Please mail forms to the  
 Administrative Address:  
**Harleysville Life Insurance Company**  
 [P.O. Box 253, Harleysville, PA 19438-0253]

## ALCOHOL USE QUESTIONNAIRE

Name of (Proposed) Insured \_\_\_\_\_ Date of Birth \_\_\_\_\_

1. Do you now use alcoholic beverages?  Yes  No  
 If Yes, please complete the table to the right.

Quantity in ounces			
	Liquor	Beer	Wine
Daily			
Weekly			

2. Did you ever drink substantially more than you do now?  Yes  No  
 If Yes, please complete the table to the right and the information below.  
 Dates: From \_\_\_\_\_ To \_\_\_\_\_  
 Why, or due to what circumstances, did you alter your drinking pattern?

Quantity in ounces			
	Liquor	Beer	Wine
Daily			
Weekly			

3. Have you ever consulted a physician or received treatment as a result of your alcohol use or associated impairment(s)?  Yes  No  
 If Yes, please complete the information below.  
 Number of times treated and nature of treatment including medication(s):

\_\_\_\_\_

Date(s) of treatment or hospitalization(s):

\_\_\_\_\_

Name(s) and address(es) of physician(s), hospitals or treatment center(s) involved:

\_\_\_\_\_

\_\_\_\_\_

4. Has any member of your immediate family had a problem of alcohol use?  Yes  No  
 If Yes, please provide details below.

\_\_\_\_\_

5. Are you a member of or do you attend meetings of "AA" or any similar organization?  Yes  No  
 If Yes, please complete the below.  
 Do you have a sponsor?  Yes  No  
 When was abstinence initiated?

\_\_\_\_\_

How frequently do you attend meetings?

\_\_\_\_\_

Other forms of treatment or therapy? Please provide details below.

\_\_\_\_\_

Have you joined and then discontinued membership in "AA" or similar reputable organization?  Yes  No  
 If Yes, please provide details and circumstances.

\_\_\_\_\_

\_\_\_\_\_

6. Have you ever been cited or arrested for driving under the influence of alcohol?  Yes  No  
 If Yes, please provide details and driver's license number.

\_\_\_\_\_

\_\_\_\_\_

7. Please add, using the reverse side if necessary, any additional information which you feel is significant regarding your use of, or treatment for, alcohol.

\_\_\_\_\_

\_\_\_\_\_

I have read the preceding questions and answers, and hereby represent to the best of my knowledge and belief that the statements and answers are complete and true, and that Harleysville Life Insurance Company may rely on the answers in the issuance of a policy. I understand and agree that this questionnaire will, with the application and other required parts, be the basis for, and an integral part of, any policy issued.

**(Proposed) Insured Signature** \_\_\_\_\_ **Date** \_\_\_\_\_



Corporate Address:  
**Harleysville Life Insurance Company**  
 [355 Maple Avenue, Harleysville, PA 19438  
 Tel 800.222.1981 www.harleysvillegroup.com]

Please mail forms to the  
 Administrative Address:  
**Harleysville Life Insurance Company**  
 [P.O. Box 253, Harleysville, PA 19438-0253]

## CLIMBING AND MOUNTAINEERING QUESTIONNAIRE

**Name of (Proposed) Insured** \_\_\_\_\_ **Date of Birth** \_\_\_\_\_

Please indicate the climbing activities in which you participate:

- Wall & indoor climbing    Rappelling    Canyoning    Trekking    Mountaineering    Ice Climbing  
 Rock climbing    Extreme climbing    Ski mountaineering    Expedition climbing

How many climbs do you participate in on average each year?

How many years' climbing experience do you have? \_\_\_\_\_ Years \_\_\_\_\_ Months

At this time do you ever undertake technical climbs alone or without ropes; or do you intend to in the future?    Yes    No  
 If Yes, provide details.

Are you a member of any climbing or mountaineering clubs?    Yes    No  
 If Yes, please provide details.

Please use the table below, advise the regions and mountains where you climb, or where you intend to climb in the future. Please provide as much information as possible including the specific peaks, maximum altitude(s) and climbing grade.

Please also indicate the time of year (seasons) in which you usually climb.

Geographical Region/ Season in which you climb	Mountain range	Peaks	Maximum altitude	UIAA or equivalent grading

Please continue in additional notes section if required.

Additional notes- please add any additional information or details you feel appropriate.

I have read the preceding questions and answers, and hereby represent to the best of my knowledge and belief that the statements and answers are complete and true, and that Harleysville Life Insurance Company may rely on the answers in the issuance of a policy. I understand and agree that this questionnaire will, with the application and other required parts, be the basis for, and an integral part of, any policy issued.

**(Proposed) Insured Signature** \_\_\_\_\_ **Date** \_\_\_\_\_



Corporate Address:  
**Harleysville Life Insurance Company**  
 [355 Maple Avenue, Harleysville, PA 19438  
 Tel 800.222.1981 www.harleysvillegroup.com]

Please mail forms to the  
 Administrative Address:  
**Harleysville Life Insurance Company**  
 [P.O. Box 253, Harleysville, PA 19438-0253]

## DRUG QUESTIONNAIRE

Name of (Proposed) Insured \_\_\_\_\_ Date of Birth \_\_\_\_\_

1. Are you now using or have you ever used any of the following, other than for treatment of a medical condition under proper medical supervision?

- a) Amphetamines (Ecstasy, Ice, MDMA, Speed, Uppers, etc.)  Yes  No
- b) Barbiturates ('Downers', etc.)  Yes  No
- c) Cannabis (Hashish, Marijuana, Pot, Weed, etc.)  Yes  No
- d) Cocaine (Coke, Crack, Snow, etc.)  Yes  No
- e) Hallucinogens (Acid, Angel dust, Haze, LSD, Microdots, etc.)  Yes  No
- f) Herbs i.e. (Catnip, Poppy, Kavakava, Lobelia, etc.)  Yes  No
- g) Opiates (Codeine, Heroin, Methadone, Morphine, Opium, Smack, etc.)  Yes  No
- h) Sedatives (Diazepam, Downers, Nitrazepam, Tranks, etc.)  Yes  No
- i) Solvents (Aerosols, Glue, etc.)  Yes  No
- j) Others \_\_\_\_\_  Yes  No

If YES to any of the above, please provide full details including name of drug and dates when usage commenced and ceased.

Type	How Often Used	Dosage or Amount Used	Dated Used		
			From	-	To
_____	_____	_____	_____	-	_____
_____	_____	_____	_____	-	_____
_____	_____	_____	_____	-	_____

2. Have you ever sought medical treatment due to drug usage or detoxification?  Yes  No  
 If Yes, please provide details including date(s) of attendance and name of doctor(s).

3. Have you suffered from any impairments associated with drug usage?  Yes  No  
 i.e. hepatitis B, HIV infection, mental illness, etc.  
 If Yes, please provide details.

4. Are you now drug-free?  Yes  No  
 If Yes, please state when usage ceased.

5. Please provide any additional information on your condition which you feel will be helpful in processing your application

I have read the preceding questions and answers, and hereby represent to the best of my knowledge and belief that the statements and answers are complete and true, and that Harleysville Life Insurance Company may rely on the answers in the issuance of a policy. I understand and agree that this questionnaire will, with the application and other required parts, be the basis for, and an integral part of, any policy issued.

(Proposed) Insured Signature \_\_\_\_\_ Date \_\_\_\_\_



Corporate Address:  
**Harleysville Life Insurance Company**  
 [355 Maple Avenue, Harleysville, PA 19438  
 Tel 800.222.1981 www.harleysvillegroup.com]

Please mail forms to the  
 Administrative Address:  
**Harleysville Life Insurance Company**  
 [P.O. Box 253, Harleysville, PA 19438-0253]

## FOREIGN RESIDENCE QUESTIONNAIRE

**Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**Country of origin:** \_\_\_\_\_ **Current Citizenship:** \_\_\_\_\_

**Date of entry to the United States:** \_\_\_\_\_

**Visa type, symbol, number and expiration date:** \_\_\_\_\_

**Employer:** \_\_\_\_\_ **Hire Date:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Occupation/Duties:** \_\_\_\_\_

**List immediate family members by relationship, age and citizenship:**

**Inside of the USA** \_\_\_\_\_

**Outside of the USA** \_\_\_\_\_

**List your assets/property both inside and outside of the USA:** \_\_\_\_\_

\_\_\_\_\_

Please provide details of previous and future foreign residence. Please state date(s) of visit(s), countries, regions, reason for visit(s), frequency and duration of visit(s):

**1. Within the last 2 years:**

Date(s) of visit(s)	Countries	Regions	Reason for Residence	Frequency	Duration
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

**2. Future Intentions within the next 2 years:**

Date(s) of visit(s)	Countries	Regions	Reason for Residence	Frequency	Duration
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

**3. Please give a brief description of your duties while residing abroad.**

**4. Do you expect to reside in non-urban areas?**  Yes  No

If Yes, please provide details of:

a) Your likely accommodation:

b) The availability of medical facilities:

c) Your travel arrangements (e.g. light aircraft, boat, etc.):

**5. Would you consider traveling to war zones or hazardous areas?**  Yes  No

If Yes, please provide details.

I have read the preceding questions and answers, and hereby represent to the best of my knowledge and belief that the statements and answers are complete and true, and that Harleysville Life Insurance Company may rely on the answers in the issuance of a policy. I understand and agree that this questionnaire will, with the application and other required parts, be the basis for, and an integral part of, any policy issued.

**(Proposed) Insured Signature** \_\_\_\_\_ **Date** \_\_\_\_\_



Corporate Address:  
**Harleysville Life Insurance Company**  
 [355 Maple Avenue, Harleysville, PA 19438  
 Tel 800.222.1981 www.harleysvillegroup.com]

Please mail forms to the  
 Administrative Address:  
**Harleysville Life Insurance Company**  
 [P.O. Box 253, Harleysville, PA 19438-0253]

## FOREIGN TRAVEL QUESTIONNAIRE

**Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**Country of origin:** \_\_\_\_\_ **Current Citizenship:** \_\_\_\_\_

**Date of entry to the United States:** \_\_\_\_\_

**Visa type, symbol, number and expiration date:** \_\_\_\_\_

**Employer:** \_\_\_\_\_ **Hire Date:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Occupation/Duties:** \_\_\_\_\_

**List immediate family members by relationship, age and citizenship:**

**Inside of the USA** \_\_\_\_\_

**Outside of the USA** \_\_\_\_\_

**List your assets/property both inside and outside of the USA:** \_\_\_\_\_

\_\_\_\_\_

Please provide details of previous and future foreign travel. Please state date(s) of visit(s), countries, regions, reason for visit(s), frequency and duration of visit(s):

**1. Within the last 2 years:**

Date(s) of visit(s)	Countries	Regions	Reason for travel	Frequency	Duration
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

**2. Future Intentions within the next 2 years:**

Date(s) of visit(s)	Countries	Regions	Reason for travel	Frequency	Duration
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

**3. Please give a brief description of your duties while traveling abroad.**

\_\_\_\_\_

**4. Do you expect to visit non-urban areas?**  Yes  No

If Yes, please give details of:

a) Your likely accommodation:

b) The availability of medical facilities:

c) Your travel arrangements (e.g. light aircraft, boat, etc.):

**5. Would you consider traveling to war zones or hazardous areas?**  Yes  No

If Yes, please give details.

I have read the preceding questions and answers, and hereby represent to the best of my knowledge and belief that the statements and answers are complete and true, and that Harleysville Life Insurance Company may rely on the answers in the issuance of a policy. I understand and agree that this questionnaire will, with the application and other required parts, be the basis for, and an integral part of, any policy issued.

**(Proposed) Insured Signature** \_\_\_\_\_ **Date** \_\_\_\_\_



Corporate Address:  
**Harleysville Life Insurance Company**  
 [355 Maple Avenue, Harleysville, PA 19438  
 Tel 800.222.1981 www.harleysvillegroup.com]

Please mail forms to the  
 Administrative Address:  
**Harleysville Life Insurance Company**  
 [P.O. Box 253, Harleysville, PA 19438-0253]

## MILITARY STATUS QUESTIONNAIRE

**Full Name of (Proposed) Insured:**

1. Branch of Service:

- Army                       Marines                       Coast Guard  
 Navy                               Airforce

2. Present duty status:

- Active                               Inactive reserve                       ROTC  
 Active reserve                       National Guard

3. Present rank:

4. Present unit:

5. Military occupational specialty:

6. Address of present unit:

7. Present assignment:

8. Are you receiving any supplemental or hazardous duty pay based on your duties?       Yes    No  
 If Yes, please provide details.

9. To your knowledge and belief, have you been told or are aware that:

- a) You or your unit will be transferred overseas?       Yes    No      If Yes, where?  
 b) You will be transferred to a new unit?                       Yes    No  
 c) You or your unit will be alerted for duty (if presently in Reserve or National Guard)?       Yes    No

I have read the preceding questions and answers, and hereby represent to the best of my knowledge and belief that the statements and answers are complete and true, and that Harleysville Life Insurance Company may rely on the answers in the issuance of a policy. I understand and agree that this questionnaire will, with the application and other required parts, be the basis for, and an integral part of, any policy issued.

**(Proposed) Insured Signature** \_\_\_\_\_ **Date** \_\_\_\_\_



Corporate Address:  
**Harleysville Life Insurance Company**  
 [355 Maple Avenue, Harleysville, PA 19438  
 Tel 800.222.1981 www.harleysvillegroup.com]

Please mail forms to the  
 Administrative Address:  
**Harleysville Life Insurance Company**  
 [P.O. Box 253, Harleysville, PA 19438-0253]

## MOTOR SPORTS QUESTIONNAIRE

**Name of (Proposed) Insured** \_\_\_\_\_ **Date of Birth** \_\_\_\_\_

What type of motor sports are you involved in (more than one category can be selected)?

- Motor car
- Formula One     GP2     Indy Racing     Champ car     Formula Three     Formula Ford  
 Formula Renault, Nippon etc.     Karting     Tour car racing     Stock car racing     Rallying  
 Drag racing     Sports car racing     Autotest     Autocross     Hill climb and sprint  
 Off-road/rallying     Rally cross     Trials     Other (please specify) \_\_\_\_\_

- Motorcycle
- Road racing     Drag racing/sprints     Hill climbs     Super moto     Motocross     Enduro  
 Trials     Speedway     Grass track     Ice racing     Sand racing     Motorcycle stunts  
 Vintage events     Other (please specify) \_\_\_\_\_

In which capacity do you participate in motor sports?     Amateur     Professional

In which type and how many events do you participate each year on average?

Please provide the following details for each vehicle you regularly race:

Model	Class of Vehicle	Engine size	Max speed	Modifications

Do you compete internationally?     Yes     No  
 If Yes, please give full details, including details of sponsors or teams, as appropriate.

How many years' motor sport experience do you have? \_\_\_\_\_ Years

What type of license do you hold?

\_\_\_\_\_

Has it ever been suspended or revoked?     Yes     No If Yes, please provide full details.

Have you ever, or do you ever intend to engage in prototype testing or record attempts?     Yes     No

If Yes, please provide full details.

I have read the preceding questions and answers, and hereby represent to the best of my knowledge and belief that the statements and answers are complete and true, and that Harleysville Life Insurance Company may rely on the answers in the issuance of a policy. I understand and agree that this questionnaire will, with the application and other required parts, be the basis for, and an integral part of, any policy issued.

**(Proposed) Insured Signature** \_\_\_\_\_ **Date** \_\_\_\_\_



Corporate Address:  
**Harleysville Life Insurance Company**  
 [355 Maple Avenue, Harleysville, PA 19438  
 Tel 800.222.1981 www.harleysvillegroup.com]

Please mail forms to the  
 Administrative Address:  
**Harleysville Life Insurance Company**  
 [P.O. Box 253, Harleysville, PA 19438-0253]

## OCCUPATION AVIATION QUESTIONNAIRE

**Full name of (Proposed) Insured:** \_\_\_\_\_

**Occupation:** \_\_\_\_\_

1. In which of the following capacities do you fly? (check all that apply)

- |                    |                              |                     |                              |
|--------------------|------------------------------|---------------------|------------------------------|
| Aerial photography | <input type="checkbox"/> Yes | Airline crew        | <input type="checkbox"/> Yes |
| Airline pilot      | <input type="checkbox"/> Yes | Armed Services      | <input type="checkbox"/> Yes |
| Commercial pilot   | <input type="checkbox"/> Yes | Construction work   | <input type="checkbox"/> Yes |
| Crop spraying      | <input type="checkbox"/> Yes | Flight instruction  | <input type="checkbox"/> Yes |
| Helicopter crew    | <input type="checkbox"/> Yes | Police work         | <input type="checkbox"/> Yes |
| Private pilot      | <input type="checkbox"/> Yes | Survey work         | <input type="checkbox"/> Yes |
| Test pilot         | <input type="checkbox"/> Yes | Other Specify _____ |                              |

**If you do not have any flying duties, you do not need to complete the rest of this questionnaire.**

2. Do you anticipate that your flying will be of a different nature in the future?  Yes  No  
 If Yes, please provide details: \_\_\_\_\_

3. Please provide the make and model of the aircraft(s) that you usually fly? \_\_\_\_\_

4. Please provide the following information:

- a) Total hours flown? \_\_\_\_\_ c) Total hours flown in the last 12 months? \_\_\_\_\_  
 b) Total hours flown expected in the next 12 months? \_\_\_\_\_

5. Please check all certificates held:

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Student           | <input type="checkbox"/> Private            | <input type="checkbox"/> Commercial               |
| <input type="checkbox"/> Airline transport | <input type="checkbox"/> Flight instruction | <input type="checkbox"/> Instrument flight rating |

6. Have you ever had your license revoke or been grounded?  Yes  No  
 If Yes, please give details: \_\_\_\_\_

7. Do you engage in aerobatic flight, stunt flying or racing?  Yes  No  
 If Yes, please give details: \_\_\_\_\_

I have read the preceding questions and answers, and hereby represent to the best of my knowledge and belief that the statements and answers are complete and true, and that Harleysville Life Insurance Company may rely on the answers in the issuance of a policy. I understand and agree that this questionnaire will, with the application and other required parts, be the basis for, and an integral part of, any policy issued.

**(Proposed) Insured Signature** \_\_\_\_\_ **Date** \_\_\_\_\_  
 IQ-008 (Ed. 08-10)



Corporate Address:  
**Harleysville Life Insurance Company**  
 [355 Maple Avenue, Harleysville, PA 19438  
 Tel 800.222.1981 www.harleysvillegroup.com]

Please mail forms to the  
 Administrative Address:  
**Harleysville Life Insurance Company**  
 [P.O. Box 253, Harleysville, PA 19438-0253]

## PARACHUTING QUESTIONNAIRE

**Name of (Proposed) Insured** \_\_\_\_\_ **Date of Birth** \_\_\_\_\_

Please indicate type of parachuting activity you are involved in (more than one category can be selected):

- Static line jumping   
  Tandem jumping   
  Free fall   
  Freestyle/formation   
  Sky diving/free flying  
 Sky surfing/sky boarding   
  BASE jumping   
  Power Parachuting

How many years of parachuting experience do you have? \_\_\_\_\_ Years \_\_\_\_\_ Months

How many jumps have you logged to date? \_\_\_\_\_ Total

How many jumps on average, do you do each year? \_\_\_\_\_ Total

Are you a member of any clubs?     Yes     No  
 Provide full details.

Have you ever, or do you ever intend to take part in any record attempts or sky diving and formation skydiving competitions?  
 Yes     No

Please provide full details.

Additional Notes- please add any additional information or details you feel appropriate

I have read the preceding questions and answers, and hereby represent to the best of my knowledge and belief that the statements and answers are complete and true, and that Harleysville Life Insurance Company may rely on the answers in the issuance of a policy. I understand and agree that this questionnaire will, with the application and other required parts, be the basis for, and an integral part of, any policy issued.

**(Proposed) Insured Signature** \_\_\_\_\_ **Date** \_\_\_\_\_



Corporate Address:  
Harleysville Life Insurance Company  
[355 Maple Avenue, Harleysville, PA 19438  
Tel 800.222.1981 www.harleysvillegroup.com]

Please mail forms to the  
Administrative Address:  
Harleysville Life Insurance Company  
[P.O. Box 253, Harleysville, PA 19438-0253]

### PRIVATE AVIATION QUESTIONNAIRE

Name of (Proposed) Insured \_\_\_\_\_ Date of Birth \_\_\_\_\_

What type of aircraft do you fly?

- Fixed wing                       Helicopter

Please provide details of make, model and name of usual aircraft that you fly: \_\_\_\_\_

Please state the type of license and any ratings you hold:

Date(s) obtained:

Student	_____	_____
Private	_____	_____
Instrument flight rating	_____	_____
Airline transport	_____	_____
Flight Instruction	_____	_____
Commercial	_____	_____

Do you ever act as a pilot on commercial transport flights or other commercial activities (eg. aerial surveying, agricultural aircraft, etc.)  Yes  No  
or do you intend to in the next 2 years?  Yes  No

If yes, please also complete a separate **Occupation Aviation Questionnaire**

Have you ever had your license revoked, restricted or suspended?  Yes  No

If Yes, please provide full details, including reasons and dates.

How many years of flying experience do you have? \_\_\_\_\_ Years \_\_\_\_\_ Months

How many flight hours have you logged to date? \_\_\_\_\_ Total Hours

How many hours do you fly on average each year? \_\_\_\_\_ Hours

How many individual flights have you logged in the last 12 months and the number of hours?

\_\_\_\_\_ Hours in last 12 months      \_\_\_\_\_ Number of flights in last 12 months

What is the usual purpose of your flights?  Business  Recreational

Please provide details of the typical locations to which you have flown over the past 12 months; and which you intend to fly to in the next 12 months.

If overseas, please indicate countries, type of terrain, length of flights, and whether licensed airfields are used.

Do you currently, or do you intend to engage in acrobatic (stunt) flights, or test flights?  Yes  No

If Yes, please provide full details.

I have read the preceding questions and answers, and hereby represent to the best of my knowledge and belief that the statements and answers are complete and true, and that Harleysville Life Insurance Company may rely on the answers in the issuance of a policy. I understand and agree that this questionnaire will, with the application and other required parts, be the basis for, and an integral part of, any policy issued.

(Proposed) Insured Signature \_\_\_\_\_ Date \_\_\_\_\_



Corporate Address:  
**Harleysville Life Insurance Company**  
 [355 Maple Avenue, Harleysville, PA 19438  
 Tel 800.222.1981 www.harleysvillegroup.com]

Please mail forms to the  
 Administrative Address:  
**Harleysville Life Insurance Company**  
 [P.O. Box 253, Harleysville, PA 19438-0253]

## SCUBA DIVING QUESTIONNAIRE

**Name of (Proposed) Insured** \_\_\_\_\_ **Date of Birth** \_\_\_\_\_

What type of diving are you involved in?  Commercial diving  Recreational diving

How long (in years) have you been scuba diving? \_\_\_\_\_

On average, how many dives do you carry out each year? \_\_\_\_\_

Do you expect the number of dives to increase next year?  Yes  No If Yes, please provide details.

What diving certification do you hold and at which level?

For instance, please state whether:

- PADI
- Other

And please circle the highest certification level you have reached:

- Basic/Resort level
- Open water
- Advanced
- Dive master
- Other

Are you a member of any diving clubs?  Yes  No

If Yes, please provide full details.

What is the maximum depth you dive to, or intend to dive to, in the future? \_\_\_\_\_

Have you ever, or do you plan to carry out, any of the following

Solo dives	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Wreck or cave diving	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Ice diving	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Free diving	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Record attempts	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Diving over 50m or mixed gas diving	<input type="checkbox"/> Yes	<input type="checkbox"/> No

If you answered Yes to any of the above, please provide full details, including the locations in which you have carried out these dives or intend to in the future:

Do you have any history of decompression sickness, barotraumas, or nitrogen narcosis?  Yes  No

If Yes, please provide full details.

Have you ever had any restrictions placed upon your diving activities for medical reasons?  Yes  No

If Yes, please provide full details.

I have read the preceding questions and answers, and hereby represent to the best of my knowledge and belief that the statements and answers are complete and true, and that Harleysville Life Insurance Company may rely on the answers in the issuance of a policy. I understand and agree that this questionnaire will, with the application and other required parts, be the basis for, and an integral part of, any policy issued.

**(Proposed) Insured Signature** \_\_\_\_\_ **Date** \_\_\_\_\_





Corporate Address:  
**Harleysville Life Insurance Company**  
 [355 Maple Avenue, Harleysville, PA 19438  
 Tel 800.222.1981 www.harleysvillegroup.com]

Please mail forms to the  
 Administrative Address:  
**Harleysville Life Insurance Company**  
 [P.O. Box 253, Harleysville, PA 19438-0253]

## STRANGER OWNED LIFE INSURANCE/ LIFE SETTLEMENT QUESTIONNAIRE

**Name of (Proposed) Insured** \_\_\_\_\_ **Date of Birth** \_\_\_\_\_

**1. Have you been approached by an agent, broker or company about selling any life insurance policy for cash payment?**       Yes  No

If Yes, please provide the following information:

- a. The name of the agent, broker and/or company: \_\_\_\_\_
- b. When you were approached about the sale: \_\_\_\_\_

**2. Is there any intention that any party, other than the Owner, will obtain any right, title, or interest in any policy issued on the life of the proposed insured as a result of this application?**       Yes  No

If Yes, please provide the following information:

- a. The name of the party(ies) intended to receive the interest: \_\_\_\_\_
- b. Their relationship to you and the nature of the interest: \_\_\_\_\_

**3. Do you intend to have the policy issued on the life of the proposed insured as a result of this application serve as collateral?**       Yes  No

If Yes, please provide the following information:

- a. The nature of the arrangement for which the policy is intended as collateral: \_\_\_\_\_
- b. The name and address of the party that will hold the policy as collateral: \_\_\_\_\_

**4. Is the premium for this policy to be financed or paid by someone other than the owner, applicant or insured as identified on the application?**       Yes  No

If Yes, please provide the following information:

- a. Provide complete details as to the terms and parties involved: \_\_\_\_\_
- b. What is the nature of the financing of the premium? : \_\_\_\_\_
- c. The name and address of the individual(s) and/ or entity providing the financing/payment of the premium.  
 \_\_\_\_\_

**5. What is the nature of your relationship with the owner of the policy as identified on the application and describe the insurable interest of the owner?**

\_\_\_\_\_

**6. What is the purpose for procuring this policy of life insurance?**

\_\_\_\_\_

I have read the preceding questions and answers, and hereby represent to the best of my knowledge and belief that the statements and answers are complete and true, and that Harleysville Life Insurance Company may rely on the answers in the issuance of a policy. I understand and agree that this questionnaire will, with the application and other required parts, be the basis for, and an integral part of, any policy issued.

**(Proposed) Insured Signature** \_\_\_\_\_ **Date** \_\_\_\_\_



Financial Information Questionnaire

Corporate Address: Harleysville Life Insurance Company [355 Maple Avenue, Harleysville, PA 19438 Tel 800.222.1981 www.harleysvillegroup.com]

Please mail forms to the Administrative Address: Harleysville Life Insurance Company [P.O. Box 253, Harleysville, PA 19438-0253]

PLEASE COMPLETE FOR APPLICATIONS OF \$1,500,001 and more

Name of Proposed Insured(s) (First, Middle Initial, Last):

1. Provide any additional details or documentation you may feel is needed to substantiate the amount of coverage applied for, and how it was determined:

2. Purpose of Insurance

- Buy/Sell, Key Person, Executive Bonus, Deferred Compensation, Creditor/Debt Protection, Pension or Profit Sharing, Mortgage Protection, Other, Charitable Giving, Estate Planning, Family Income Replacement, Final Expenses

3. If purpose of insurance is creditor insurance/debtor protection: Amount of loan: \$ Term of loan:

Table with 2 columns: 4. Earned Income (Salary, Bonus, Other, Unearned Income, Total) and 5. Current personal finances (Assets at current Market value, Liabilities, Net Worth). Rows for Last Year and Previous Year.

6. Total coverage to be placed in force from all carriers: \$ Total coverage currently in force: Personal \$ Business \$

7. Is any portion of the premium for this policy being financed through a loan from any source? Yes No If "Yes", provide complete details and copy of the loan agreement

If this is a Business related sale please complete question 8.

8. Is Proposed Insured and Owner a business? Yes No % of Ownership? Are other partners, corporate officers or key employees insured or being insured with similar amounts? Yes No If "No", why not?

For other business owners, please provide the following information:

Table with 4 columns: Business Owner, Title, % of Ownership, Amount of Life Insurance in force

Net Worth of Business: Book Value \$ Fair Market Value \$

How was the value of business determined?

Gross Annual Sales \$ Net Annual Income of business \$

I have read the preceding questions and answers, and hereby represent to the best of my knowledge and belief that the statements and answers are complete and true, and that Harleysville Life Insurance Company may rely on the answers in the issuance of a policy. I understand and agree that this questionnaire will, with the application and other required parts, be the basis for, and an integral part of, any policy issued.

(Proposed) Insured Signature Date



Corporate Address:  
**Harleysville Life Insurance Company**  
[355 Maple Avenue, Harleysville, PA 19438  
Tel 800.222.1981 www.harleysvillegroup.com]

Please mail forms to the  
Administrative Address:  
**Harleysville Life Insurance Company**  
[P.O. Box 253, Harleysville, PA 19438-0253]

## AMENDMENT OF APPLICATION FOR LIFE INSURANCE

**POLICY NO:**

**INSURED:**

The APPLICATION FOR LIFE INSURANCE with **HARLEYSVILLE LIFE INSURANCE COMPANY**, dated \_\_\_\_\_ (a copy of which is attached to your Life Insurance Policy) is amended as follows:

### APPLICANT'S STATEMENT

I (We) have read this Amendment of Application for Life Insurance, and hereby represent to the best of my (our) knowledge and belief that the information contained in the Amendment is complete and true, and that Harleysville Life Insurance Company may rely on the information in the amendment of the policy. I (We) understand and agree that this Amendment will be an integral part of the policy issued; that no waiver or modification will bind the Company unless in writing and signed by the President, a Vice President or the Secretary of Harleysville Life Insurance Company. **Please place a copy of this Amendment with your Policy.**

Dated the \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_.

SIGNED AT: \_\_\_\_\_  
**City and State**

\_\_\_\_\_  
**Signature of Insured**

DATED ON \_\_\_\_\_  
**Month/Day/Year**

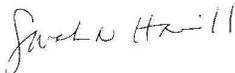
\_\_\_\_\_  
**Signature of Parent or Legal Guardian**  
(If Insured is under the age of majority required by the state where the policy is issued for delivery)

\_\_\_\_\_  
**Signature of Owner** (if other than Insured)

\_\_\_\_\_  
**Signature of Applicant** (if other than Insured)

**The original of this Amendment is to be signed, dated and returned immediately to Harleysville Life Insurance Company. A signed and dated copy of this Amendment must be placed with your Policy.**

This Amendment is signed at our home office in Harleysville, Pennsylvania.

[  ]

[Sarah N. Hamill]  
[Vice President, Marketing and Life Operations]

**HARLEYSVILLE LIFE INSURANCE COMPANY**  
HARLEYSVILLE, PENNSYLVANIA 19438

**CERTIFICATE OF POLICY ENDORSEMENT**

PLEASE KEEP THIS ENDORSEMENT AND ACCOMPANYING FORMS WITH YOUR POLICY.

The Harleysville Life Insurance Company certifies that the policy listed below has been amended in accordance with the attached application for policy change.

This endorsement and the attached application for policy change form a part of the original contract and application and shall constitute the entire contract between the parties hereto.

Policy Number:  
Issue Date:  
Insured's Name:

**ADDITION OF**

Policy Benefit or Benefit Rider:  
Benefit Amount:  
Term of Coverage:  
Date of Expiry:  
Benefit Premium:

**ADDITION OF**

Policy Benefit or Benefit Rider:  
Benefit Amount:  
Term of Coverage:  
Date of Expiry:  
Benefit Premium:

**DELETION OF**

Policy Benefit or Benefit Rider:  
Amount:  
Term of Coverage:  
Benefit Premium:

**DELETION OF**

Policy Benefit or Benefit Rider:  
Amount:  
Term of Coverage:  
Benefit Premium:

**CHANGE(S) TO POLICY:**

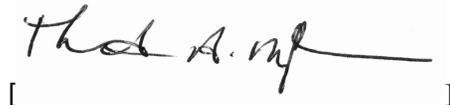
Total premiums shown on the policy are hereby changed as follow:

Total premium on this Policy:  
Interval of Premium Payment:

Any reference in attached benefit riders to page three of the policy or the face of the policy shall mean this endorsement of Policy Change. The change(s) listed above were executed at the Home Office of Harleysville Life Insurance Company in Harleysville, Pa., on: .



[Robert A. Kauffman]  
[Director and Secretary]



[Theodore A. Majewski]  
[President and Chief Operating Officer]

Registrar



Corporate Address:  
**Harleysville Life Insurance Company**  
[355 Maple Avenue, Harleysville, PA 19438  
Tel 800.222.1981 www.harleysvillegroup.com]

Please mail forms to the  
Administrative Address:  
**Harleysville Life Insurance Company**  
[P.O. Box 253, Harleysville, PA 19438-0253]

## HARLEYSVILLE LIFE INSURANCE COMPANY TEMPORARY LIFE INSURANCE AGREEMENT

If payment of two months premium at the rate class quoted at the time of application by Pre-Authorized Check ("PAC") or the first modal premium has been accepted by Harleysville Life Insurance Company ("Company") as advance payment for an Application For Life Insurance ("Application") and any Proposed Primary Insured or Proposed Other Insured (collectively "Proposed Insureds") covered under this Temporary Life Insurance Agreement ("Agreement") dies while this Agreement is in effect, the Company will pay to the beneficiary or beneficiaries designated in the Application the lesser of: (a) the amount of all death benefits applied for in the Application covering any deceased Proposed Insured, excluding *all accidental and supplemental death benefits and all benefits under coverage riders* except for a term rider on the Proposed Primary Insured; or (b) \$1,000,000 per deceased Proposed Insured. This total benefit limit applies to the aggregate of all insurance coverage applied for under the Application, as well as all other applications, and Temporary Life Insurance Agreements or Conditional Receipts currently being considered by the Company.

### Date Coverage Begins

Subject to the Terms and Conditions and Termination provisions below, coverage under this receipt will begin on:

1. The date of this Agreement, but only if Part 1 of the Application has been completed, signed and dated on the same date as the date this Agreement is signed, and
2. The date payment of an amount equal to 2 months premium by PAC, or one modal premium is received.

### Terms and Conditions

1. If any of the Eligibility Questions on page two of this Agreement are answered "Yes" or left blank, no insurance will take effect under this Agreement and no insurance agent, producer or broker is authorized to accept payment.
2. Any material misstatement or materially incorrect answer made in any part of the Application or in this Agreement limits the Company's liability to a refund of the premium paid.
3. There is no coverage under this Agreement if no payment is made or the check paid with this Agreement it is not honored by the bank.
4. There is no coverage under this Agreement if the amount paid in consideration of this Agreement is not enough to cover at least:
  - a) two months of coverage by PAC, or
  - b) the first modal premium,for the death benefit at the rate class quoted at the time of application for all of the Proposed Insureds.
5. There is no coverage under this Agreement for any death resulting from suicide. In such cases, our liability is limited to refund of premium paid.
6. Any proposed insured must be at least 15 days of age and not older than age 70.
7. The policy effective date of any policy issued will be the effective date identified in the policy. The amount remitted for this Agreement will be applied to the first modal premium for the policy.
8. The Company reserves the right to terminate this Agreement at any time.

### Date Agreement Terminates

This Agreement will automatically terminate:

1. If required medical examinations are not conducted within 45 days of the date the Application was signed. In this case we will refund payment.
2. On the date the Company issues the policy of insurance applied for. Insurance coverage will then be provided by the policy as of the effective date of the issued policy.
3. On the earlier of the date on the written notice by mail to the owner, or other notification to the owner that the Company declined to offer coverage. The Company has the right to decline to offer coverage as applied for at anytime. In this case we will refund payment
4. On the date of owner's request to stop considering the Application. In this case we will refund payment.
5. On the earlier of the date on the written notice by mail to the owner or the date the owner learns that the Company is considering offering coverage at a rate class other than the one quoted at the time of Application. In this case we will refund payment.

Unless first terminated by any provision stated in 1 through 5 above, the Company may terminate coverage 90 calendar days from the date of this Agreement. In this case we will refund payment.

**Eligibility Questions**

If any of the following Eligibility Questions are answered "Yes" or left blank, no insurance will take effect under this Agreement and no insurance agent, producer or broker is authorized to accept payment.

- 1. Within the past 90 days, has any proposed insured been admitted to a hospital or other medical facility, been advised to be admitted, had surgery performed or recommended (other than simple fractures or childbirth), or been advised to have a diagnostic test other than an HIV or AIDS test?  YES  NO
- 2. Within the past 10 years, has any proposed insured been treated for heart trouble, stroke, cancer, drug or alcohol use, or had such treatment recommended by a physician or other health care provider?  YES  NO
- 3. Has any proposed insured ever been diagnosed as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) caused by the Human Immunodeficiency Virus (HIV) infection or been treated for or had treatment recommended for AIDS or ARC by a member of the medical profession?  YES  NO
- 4. Is any proposed insured under 15 days old or over 70 years of age?  YES  NO

Advanced payment has been given in the amount of \$ \_\_\_\_\_ (equal to 2 months for PAC or one modal premium) at the \_\_\_\_\_ rate class quoted at the time of application.

I (we) have read this agreement and represent that I (we) understand its meaning and that the above answers are full, complete and true to the best of my (our) knowledge and belief. I (we) understand and agree to all its terms and conditions.

\_\_\_\_\_  
**Signature of Proposed Insured**

\_\_\_\_\_  
**Signature of Owner**  
(if other than Proposed Insured )

\_\_\_\_\_  
**Signature of Parent or Natural Guardian**  
(if Proposed Insured is under the age of majority required by the state where the policy is issued for delivery)

\_\_\_\_\_  
**Signature of Other Insured**

\_\_\_\_\_  
**Signature of Licensed Agent**

**Dated on (Month, Day, Year)** \_\_\_\_\_

**Signed at (City, and State)** \_\_\_\_\_



Corporate Address:  
**Harleysville Life Insurance Company**  
 355 Maple Avenue, Harleysville, PA 19438  
 Tel 800.222.1981 www.harleysvillegroup.com]

Please mail forms to the  
 Administrative Address:  
**Harleysville Life Insurance Company**  
 [P.O. Box 253, Harleysville, PA 19438-0253]

**MEDICAL EXAMINATION FORM**

Policy Number: \_\_\_\_\_  
 (To be completed by the Home Office)

**MEDICAL INFORMATION**

**Please Provide:**

**1. Name of Proposed Insured** \_\_\_\_\_ **Date of Birth** \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ Weight change (> 10 lbs) in last 12 months \_\_\_\_\_ Reason for weight change \_\_\_\_\_

Personal Primary Physician: Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Telephone Number: \_\_\_\_\_

**2. To the best of your knowledge and belief, has a parent or sibling died from coronary artery disease, cerebrovascular disease, diabetes, mellitus, or cancer?**

Relationship	Age at Death	Cause of Death
Father		
Mother		
Brothers and Sisters		

**3. In the past 5 years, ever use tobacco or nicotine products in any form?**  
**If Yes, please provide details:**

Product	Date Last Used (month/year)	Amount/Frequency	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cigarettes	_____	_____		
Cigar/Pipe	_____	_____		
Chewing Tobacco	_____	_____		
Other: _____				

**4. Have you ever been diagnosed with, been treated for or consulted a physician for:**  
**(If Yes, please provide full details)**

a. depression, anxiety, psychosis, anorexia, bulimia, or other mental, nervous or emotional disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No
b. seizures, tremors, headaches, paralysis, stroke, transient ischemic attack, multiple sclerosis, Parkinson's, Alzheimer's, or other disorder of the brain, spinal cord, nerves or muscles?	<input type="checkbox"/> Yes <input type="checkbox"/> No
c. cancer, tumor, or any other malignant disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No
d. cyst, polyp, lump or any disorder of the skin or lymph nodes?	<input type="checkbox"/> Yes <input type="checkbox"/> No
e. diabetes or elevated blood sugar, or any other disorder of the thyroid, pituitary, endocrine glands?	<input type="checkbox"/> Yes <input type="checkbox"/> No
f. chest pain, angina, high blood pressure, high cholesterol/triglycerides, palpitations, irregular heartbeat, heart murmur, heart attack, peripheral vascular disease, phlebitis or any other disorder of the heart or blood vessels?	<input type="checkbox"/> Yes <input type="checkbox"/> No
g. anemia, blood clots, leukemia, lymphoma, immune deficiency or any other disorder of the blood, lymph glands or immune system (excluding HIV or AIDS)?	<input type="checkbox"/> Yes <input type="checkbox"/> No



Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

New Jersey: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

### APPLICANT'S STATEMENT

I have read the preceding questions and answers, and hereby represent to the best of my knowledge and belief that the statements and answers are complete and true, and that Harleysville Life Insurance Company may rely on the answers in the issuance of a policy or granting of an Application for Policy Change. I understand and agree that this Medical Examination Form and other required parts will be the basis for granting a policy change or issuing a policy, and an integral part of the Application for Policy Change and the policy issued; that no waiver or modification will bind the Company unless in writing and signed by the President, a Vice President or the Secretary of Harleysville Life Insurance Company. I (We) understand and agree that a sales representative does not have the company's authorization to accept risk, pass on insurability, or make, void, waive, or change any conditions or provisions of the application, policy or receipt.

I understand that Harleysville Life Insurance Company will not disclose this information to any person or organization except its reinsurer(s); the Medical Information Bureau (MIB, Inc.); other persons or organizations performing business or legal services in connection with my examination, including employees of Harleysville Insurance, or as may be otherwise lawfully required, or as I further authorize.

SIGNED AT: \_\_\_\_\_  
**City and State**

DATED ON: \_\_\_\_\_  
**Month/Day/Year**

P \_\_\_\_\_  
**Signature of Insured**

Ü \_\_\_\_\_  
**Signature of Parent or Legal Guardian**  
(If Insured is under the age of majority  
required by the state where the policy is  
issued for delivery)

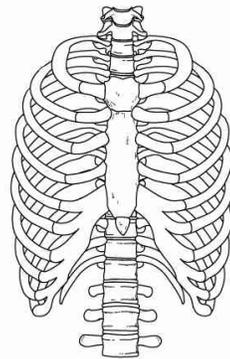
## INSTRUCTIONS TO THE MEDICAL EXAMINER

1. When an Examination is begun the report thereof becomes the property of the Company and must not be suppressed or destroyed regardless of your recommendation and regardless of whether the proposed insured or any other person offers to pay the medical fee in order to avoid a declination.
2. Any erasures or alterations in the statements made by the proposed insured must be initialed by him.
3. Any erasures or alterations in your report should be initialed by you.
4. Your report should give the Company a description of the person or persons examined.

### Medical Examiner's Report

Name of Agent \_\_\_\_\_ Amount of Insurance Proposed \_\_\_\_\_

5.a. Height (in shoes) ft.      in.	Weight (clothed) lbs.	Chest (full Inspiration) in.	Chest (forced Expiration) in.	Abdomen, at Umbilicus in.	Details of "Yes" answers. (Identify item.)
b. Did you weigh?    Yes    No		Did you measure?    Yes    No			
c. Is appearance unhealthy or older than stated age?		Yes    No			
6. Blood Pressure (obtain 3 readings)					
Systolic					
Diastolic    Disappearance of sound  {5th phase					
7. Pulse:		At Rest	After Exercise	3 Minutes Later	
Rate:					
Irregularities per min.					
8. Heart: Is there any:					
Enlargement    Yes    No		Dyspnea    Yes    No			
Murmur(s)    Yes    No		Edema    Yes    No			
(describe below — if more than one, describe separately)					
<u>Location</u>		<u>Indicate</u>			
Constant    .. ..		Apex by: X			
Inconstant    .. ..					
Transmitted    .. ..		Murmur area by: O			
Localized    .. ..					
Systolic    .. ..		Point of greatest intensity by: O			
Presystolic    .. ..					
Diastolic    .. ..		Transmission by:			
Soft (Gr. 1-2)    .. ..					
Mod. (Gr. 3-4)    .. ..					
Loud (Gr. 5-6)    .. ..					
After Exercise:					
Increased    .. ..		For comments and your impression?			
Absent    .. ..					
Unchanged    .. ..					
Decreased    .. ..					



<p>9. Is there on examination any abnormality of the following: (Circle appropriate items and give details.)</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 50%;"></th> <th style="width: 10%;">Yes</th> <th style="width: 10%;">No</th> </tr> </thead> <tbody> <tr> <td>a. Eyes, ears, nose, mouth, pharynx? (if vision or hearing markedly impaired, indicate degree and correction.)</td> <td style="text-align: center;">..</td> <td style="text-align: center;">..</td> </tr> <tr> <td>b. Skin; lymph nodes, varicose veins or peripheral arteries?</td> <td style="text-align: center;">..</td> <td style="text-align: center;">..</td> </tr> <tr> <td>c. Nervous system (include reflexes, gait, paralysis)?</td> <td style="text-align: center;">..</td> <td style="text-align: center;">..</td> </tr> <tr> <td>d. Respiratory system?</td> <td style="text-align: center;">..</td> <td style="text-align: center;">..</td> </tr> <tr> <td>e. Abdomen (include scars)?</td> <td style="text-align: center;">..</td> <td style="text-align: center;">..</td> </tr> <tr> <td>f. Genitourinary system (include prostate)?</td> <td style="text-align: center;">..</td> <td style="text-align: center;">..</td> </tr> <tr> <td>g. Endocrine system (include thyroid and breasts)?</td> <td style="text-align: center;">..</td> <td style="text-align: center;">..</td> </tr> <tr> <td>h. Musculoskeletal system (include spine, joints, amputations, deformities)?</td> <td style="text-align: center;">..</td> <td style="text-align: center;">..</td> </tr> </tbody> </table>					Yes	No	a. Eyes, ears, nose, mouth, pharynx? (if vision or hearing markedly impaired, indicate degree and correction.)	..	..	b. Skin; lymph nodes, varicose veins or peripheral arteries?	..	..	c. Nervous system (include reflexes, gait, paralysis)?	..	..	d. Respiratory system?	..	..	e. Abdomen (include scars)?	..	..	f. Genitourinary system (include prostate)?	..	..	g. Endocrine system (include thyroid and breasts)?	..	..	h. Musculoskeletal system (include spine, joints, amputations, deformities)?	..	..	<p>Details of "Yes" answers. (Identify item.)</p>	
	Yes	No																														
a. Eyes, ears, nose, mouth, pharynx? (if vision or hearing markedly impaired, indicate degree and correction.)	..	..																														
b. Skin; lymph nodes, varicose veins or peripheral arteries?	..	..																														
c. Nervous system (include reflexes, gait, paralysis)?	..	..																														
d. Respiratory system?	..	..																														
e. Abdomen (include scars)?	..	..																														
f. Genitourinary system (include prostate)?	..	..																														
g. Endocrine system (include thyroid and breasts)?	..	..																														
h. Musculoskeletal system (include spine, joints, amputations, deformities)?	..	..																														
<p>10. Are there any hernias? Are you aware of additional medical history? (A confidential report may be sent to the Medical Director)</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 50%;"></th> <th style="width: 10%;">Yes</th> <th style="width: 10%;">No</th> </tr> </thead> <tbody> <tr> <td>Are there any hernias?</td> <td style="text-align: center;">..</td> <td style="text-align: center;">..</td> </tr> <tr> <td>Are you aware of additional medical history?</td> <td style="text-align: center;">..</td> <td style="text-align: center;">..</td> </tr> </tbody> </table>					Yes	No	Are there any hernias?	..	..	Are you aware of additional medical history?	..	..																				
	Yes	No																														
Are there any hernias?	..	..																														
Are you aware of additional medical history?	..	..																														
<p>Urinalysis: Specific Gravity</p>	<p>Albumin</p>	<p>Sugar</p>	<p>Micro.</p>	<p>Signature of Medical Examiner</p> <p>• _____</p> <p>PLEASE PRINT: Name of Medical Examiner</p> <p>• _____</p> <p>Address of Medical Examiner</p> <p>• _____</p> <p style="text-align: center;">Street Address</p> <p style="text-align: center;">City and State and Zip Code</p>																												
<p>Examination made: _____ At _____ <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.</p> <p>At Applicant's place of business ..</p> <p>At Applicant's residence ..</p> <p>At Examiner's office ..</p> <p>On _____, 20____</p> <p style="text-align: center;">Month                      Day                      Year</p>																																

SERFF Tracking Number: MCHX-G126868655 State: Arkansas  
 Filing Company: Harleysville Life Insurance Company State Tracking Number: 47110  
 Company Tracking Number: IA-006 (ED. 08-10)  
 TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other  
 Product Name: IA-006 (Ed. 08-10) Individual Life Insurance Appl  
 Project Name/Number: IA-006 (Ed. 08-10) Individual Life Insurance Application - Harleysville Life Insurance Company/IA-006 (Ed. 08-10) Individual Life Insurance Application - Harleysville Life Insurance Company

## Supporting Document Schedules

	Item Status:	Status Date:
<p><b>Satisfied - Item:</b> Flesch Certification  <b>Comments:</b>  <b>Attachments:</b>            AR Readability Certification.PDF            AR Cert of Compl 23-79-138 &amp; RR 49.PDF            AR Cert of Compl with Rule 19.PDF</p>		
<p><b>Satisfied - Item:</b> Application  <b>Comments:</b>            Please see form schedule.</p>		
<p><b>Satisfied - Item:</b> Submission Letter  <b>Comments:</b>  <b>Attachment:</b>            AR Submission Letter 10_19_10.PDF</p>		
<p><b>Satisfied - Item:</b> Authorization Letter  <b>Comments:</b>  <b>Attachment:</b>            2010 Harleysville Third Party Authorization Letter.PDF</p>		

SERFF Tracking Number: MCHX-G126868655 State: Arkansas  
Filing Company: Harleysville Life Insurance Company State Tracking Number: 47110  
Company Tracking Number: IA-006 (Ed. 08-10)  
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other  
Product Name: IA-006 (Ed. 08-10) Individual Life Insurance Appl  
Project Name/Number: IA-006 (Ed. 08-10) Individual Life Insurance Application - Harleysville Life Insurance Company/IA-006 (Ed. 08-10) Individual Life Insurance Application - Harleysville Life Insurance Company

**Satisfied - Item:** Statement of Variability

**Comments:**

**Attachment:**

Statement of Variability-10\_19\_10.PDF

**Item Status:**

**Status  
Date:**

**Satisfied - Item:** Guaranty Association Notice

**Comments:**

**Attachment:**

GAN-009 (AR) (Ed\_ 01-04) Guaranty Assoc Notice-AR.PDF

**Item Status:**

**Status  
Date:**

**Satisfied - Item:** Consumer Information Notice

**Comments:**

**Attachment:**

LFEA-138 (Ed\_ 10-09) ARK Notice to Policyholders.PDF

**STATE OF ARKANSAS**  
**READABILITY CERTIFICATION**

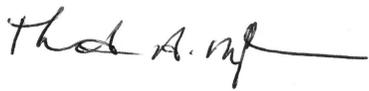
**COMPANY NAME:** Harleysville Life Insurance Company

This is to certify that the form(s) referenced below has achieved a Flesch Reading Ease Score as indicated below and complies with the requirements of Ark. Stat. Ann. Section 66-3251 through 66-3258, cited as the Life and Disability Insurance Policy Language Simplification Act.

<b>Form Number</b>	<b>Score</b>
IA-006 (Ed. 08-10)	50
IA-007 (Ed. 08-10)	50
IA-008 (Ed. 08-10)	50
IA-009 (Ed. 08-10)	50
IA-010 (Ed. 08-10)	50
IA-011 (Ed. 08-10)	50
IA-013 (Ed. 08-10)	50
IQ-001 (Ed. 08-10)	50
IQ-002 (Ed. 08-10)	50
IQ-003 (Ed. 08-10)	50
IQ-004 (Ed. 08-10)	50
IQ-005 (Ed. 08-10)	50
IQ-006 (Ed. 08-10)	50
IQ-007 (Ed. 08-10)	50
IQ-008 (Ed. 08-10)	50
IQ-009 (Ed. 08-10)	50

**STATE OF ARKANSAS**  
**READABILITY CERTIFICATION**

<b>Form Number</b>	<b>Score</b>
IQ-010 (Ed. 08-10)	50
IQ-011 (Ed. 08-10)	50
IQ-012 (Ed. 08-10)	50
IQ-013 (Ed. 08-10)	50
IQ-014 (Ed. 08-10)	50
IM-019 (Ed. 08-10)	50
IM-021 (Ed. 08-10)	50
IM-028 (Ed. 08-10)	50
IM-030 (Ed. 08-10)	50

Signed:   
Name: Theodore A. Majewski  
Title: President and Chief Operating Officer  
Date: 10/20/10

**CERTIFICATE OF COMPLIANCE**

Insurer: **HARLEYSVILLE LIFE INSURANCE COMPANY**

Form Numbers:

**IA-006 (Ed. 08-10), et al. – Application for Individual Life Insurance**

I hereby certify that the filing above meets all applicable Arkansas requirements including Regulation 49 (Life and Health Guaranty Fund Notice) and Ark. Code Ann. 23-79-138 and Bulletin 11-88 (Consumer Information Notice).



\_\_\_\_\_  
Signature of Company Officer

Theodore A. Majewski

\_\_\_\_\_  
Name

President and Chief Operating Officer

\_\_\_\_\_  
Title

10/19/10

\_\_\_\_\_  
Date

**Certificate of Compliance with  
Arkansas Rule and Regulation 19**

Insurer: **HARLEYSVILLE LIFE INSURANCE COMPANY**

Form Number(s): **IA-006 (Ed. 08-10), et al. – Application for Individual Life  
Insurance**

I hereby certify that the filing above meets all applicable Arkansas requirements including the requirements of Rule and Regulation 19.



\_\_\_\_\_  
Signature of Company Officer

Theodore A. Majewski  
\_\_\_\_\_  
Name

\_\_\_\_\_  
President and Chief Operating Officer

Title

10/19/10  
\_\_\_\_\_  
Date

Date

.....

# McHugh Consulting Resources, Inc.

October 22, 2010

Jay Bradford  
Insurance Commissioner  
Arkansas Department of Insurance  
Compliance - Life and Health  
1200 West Third Street  
Little Rock, AR 72201-1904

Re: **HARLEYSVILLE LIFE INSURANCE COMPANY**  
**NAIC # 64327, FEIN # 23-1580983**

**Individual Life Insurance Application Filing**

- Form IA-006 (Ed. 08-10), Application for Individual Life Insurance
- Form IA-007 (Ed. 08-10), Proposed Other Insured Supplement
- Form IA-008 (Ed. 08-10), Children's Insurance Supplement
- Form IA-009 (Ed. 08-10), Application for Reinstatement
- Form IA-010 (Ed. 08-10), Application for Policy Change
- Form IA-011 (Ed. 08-10), Tobacco Use Application for Policy Change
- Form IA-013 (Ed. 08-10), Payor Benefit Supplement
- Form IQ-001 (Ed. 08-10), Alcohol Use Questionnaire
- Form IQ-002 (Ed. 08-10), Climbing and Mountaineering Questionnaire
- Form IQ-003 (Ed. 08-10), Drug Questionnaire
- Form IQ-004 (Ed. 08-10), Foreign Residence Questionnaire
- Form IQ-005 (Ed. 08-10), Foreign Travel Questionnaire
- Form IQ-006 (Ed. 08-10), Military Status Questionnaire
- Form IQ-007 (Ed. 08-10), Motor Sports Questionnaire
- Form IQ-008 (Ed. 08-10), Occupation Aviation Questionnaire
- Form IQ-009 (Ed. 08-10), Parachuting Questionnaire
- Form IQ-010 (Ed. 08-10), Private Aviation Questionnaire
- Form IQ-011 (Ed. 08-10), Scuba Diving Questionnaire
- Form IQ-012 (Ed. 08-10), Sports Aviation Questionnaire
- Form IQ-013 (Ed. 08-10), Stranger Owned Life Insurance/Life Settlement Questionnaire
- Form IQ-014 (Ed. 08-10), Financial Information Questionnaire
- Form IM-019 (Ed. 08-10), Amendment to the Application
- Form IM-021 (Ed. 08-10), Certificate of Policy Endorsement
- Form IM-028 (Ed. 08-10), Temporary Life Insurance Agreement
- Form IM-030 (Ed. 08-10), Medical Exam Form
- Statement of Variability

Dear Commissioner Bradford:

McHugh Consulting Resources, Inc. has been requested to file the attached forms on behalf of Harleysville Life Insurance Company. We respectfully attach an authorization letter for your files.

10/22/2010

We are attaching the above-captioned filing for your review and approval for Harleysville Life Insurance Company. These forms are new and are not intended to your Department. The forms are being submitted in final printed form subject only to changes in font style, margins, page numbers, ink, and paper stock. For example, formatting may change slightly when the document is assembled through an automated document assembly system. Printing standards will never be less than those required by law.

The above forms will be used when applying for Term Life, Whole Life and Universal Life products that have been previously approved by your Department as listed below and may be used with future products.

- LFCG-027 (Ed. 5-97) approved on August 13, 2001
- IPWL - 200 (Ed. 08-08) approved on December 22, 2008
- IPUL 5 100 (Ed. 08-08) approved on November 18, 2008
- IPUL 6 100 (Ed. 05-09) approved on June 16, 2009

For clarification purposes, Form IA-013 (Ed. 08-10), Payor Benefit Supplement is currently only used with the Whole Life product and Form IA-007 (Ed. 08-10), Proposed Other Insured Supplement is only used with the Term Life and Universal Life products, where applicable.

Currently these application forms will only be used in paper format. If, in the future, Harleysville decides to use them in either an electronic format or telephonic, they will file the procedures and necessary documentation with your Department, if applicable.

Please note this product is currently pending with the Interstate Insurance Product Regulation Commission in which Pennsylvania, Harleysville's state of domicile, has enacted legislation and is a member.

Attached are any required certifications, transmittal forms and/or filing fees.

While every effort is made to submit filings without mistakes, we reserve the right to make corrections to any typographical errors such as misspellings or minor grammatical errors noted after filing and approval.

Harleysville Life Insurance Company will deem these forms approved, if upon the expiration of the initial review period, your Department has not extended the review period or otherwise has not responded to this submission.

We trust the attached is found to be in order and look forward to receiving your favorable reply. Should you have any questions or if we may provide any additional information, please do not hesitate to contact the undersigned. Thank you for your consideration in this matter.

Very truly yours,



Linda Boyce  
Consultant

Attachments

**Harleysville Life Insurance**  
355 Maple Avenue  
Harleysville, PA 19438-2297  
www.harleysvillelife.com

Tel 800.222.1981  
215.513.6400  
Fax 215.513.6410



February 22, 2010

NAIC Company Code: 64327

Re: Attached Filing Submission

Please accept this letter as authorization from Harleysville Life Insurance Company for McHugh Consulting Resources, Inc. to file any or all policy forms as well as actuarial materials as referenced in the corresponding SERFF filing on behalf of Harleysville Life Insurance Company.

Sincerely,

A handwritten signature in black ink that reads "Theodore A. Majewski". The signature is fluid and cursive, with a long horizontal stroke extending to the right.

Theodore A. Majewski  
President and Chief Operating Officer  
Harleysville Life Insurance Company

HARLEYSVILLE LIFE INSURANCE COMPANY  
STATEMENT OF VARIABILITY

*The following items on the Forms are bracketed and considered variable.*

**All Forms**

**Page 1**

Company address, telephone number and web address could change in the future.

Blanks provided in the forms will be completed by the proposed insured, applicant or agent where appropriate.

**Form IA-006 (Ed. 08-10), Application for Individual Life Insurance**

**Section IV Payment**

We may add a Credit Card billing method in the future.

**Page 2**

**Section V Plan of Insurance**

Applicable Riders may be discontinued on certain plans in the future or may not be available in all states.

**Pages 4 and 7**

**Authorization to Obtain and Disclose Information**

Pharmaceutical data bases may be used in the future.

Temporary Insurance Agreement may change in the future to a Conditional Receipt.

**Form IA-007 (Ed. 08-10), Proposed Other Insured Supplement**

**Page 4**

**Authorization to Obtain and Disclose Information**

Pharmaceutical data bases may be used in the future.

Temporary Insurance Agreement may change in the future to a Conditional Receipt.

**Form IA-008 (Ed. 08-10), Children's Insurance Supplement**

**Page 3**

Authorization to Obtain and Disclose Information

Pharmaceutical data bases may be used in the future.

**Page 4**

Temporary Insurance Agreement may change in the future to a Conditional Receipt.

**Form IA-009 (Ed. 08-10), Application for Reinstatement**

**Page 3**

Authorization to Obtain and Disclose Information

Pharmaceutical data bases may be used in the future.

**Form IA-010 (Ed. 08-10), Application for Policy Change**

**Pages 1 and 2**

Section II

Applicable Riders may be discontinued on certain plans in the future or may not be available in all states.

**Page 3**

Authorization to Obtain and Disclose Information

Pharmaceutical data bases may be used in the future.

**Form IA-011 (Ed. 08-10), Tobacco Use Application for Policy Change**

**Page 1**

Pro Provider is currently the marketing name for the product that allows the Alternative Tobacco class, this may change in the future.

**Form IA-013 (Ed. 08-10), Payor Benefit Supplement**

**Page 1**

Title

This form is currently used with the Whole Life product only, but that may change in the future.

**Page 3**

Authorization to Obtain and Disclose Information

Pharmaceutical data bases may be used in the future.

**Page 4**

Temporary Insurance Agreement may change in the future to a Conditional Receipt.

**Form IM-019 (Ed. 08-10), Amendment of Application for Life Insurance**

The Officer's signature, name and title may change in the future.

**Form IM-021 (Ed. 08-10), Certificate of Policy Endorsement**

The Officers' signatures, names and titles may change in the future.

## **LIMITATIONS AND EXCLUSIONS UNDER THE ARKANSAS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT**

Residents of this state who purchase life insurance, annuities or health and accident insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the Arkansas Life and Health Insurance Guaranty Association ("Guaranty Association"). The purpose of the Guaranty Association is to assure that policy and contract owners will be protected, within certain limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the claims of policy owners who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by the member insurers through the Guaranty Association is not unlimited, however. And, as noted in the box below, this protection is not a substitute for consumers' care in selecting insurance companies that are well managed and financially stable.

### **DISCLAIMER**

The Arkansas Life and Health Insurance Guaranty Association ("Guaranty Association") may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions and require continued residency in this state. You should not rely on coverage by the Guaranty Association in purchasing an insurance policy or contract.

Coverage is NOT provided for your policy or contract or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as non-guaranteed amounts held in a separate account under a variable life and variable annuity contract.

Insurance companies or their agents are required by law to provide you with this notice. However, insurance companies and their agents are prohibited by law from using the existence of the Guaranty Association to induce you to purchase any kind of insurance policy.

The Arkansas Life and Health Insurance Guaranty Association  
c/o The Liquidation Division  
1023 West Capitol  
Little Rock, Arkansas 72201

Arkansas Insurance Department  
1200 West Third Street  
Little Rock, Arkansas 72201-1904

The state law that provides for this safety-net is called the Arkansas Life and Health Insurance Guaranty Association Act ("Act"). Below is a brief summary of the Act's coverages, exclusions and limits. This summary does not cover all provisions of the ACT; nor does it in any way change anyone's rights or obligations under the ACT or the rights or obligations of the Guaranty Association.

### **COVERAGE**

Generally, individuals will be protected by the Guaranty Association if they live in this state and hold a life, annuity or health insurance contract or policy, or if they are insured under a group insurance contract issued by a member insurer. The beneficiaries, payees or assignees of policy or contract owners are protected as will, even if they live in another state.

### **EXCLUSIONS FROM COVERAGE**

However, persons owning such policies are NOT protected by the Guaranty Association if:

- They are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);

- The insurer was not authorized to do business in this state;
- Their policy or contract was issued by a nonprofit hospital or medical service organization, an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policy or contract owner is subject to future assessments, or by an insurance exchange.

The Guaranty Association also does NOT provide coverage for:

- Any policy or contract or portion thereof which is not guaranteed by the insurer or for which the owner has assumed the risk, such as non-guaranteed amounts held in a separate account under a variable life or variable annuity contract;
- Any policy of reinsurance (unless an assumption certification was issued):
- Interest rate yields that exceed an average rate;
- Dividends and voting rights and experience rating credits;
- Credits given in connection with the administration of a policy by a group contract holder;
- Employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);
- Unallocated annuity contracts (which give rights to group contract holders, not individuals).
- Unallocated annuity contracts issued to/in connection with benefit plans protected under Federal Pension Benefit Corporation ("FPBC") (whether the FPBC is yet liable or not);
- Portions of an unallocated annuity contract not owned by a benefit plan or a government lottery (unless the owner is a resident) or issued to a collective investment trust or similar pooled fund offered by a bank or other financial institution);
- Portions of a policy or contract to the extent assessments required by law for the Guaranty Association are preempted by State or Federal law;
- Obligations that do not arise under the policy or contract, including claims based on marketing materials or side letters, riders, or other documents which do not meet filing requirements, or claims for policy misrepresentations, or extra-contractual or penalty claims;
- Contractual agreements establishing the member insurer's obligations to provide book value accounting guarantees for defined contribution benefit plan participants (by reference to a portfolio of assets owned by a nonaffiliate benefit plan or its trustees).

## **LIMITS ON AMOUNT OF COVERAGE**

The Act also limits the amount the Guaranty Association is obligated to cover: The Guaranty Association cannot pay more than what the insurance company would owe under a policy or contract. Also, for any one insured life, the Guaranty Association will pay a maximum of \$300,000 – no matter how many policies and contracts there were with the same company, even if they provided different types of coverages. Within this overall \$300,000 limit, the Association will not pay more than \$300,000 in health insurance benefits, \$300,000 in present value of annuity benefits, or \$300,000 in life insurance death benefits or cash surrender values – again, no matter how many policies and contracts there were with the same company, and no matter how many different types of coverages. There is a \$1,000,000 limit with respect to any contract holder for unallocated annuity benefits, irrespective of the number of contracts held by the contract holder. These are limitations for which the Guaranty Association is obligated before taking into account either its subrogation and assignment rights or the extent to which those benefits could be provided out of the assets of the impaired or insolvent insurer.

**HARLEYSVILLE LIFE INSURANCE COMPANY**  
Harleysville, Pennsylvania

**FOR POLICIES ISSUED IN ARKANSAS**

Issued by Harleysville Life Insurance Company to the Policyholder.

**KEEP THIS NOTICE WITH YOUR INSURANCE PAPERS**

**PROBLEMS WITH YOUR INSURANCE?** If you are having problems with your insurance company or agent, do not hesitate to contact the insurance company or agent to resolve your problem.

Harleysville Life Insurance Company  
355 Maple Avenue  
Customer Relations Department  
Harleysville PA 19438  
1-800-222-1981

Policyholder Service Office of Company: Harleysville Life Insurance Company

Address: 355 Maple Avenue Harleysville, PA 19438

Telephone Number: 1-800-222-1981

Name of Agent: \_\_\_\_\_

Address: \_\_\_\_\_

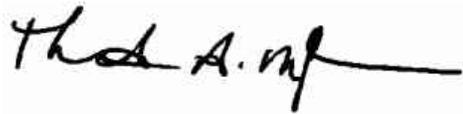
Telephone Number: \_\_\_\_\_

If we at Harleysville Life Insurance Company fail to provide you with reasonable and adequate service, you should feel free to contact:

Arkansas Insurance Department  
1200 West Third Street  
Little Rock, AR 72201  
(501) 371-2640 or (800) 852-5494



Robert A. Kauffman  
Director and Secretary



Theodore A. Majewski  
President and Chief Operating Officer