

SERFF Tracking Number: MCHX-G126735753 State: Arkansas
 Filing Company: Harleysville Life Insurance Company State Tracking Number: 46298
 Company Tracking Number: IPT-001 (ED. 07-10)
 TOI: L04I Individual Life - Term Sub-TOI: L04I.103 Renewable - Single Life -
 Fixed/Indeterminate Premium
 Product Name: IPT-001 (Ed. 07-10) Indiv Simplified Issue Term Li
 Project Name/Number: IPT-001 (Ed. 07-10) Indiv Simplified Issue Term Life Harleysville Life Ins Company /IPT-001 (Ed. 07-10) Indiv Simplified Issue
 Term Life Harleysville Life Ins Company

Filing at a Glance

Company: Harleysville Life Insurance Company

Product Name: IPT-001 (Ed. 07-10) Indiv
Simplified Issue Term Li

TOI: L04I Individual Life - Term

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Filing Type: Form

SERFF Tr Num: MCHX-
G126735753

SERFF Status: Closed-Approved-
Closed

Co Tr Num: IPT-001 (ED. 07-10)

Author: SPI McHughConsulting
Date Submitted: 07/22/2010

State: Arkansas

State Tr Num: 46298

State Status: Approved-Closed

Reviewer(s): Linda Bird

Disposition Date: 08/03/2010

Disposition Status: Approved-
Closed

Implementation Date:

Implementation Date Requested: On Approval

State Filing Description:

General Information

Project Name: IPT-001 (Ed. 07-10) Indiv Simplified Issue Term Life
Harleysville Life Ins Company

Project Number: IPT-001 (Ed. 07-10) Indiv Simplified Issue Term Life
Harleysville Life Ins Company

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Filing Status Changed: 08/03/2010

Deemer Date:

Submitted By: SPI McHughConsulting

Filing Description:

Re: HARLEYSVILLE LIFE INSURANCE COMPANY

NAIC # 64327, FEIN # 23-1580983

Status of Filing in Domicile: Pending

Date Approved in Domicile:

Domicile Status Comments:

Market Type: Individual

Group Market Size:

Group Market Type:

Explanation for Other Group Market Type:

State Status Changed: 08/03/2010

Created By: SPI McHughConsulting

Corresponding Filing Tracking Number:

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Individual Term Life Filing

IPT-001 (AR) (Ed. 07-10), Individual Simplified-Issue Term Policy

IPT-001 (Ed. 07-10), Schedule of Benefits and Premiums

IA-012 (Ed. 07-10), Application for Simplified-Issue Term Policy

Actuarial Memoranda

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 replace any existing forms currently on file with 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.

This is a Simplified-Issue Level Term Life Insurance Policy to Age 95. The premiums are guaranteed for the initial term period of 10, 15, 20 or 30 years, increasing annually thereafter. After the initial term period, one-year renewal term periods will be allowed until the policy anniversary immediately following the Insured's 95th birthday.

This is not an illustrated product. It will be marketed through Harleysville's current distribution system of independent agents.

We have attached a Schedule of Benefits and Premiums page along with the Actuarial Memorandum.

Application form IA-012 (Ed. 07-10) will be used to apply for this product. Currently this Application will only be used in paper format.

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

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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

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: \$150.00

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 Term Life Harleysville Life Ins Company
 Retaliatory? No
 Fee Explanation:
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Harleysville Life Insurance Company	\$150.00	07/22/2010	38225013

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	08/03/2010	08/03/2010

Amendments

Schedule	Schedule Item Name	Created By	Created On	Date Submitted
Form	Application for Simplified-Issue Term Policy	SPI McHughConsulting	07/26/2010	07/26/2010
Supporting Document	07.26.10 Marked Application IA-012 (Ed. 07-10)	SPI McHughConsulting	07/26/2010	07/26/2010

SERFF Tracking Number: MCHX-G126735753 *State:* Arkansas
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Disposition

Disposition Date: 08/03/2010

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		Yes
Supporting Document	Life & Annuity - Acturial Memo		No
Supporting Document	Submission Letter		Yes
Supporting Document	Authorization Letter		Yes
Supporting Document	Statement of Variability		Yes
Supporting Document	AR Guaranty Association Notice		Yes
Supporting Document	AR Consumer Notice		Yes
Supporting Document	07.26.10 Marked Application IA-012 (Ed. 07-10)		Yes
Form	Individual Simplified-Issue Term Policy		Yes
Form	Schedule of Benefits and Premiums		Yes
Form (revised)	Application for Simplified-Issue Term Policy		Yes
Form	Application for Simplified-Issue Term Policy	Replaced	Yes

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Amendment Letter

Submitted Date: 07/26/2010

Comments:

Dear Reviewer:

Please accept our apology. Attached is a revised application. A change was made to the first section. Check boxes have been added to where the applicant picks their sex. A marked copy of the application has been provided to help see the revision. No other revision has been made.

Thank you for your time and patience. We appreciate it.

Sincerely,

Tim Hager
 Compliance Project Specialist
 McHugh Consulting Resources, Inc.
 215-230-7960
 mcr@mchughconsulting.com

Changed Items:

Form Schedule Item Changes:

Form Schedule Item Changes:

Form Number	Form Type	Form Name	Action	Form Action Other	Previous Filing #	Replaced Form #	Readability Score	Attachments
IA-012 (Ed. 07-10)	Application/EApplication nrollment Form	Application for Simplified-Issue Term Policy	Revised				45.000	IA-012 (Ed_07-10) - SI Term App-07_26_10.PDF

Supporting Document Schedule Item Changes:

User Added -Name: 07.26.10 Marked Application IA-012 (Ed. 07-10)

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Comment:

IA-012 (Ed_ 07-10) - SI Term App-07_26_10marked.PDF

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Form Schedule

Lead Form Number: IPT-001 (AR) (Ed. 07-10)

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	IPT-001 (AR) (Ed. 07-10)	Policy/Contract/Individual Simplified	Individual Simplified- Issue Term Policy Certificate	Initial		64.000	IPT-001 (AR) (Ed_ 07-10) - SITerm Policy final 7_22_10.PDF
	IPT-001 (Ed. 07-10)	Schedule Pages	Schedule of Benefits and Premiums	Initial		75.000	IPT-001 (Ed_ 07-10) SITerm Page 3s.PDF
	IA-012 (Ed. 07-10)	Application/ Enrollment Form	Application for Simplified-Issue Term Policy	Revised	Replaced Form #: Previous Filing #:	45.000	IA-012 (Ed_ 07-10) - SI Term App- 07_26_10.PDF



**Harleysville Life Insurance Company
Harleysville, Pennsylvania**

[355 Maple Avenue – Harleysville, PA 19438-2297
Tel 800.222.1981 • 215.256.5000 – www.harleysvillelife.com]

**Thank you for choosing Harleysville Life Insurance Company.
For Inquiries, Information and Resolution of Complaints, please call: [1-800-222-1981]**

[Arkansas Insurance Department 1-501-371-2800]

HARLEYSVILLE LIFE INSURANCE COMPANY (referred to in this Policy as We, Us or Our) WILL PAY THE Proceeds to the Beneficiary upon receipt of due proof of the Insured's death that occurred during any Term Period. Payment will be made only if this Policy is In Full Force on the date of the Insured's death subject to the terms and conditions of this Policy.

The Initial Term Period begins on the Policy Effective Date and ends on the Expiry Date stated on the Schedule of Benefits and Premiums page of this Policy (referred to as Page 3). After the Initial Term Period, one-year renewal term periods will be allowed until the Policy Anniversary immediately following the Insured's 95th birthday. Each one-year renewal term period begins on a Policy Anniversary, and ends the day before the next Policy Anniversary.

Premiums are level and guaranteed for the Initial Term Period as stated on Page 3 and will increase annually thereafter. If premiums are paid to the end of each term period, this Policy may be renewed without Evidence of Insurability for the additional term periods for which premiums are shown on Pages 3A-1 and 3A-2, if applicable. At the end of each term period except the last, a period of 31 days is allowed for renewal. If the Insured dies during such 31 day period, the Policy will be renewed automatically and a monthly premium will be deducted from the Proceeds paid.

20 Day Right to Examine Policy. Please examine Your Policy. Within 20 days after delivery, You can return it to Us, or to the representative from whom it was purchased, or to any other agent of Our company, with a Written Request for a full refund of premium, including any fees or charges. Upon such request, this Policy will be void from the Policy Effective Date and the parties shall be in the same position as if no Policy had been issued. If this is a replacement of an existing Policy or Contract, Your right to examine this Policy is extended from twenty days to thirty days, or any longer period as may be required by applicable law of the state where the Policy is delivered or issued for delivery.

This Policy is signed at Our home office in Harleysville, Pennsylvania.

[Robert A. Kauffman]
[Director and Secretary]

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

**LEVEL TERM LIFE INSURANCE POLICY TO AGE 95
WITH PREMIUMS GUARANTEED FOR THE INITIAL TERM PERIOD
RENEWABLE
NONPARTICIPATING**

**READ THIS POLICY CAREFULLY.
This Policy is a legal contract between You and Us.**

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Policy Provisions	4-7	Settlement Option Tables	8
Premiums	5	Endorsements (if any)	Attached at end

DEFINITIONS

Age - The Insured's age at the Insured's last birthday.

Beneficiary - The person(s) who is (are) named in the application or by later designation to receive the Face Amount of this Policy.

Default - Any premium not paid when due will be in default.

Evidence of Insurability - Information about an Insured which is used to approve or Reinstate this Policy.

Expiry Date - The date the Initial Term Period expires as indicated on Page 3. If this Policy is renewed, the Expiry Date occurs annually after the Initial Term Period with the final Expiry Date being the Policy Anniversary immediately after the Insured's 95th birthday.

Face Amount - The amount of insurance coverage as shown on Page 3.

Grace Period - The 31 days following the premium due date.

In Force - The Insured's life remains insured under the terms of Your Policy.

In Full Force - Your Policy is In Force and no unpaid premium is more than 31 days overdue.

Initial Term Period - The initial years of the Policy during which premiums are guaranteed not to change, as described on Page 3.

Insured - The person whose life is insured under this Policy as shown on Page 3.

Lapse - Your Policy is no longer In Force if premiums remain unpaid upon expiration of the Grace Period.

Policy - The Policy consists of this document, including all applicable endorsements and the application. It establishes the terms, provisions and conditions of insurance coverage.

Policy Anniversary - The same month and day as the Policy Effective Date for each succeeding year this Policy remains In Force.

Policy Effective Date - The date the coverage under the Policy is placed in force. This Policy will be placed in force and become effective as soon as it has been accepted by You and the first premium has been paid during the lifetime and condition of health of the insured as described in the application for life insurance. We will use this date to determine the start of the suicide and incontestability periods. Also, Policy Anniversaries, policy years, policy months and premium due dates are determined from this date.

Premium Class - The mortality classifications assigned to the Insured under this Policy as shown on Page 3.

Proceeds - The amount We will pay to the Beneficiary under the terms of Your Policy if the Insured dies.

Reinstate - To restore coverage after this Policy has lapsed.

Term Period - The period beginning on the Policy Effective Date or any subsequent Policy Anniversary, and ending the day before the next Policy Anniversary.

We, Our, Us - Harleysville Life Insurance Company, Harleysville, Pennsylvania 19438.

Written Request - A request in writing in a form acceptable to Us signed by You.

You, Your - The owner of this Policy.

POLICY PROVISIONS

Ownership - This Policy belongs to You. Unless You provide otherwise by Written Request, You exercise all rights and privileges in Your Policy while the Insured is living. If You are not the Insured and You die, Your estate will be the Owner unless otherwise provided.

You may change the Owner by Written Request. You must make this change while the Insured is alive. The change is not valid until We approve Your request in writing, at which time the change will take effect on the date the request was signed by You, unless You specify otherwise in Your written request. The change is subject to:

1. The rights of any assignee of which We have been notified.
2. Any payment made or other action taken by Us prior to receipt of Your request.

Beneficiary - The Beneficiary is named in the application, unless a later change is shown in Our records. We will pay the Proceeds to the Beneficiary. If You have not named a Beneficiary or the Beneficiary is not alive, You or Your estate will be the Beneficiary.

You may change the Beneficiary by Written Request. You must make this change while the Insured is alive. The change is not valid until We approve Your request in writing, at which time the change in Beneficiary shall take effect on the date the notice of change is signed by You, unless You specify otherwise in Your written request. The change is subject to any payments made or actions taken by Us prior to receipt of this notice.

Renewal Provision - If Your Policy is In Full Force, You may renew Your Policy for an additional Term Period on the Expiry Date of the Initial Term Period or any subsequent Term Period and before the Policy Anniversary immediately following the Insured's 95th birthday. Evidence of Insurability is not required. The provisions of this Policy will apply to each renewal. The term period of any renewal will be 1 year.

The first premium of the renewal period must be received by Us before renewal becomes effective. This premium must be received by Us on or before its due date or during the applicable Grace Period. The due date will be the Expiry Date of the preceding Term Period.

After the Initial Term Period, the annual premium will increase to the yearly renewal term premium as shown on Pages 3A-1 and 3A-2, if applicable, in the table of Guaranteed Maximum Annual Premiums.

Consideration; Entire Contract - This Policy, including all applicable endorsements, is issued in consideration of: (a) the attached application; and (b) the payment in advance of the first premium. This Policy and the application are the entire contract between You and Us. Statements made in the application are considered representations and not warranties, except in the case of fraud. No statement will void this Policy or be used as a defense to a claim unless made in the application. Any application for reduction in Premium Class will also be attached to and made part of this Policy.

Modification of Policy - No agent has authority to change this Policy or waive any of its provisions. Any change in this Policy will be binding on Us only when endorsed by Our President, Vice President, Secretary or Assistant Secretary.

Payments by Us - Any amount payable by Us will be made from Our home office in Harleysville, Pennsylvania.

Incontestability - This Policy will not be contestable after it has been In Force during the Insured's lifetime for two years from the Policy Effective Date or date of reinstatement, except for nonpayment of premium or acts of fraud, when permitted by applicable law in the state where the Policy is delivered or issued for delivery. If the Policy has been Reinstated, the contestable period is based only upon statements provided in the reinstatement application, unless the original contestable period has not yet expired.

Suicide - Suicide, while sane or insane, within two years from the Policy Effective Date, will limit the Proceeds payable under this Policy to the total premiums paid.

Misstatement of Age or Sex - Based on the date of birth shown on the application for insurance, the Insured's Age is the age attained as of the Insured's last birthday immediately preceding the next Policy Anniversary. If the Age or sex shown on Page 3 is not correct, any Proceeds payable will be based upon the Face Amount the premium would have purchased at the correct Age and sex on the basis of published rates used by Us on the Policy Effective Date.

If the correct Age is outside the issue age ranges of the form, a premium and Face Amount shall be extrapolated.

Reduction in Premium Class - You may request that We reduce the Premium Class assigned on the Insured. The Reduction in Premium Class applies only to a reclassification from smoker to non-smoker based on the Insured's changed smoking habits. The Insured is eligible to apply for non-smoker status after the Policy has been In Force for at least 12 months. We will apply the same underwriting rules for reclassification to a non-smoker that were available on the Policy Effective Date. We must receive satisfactory evidence that the Insured has stopped smoking.

A Reduction in Premium Class will be subject to the following conditions: (a) You will be required to pay for any evidence We may need to establish the Insured's health; (b) any evidence We may require must be provided by a medical examiner approved by Us; and (c) a new Policy will not be issued; however, a new Schedule of Benefits and Premiums page will be provided to the owner.

Assignment - You may assign Your Policy while the Insured is alive. The change is not valid until We approve Your request in writing, at which time the Assignment shall take effect on the date the notice of Assignment is signed by You, unless You specify otherwise in Your written request. The change is subject to any payments made or actions taken by Us prior to receipt of this notice. The Assignment will affect Your rights and the rights of any Beneficiary. We shall not be liable for the validity of any Assignment.

Nonparticipating - This Policy does not participate in Our earnings or surplus.

PREMIUMS

Payment of Premiums - You must pay Us each premium when due for the amount and for the mode shown on Page 3 during the Initial Term Period. Subsequent premiums are determined according to the Premium Change Provision. You must pay the initial premium in advance of the Policy Effective Date. You must pay all subsequent premiums on or before the first day of the mode. You may pay Us at Our Home Office or one of Our authorized agents. We will send You a receipt, signed by one or more of the Officers who are designated in the Policy, if You request one.

You may change the mode of premium payment subject to the following:

1. You must send Us a Written Request before the Grace Period expires,
2. A premium must fall due on every Policy Anniversary, and
3. We must make the change based on Our rates and rules in effect on the Policy Effective Date.

This Policy terminates on the due date of any premium not paid on or before that date, subject to the Grace Period provision.

Premium Change - The premium for this Policy, shown on Page 3, is guaranteed not to change during the Initial Term Period shown on Page 3. After this Initial Term Period, the annual premium will increase to the yearly renewable term premium as shown on Pages 3A-1 and 3A-2, if applicable, in the table of Guaranteed Maximum Annual Premiums. We will give You written notice of the new premium 30 days before the premium change takes effect.

Grace Period - A grace period of 31 days will be allowed for payment of any premium after the first premium payment. The Policy will remain In Force during the Grace Period. Any payments sent by U.S. mail shall be postmarked within the Grace Period. At the end of the applicable Grace Period, if You have not paid the premium due, this Policy will Lapse and coverage will terminate unless it is Reinstated.

Reinstatement - If You do not pay a premium and Your Policy lapses, We will Reinstatement it if all of the following conditions are met:

1. You must send a Written Request for reinstatement to Our Home Office within 3 years after Your Policy has lapsed,
2. The Insured must be insurable in the same premium class according to Our underwriting standards, and
3. You must pay all overdue premiums plus 6% interest compounded annually on these premiums to the date of reinstatement.

Premium Adjustment at Death - Any part of a premium which pays for coverage beyond the date of death will be returned. If death occurs during a Grace Period, any part of any unpaid premium due prior to the date of death will be deducted from the Proceeds paid.

DEATH BENEFIT

Death Benefit Proceeds – When a Policy becomes a claim upon the death of the Insured, We will pay Proceeds equal to the Face Amount of the Policy plus any applicable interest plus the Premium Adjustment at Death.

Applicable interest is determined as follows:

1. Interest shall accrue and be payable from the date of death.
2. Interest shall accrue at the rate or rates applicable to the Policy for funds left on deposit or, if We have not established a rate for funds left on deposit, at the Two Year Treasury Constant Maturity Rate as published by the Federal Reserve. In determining the effective annual rate or rates, We shall use the rate in effect on the date of death.

Due proof of death includes, but is not limited to, a fully completed Beneficiary claim form, a certified copy of the death certificate of the Insured or other lawful evidence providing equivalent information, and the return of the Schedule of Benefits and Premiums page or a completed Request for Duplicate Policy form.

Payment will be issued in a timely fashion and in accordance with the Beneficiary designations of record or the provisions of this Policy.

OPTIONAL INCOME PAYMENT OF PROCEEDS

Settlement Options - Proceeds of \$2,000 or more which are payable under this Policy may be applied under any of these options:

Option 1 - Fixed Period - We will make equal payment amounts payable for a fixed period of up to 30 years. The amount of each payment will be determined from the Settlement Option Table.

Option 2 - Life Income - We will make monthly payments for the lifetime of the payee for life only or provide a life income with 10 years certain. Option 2 is available at the Ages and factors shown in the Settlement Option Table.

Option 3 - Fixed Amount - Payments of a fixed amount will be made until the Proceeds and interest are fully paid. Payments will be of an amount not less than \$5 per month for each \$1,000 of Proceeds.

Option 4 - Interest Income - Annual interest payments on Proceeds left on deposit with Us will be made for: (a) the life of the payee; or (b) a fixed period not to exceed 30 years.

At the time of their commencement, the annuity benefits provided under these options will not be less than those that would be provided by the application of the Death Benefit Proceeds to purchase a single consideration immediate annuity contract at purchase rates offered by the company at the time to the same class of annuitants.

Conditions - Election of options is subject to the following conditions:

1. Election must be made by You while the Insured is living. If no election is made by the time of the Insured's death, then the Beneficiary may elect an option.
2. A change of Beneficiary after election of an option revokes any prior election.

3. Proceeds must be sufficient to produce installment or interest payments of at least \$20.
4. Options are available only with Our written consent if: (a) this Policy is assigned; or (b) the payee is a trustee or business entity.
5. Unless the option was elected by the person to receive the payment, withdrawal or transfer of Proceeds between options may be made only to the extent stated in the election. Option 2 may not be changed after income payments begin.

Annuity Option - The payee may use the Proceeds under the Policy to purchase a Single Premium Immediate Annuity being issued by Us on the date of settlement. The payee may elect this by filing a written request within 31 days of settlement. The annuity must be on the payee's own life.

Request for Alternate Payment – The payee may request another form of payment in writing. However, We must approve this request.

Interest - We may pay or credit interest in addition to the interest specified under any of the Settlement Options. We alone will determine the time and amount of this interest. The interest rate used to compute income payments will also be used to determine the withdrawal value of guaranteed payments that remain unpaid at the payee's death, except for Option 2 – Life Income Only.

TABLES OF MONTHLY PAYMENTS UNDER OPTIONAL INCOME PAYMENT OF PROCEEDS
Per \$1,000 of Proceeds Settled

Settlement Option 1 - Fixed Period

<u>Years</u>	<u>Payment</u>	<u>Years</u>	<u>Payment</u>
5	17.34	18	5.61
6	14.59	19	5.36
7	12.63	20	5.14
8	11.18	21	4.94
9	10.06	22	4.76
10	9.18	23	4.60
11	8.44	24	4.45
12	7.82	25	4.31
13	7.31	26	4.18
14	6.87	27	4.06
15	6.49	28	3.95
16	6.17	29	3.85
17	5.88	30	3.76

Rates for period not shown will be furnished upon request.

Settlement Option 2 - Life Income

----- Life Income with 10 Years Certain -----

<u>Age</u>	<u>Male</u>	<u>Female</u>	<u>Age</u>	<u>Male</u>	<u>Female</u>
50	3.26	3.03	68	5.06	4.63
51	3.32	3.09	69	5.22	4.77
52	3.39	3.15	70	5.37	4.92
53	3.46	3.21	71	5.53	5.08
54	3.53	3.27	72	5.70	5.25
55	3.61	3.34	73	5.87	5.42
56	3.69	3.41	74	6.04	5.60
57	3.78	3.48	75	6.22	5.79
58	3.87	3.56	76	6.40	5.98
59	3.96	3.64	77	6.59	6.18
60	4.06	3.73	78	6.77	6.39
61	4.17	3.82	79	6.95	6.59
62	4.28	3.92	80	7.13	6.80
63	4.39	4.02	81	7.31	7.01
64	4.52	4.13	82	7.48	7.21
65	4.64	4.24	83	7.65	7.41
66	4.78	4.37	84	7.81	7.60
67	4.92	4.49	85	7.97	7.78

----- Life Income Only -----

<u>Age</u>	<u>Male</u>	<u>Female</u>	<u>Age</u>	<u>Male</u>	<u>Female</u>
50	3.28	3.04	68	5.30	4.74
51	3.34	3.10	69	5.49	4.90
52	3.41	3.16	70	5.69	5.08
53	3.49	3.22	71	5.91	5.27
54	3.56	3.29	72	6.14	5.47
55	3.64	3.36	73	6.39	5.69
56	3.73	3.43	74	6.65	5.93
57	3.82	3.51	75	6.93	6.19
58	3.92	3.59	76	7.23	6.46
59	4.02	3.67	77	7.56	6.76
60	4.13	3.76	78	7.90	7.09
61	4.24	3.86	79	8.27	7.44
62	4.37	3.96	80	8.67	7.81
63	4.50	4.07	81	9.09	8.22
64	4.64	4.19	82	9.54	8.67
65	4.79	4.31	83	10.03	9.15
66	4.94	4.45	84	10.55	9.68
67	5.11	4.59	85	11.11	10.24

Rates for ages not shown will be furnished upon request.

Basis of Settlement Options: Payments under the Option Tables are based on 2% interest and the Annuity 2000 Mortality Table with 10 Years Projected using Projected Scale G.



Harleysville Life Insurance Company

[355 Maple Avenue – Harleysville, PA 19438-2297
Tel 800.222.1981 • 215.256.5000 – www.harleysvillelife.com]

**LEVEL TERM LIFE INSURANCE POLICY TO AGE 95
WITH PREMIUMS GUARANTEED FOR THE INITIAL TERM PERIOD
RENEWABLE
NONPARTICIPATING**

SCHEDULE OF BENEFITS AND PREMIUMS

Policy Number: [L99999999]

Policy Effective Date: [July 01, 2010]

POLICY INFORMATION

Insured: [John Doe]

Age: [35]

Sex: [M]

Face Amount: [\$95,000]

Premium Class: [Non-Tobacco]

Policy Number: [L99999999]

Policy Effective Date: [July 01, 2010]

Expiry Date: [July 01, 2030]

Final Expiry Date: [July 01, 2070]

Beneficiary and Owner as stated in the application unless changed as provided for in the Policy.

DESCRIPTION OF BENEFITS AND PREMIUMS

Insured	Face Amount	Premium *	Initial Term Period **
SI Term Insurance End of schedule	[\$95,000]	[\$241.00]	[20] years

* Annual premiums are shown.

The first premium of [\$65.07] is due on or before the Policy Effective Date.
It is payable by the [quarterly] mode of premium payment.

** After the Initial Term Period, the annual premium will increase to the yearly renewable term premium as shown on Pages 3A-1 and 3A-2, if applicable, in the table of Guaranteed Maximum Annual Premiums. Full details are included in the Premium Change Provision on Page 5.

You must pay the premiums for each benefit listed above for the number of years shown or until the Insured dies. The Policy Effective Date and the Age of the Insured apply to each benefit unless We state otherwise.

Policy Number: [L99999999]

Policy Effective Date: [July 01, 2010]

ANNUAL PREMIUMS – INSURED COVERAGE

Age	Guaranteed Maximum Annual Premiums *
[35	\$241.00
36	\$241.00
37	\$241.00
38	\$241.00
39	\$241.00
40	\$241.00
41	\$241.00
42	\$241.00
43	\$241.00
44	\$241.00
45	\$241.00
46	\$241.00
47	\$241.00
48	\$241.00
49	\$241.00
50	\$241.00
51	\$241.00
52	\$241.00
53	\$241.00
54	\$241.00
55	\$1,728.70
56	\$1,916.80
57	\$2,099.20
58	\$2,281.60
59	\$2,495.35
60	\$2,754.70
61	\$3,071.05
62	\$3,438.70
63	\$3,840.55
64	\$4,259.50
65	\$4,695.55
66	\$5,137.30
67	\$5,599.00
68	\$6,086.35
69	\$6,633.55]

* The premiums illustrated above include a \$70.00 policy fee.

After the first [twenty] years, annual premium will increase in accordance with the Premium Change Provision on Page 5.

Yearly renewable term premiums begin after the Initial Term Period.

Policy Number: [L99999999]

Policy Effective Date: [July 01, 2010]

ANNUAL PREMIUMS – INSURED COVERAGE

Age	Guaranteed Maximum Annual Premiums *
[70	\$7,271.95
71	\$8,047.15
72	\$8,953.45
73	\$9,908.20
74	\$10,934.20
75	\$12,051.40
76	\$13,311.10
77	\$14,776.00
78	\$16,477.45
79	\$18,384.10
80	\$20,510.20
81	\$22,821.55
82	\$25,269.70
83	\$27,943.00
84	\$30,915.55
85	\$34,221.55
86	\$37,858.15
87	\$41,788.30
88	\$45,966.40
89	\$50,349.70
90	\$54,715.90
91	\$59,013.70
92	\$63,516.70
93	\$68,264.80
94	\$73,266.55]

* The premiums illustrated above include a \$70.00 policy fee.

After the first [twenty] years, annual premium will increase in accordance with the Premium Change Provision on Page 5.

Yearly renewable term premiums begin after the Initial Term Period.



[P.O. Box 253
Harleysville, PA 19438
800.222.1981 www.harleysvillelife.com]

Harleysville Life Insurance Company
Simplified-Issue Term Life
Individual Life Insurance Application

1. Proposed Insured
Last Name, First Name, Middle Initial: _____
Residence Address/Phone #: _____
Date of Birth: _____ State of Birth: _____ Sex: M F Height/Weight: _____ Occupation: _____
Social Security Number: _____ Drivers License #/State: _____
Personal Care Physician Name/Address: _____

2. Do you currently or have you in the past 12 months used any form of tobacco or nicotine product more than 3 times/month – this includes cigarettes, cigars, pipes, chewing tobacco, snuff, nicotine patches or nicotine gum?
 Yes No

3. Owner Information (If other than Proposed Insured)
Last Name, First Name, Middle Initial: _____
Residence Address/Phone #: _____
Relationship to Proposed Insured: _____ SS#/Tax ID #: _____

4. Beneficiary Information (Name and Relationship, % share of proceeds, age if minor, SS # and/or Date of Birth)
Primary: _____ Contingent: _____

5. Type of Plan / Premium and Billing:
Term Period: 10 15 20 30
Amount: _____
Payment Mode: Annual Semi-Annual Quarterly
 9-Pay Pre-Authorized Check (PAC)
 Credit Card- except for first premium payment]

6. History – DO NOT Submit the application if any question is answered “Yes”.		
A. Have you ever had an application for Life Insurance Declined, Postponed, Rated above Table 4 or “D”, or Modified?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
B. Currently or in the past 2 years have you engaged in or do you plan to engage in: Skin/Scuba Diving (other than recreational), Mountain, Ice or Rock Climbing, Aviation Sports, Motor Sports, Parachuting, or have you flown as a pilot for other than a scheduled commercial airline?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
C. Have you, in the past 10 years, pled guilty or no contest or been convicted of a felony offense, or been on probation or parole for a felony offense or are felony charges currently outstanding against you?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
D. In the past 5 years have you pled guilty to or been convicted of reckless driving, driving while impaired or under the influence of alcohol or drugs, or have you had, or is your license suspended or revoked for reasons other than non-moving violations?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
E. Currently or in the past 12 months have you been hospitalized, confined to a nursing home, hospice, wheelchair or bed, or institutionalized, received home health care, or needed assistance with normal activities of daily living or have you been diagnosed as having a terminal medical condition that is expected to result in death within the next 12 months?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
F. In the past 10 years have you been diagnosed with or treated by a member of the medical profession for:		
1. Coronary Artery Disease, Heart Surgery, Valvular Heart Disease, Congestive Heart Failure, Heart Arrhythmia, Cardiomyopathy, Arteriosclerosis, Stroke, Cerebral Vascular Disease (TIA), Aneurysm, Peripheral Vascular Disease (PVD), Heart Attack, Angina or other Cardiovascular Disorder?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2. Chronic Bronchitis, Chronic Lung Disease, Chronic Obstructive Pulmonary Disease (COPD), Emphysema, Cystic Fibrosis or a Chronic Respiratory Disorder?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
3. Major Depression, Suicide Attempts, Bipolar, Schizophrenia, Alzheimer’s Disease, Dementia, Parkinson’s Disease, Demyelinating Disease including Multiple Sclerosis, Paraplegia, Quadriplegia?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
4. Diabetes (current age under 35, insulin dependent or uncontrolled), Chronic Kidney Disease or Chronic Liver Disease, Ulcerative Colitis, Hepatitis B or C, Crohn’s disease, Alcoholism, Alcohol Abuse, Illegal or Prescribed Drug Abuse?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
5. Cancer (other than Basal or Squamous Cell skin cancer), Hodgkin’s Disease, Lymphoma, Leukemia, Blood or Platelet Disorder, Muscle or Connective Tissue Disorder (including Lupus and Scleroderma or Sarcoidosis)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
G. 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 HIV (Human Immunodeficiency Virus) positive?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
H. In the past 12 months have you seen a physician or other medical provider or been hospitalized for more than 24 hours for any accident, illness, or medical condition, for which the diagnosis is still pending or for which further tests (excluding an HIV or AIDS test) or treatment are necessary?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

7. Other Insurance In Force / Replacement of Insurance

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

If Yes, please complete the following:

COMPANY AMOUNT POLICY # YEAR ISSUED PURPOSE

Is this insurance applied for intended to replace or change any existing life insurance policies or annuity contracts?

Yes No
 Yes No
 Yes No

If any of these questions are answered Yes, please complete a replacement form.

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.

APPLICANT'S STATEMENT / AGREEMENTS

I (We) have read the preceding questions and answers, and hereby represent to the best of my (our) knowledge and belief, that all 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 Harleysville Life Insurance 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 all delivery requirements have been properly completed and returned to Harleysville Life Insurance Company, and the first premium is paid in full while the proposed insured is alive.

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

I (We) authorize the Medical Information Bureau, governmental motor vehicle agencies and pharmaceutical databases to release to Harleysville Life Insurance Company and its reinsurers any of the following pertaining to me or my child: information relating to physical and mental condition; medical care, diagnosis or treatment; and avocation, insurance, aviation activity, criminal activity, financial information, occupation and driving record. This information will be used by Harleysville Life Insurance Company and its reinsurers to determine eligibility for insurance.

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; other persons or organizations performing business or legal services in connection with my application, including employees of Harleysville Insurance, or as may be otherwise lawfully required, or as I (We) further authorize.

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 in section 1 is/are true, correct and complete.

I (We) acknowledge receiving the Notice of Information Practices and authorize Harleysville Life Insurance Company to obtain and use the information as described above.

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 and amendments issued by Harleysville Life Insurance Company, will be attached to and made a part of the policy and delivered to the policy owner.

SIGNED AT: _____
City and State

P _____
Signature of Insured

DATED ON: _____
Month/Day/Year

P _____
Signature of Owner (if other than Insured)

AGENT CERTIFICATION

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.

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.

DATE: _____

P _____
Signature of Licensed Agent

Print Name of Licensed Agent

SERFF Tracking Number: MCHX-G126735753 State: Arkansas
 Filing Company: Harleysville Life Insurance Company State Tracking Number: 46298
 Company Tracking Number: IPT-001 (ED. 07-10)
 TOI: L041 Individual Life - Term Sub-TOI: L041.103 Renewable - Single Life - Fixed/Indeterminate Premium
 Product Name: IPT-001 (Ed. 07-10) Indiv Simplified Issue Term Li
 Project Name/Number: IPT-001 (Ed. 07-10) Indiv Simplified Issue Term Life Harleysville Life Ins Company /IPT-001 (Ed. 07-10) Indiv Simplified Issue Term Life Harleysville Life Ins Company

Supporting Document Schedules

Item Status: **Status Date:**

Satisfied - Item: Flesch Certification

Comments:

Attachments:

AR Readability Certification.PDF
 AR Cert of Compliance with Rule 19.PDF
 AR Cert of Compliance 23-79-138 and RR 49.PDF

Item Status: **Status Date:**

Satisfied - Item: Application

Comments:

Please see form schedule.

Item Status: **Status Date:**

Satisfied - Item: Submission Letter

Comments:

Attachment:

AR Submission Letter 7_22_10.PDF

Item Status: **Status Date:**

Satisfied - Item: Authorization Letter

Comments:

Attachment:

2010 Harleysville Third Party Authorization Letter.PDF

Item Status: **Status**

SERFF Tracking Number: MCHX-G126735753 State: Arkansas
Filing Company: Harleysville Life Insurance Company State Tracking Number: 46298
Company Tracking Number: IPT-001 (ED. 07-10)
TOI: L04I Individual Life - Term Sub-TOI: L04I.103 Renewable - Single Life -
Fixed/Indeterminate Premium
Product Name: IPT-001 (Ed. 07-10) Indiv Simplified Issue Term Li
Project Name/Number: IPT-001 (Ed. 07-10) Indiv Simplified Issue Term Life Harleysville Life Ins Company /IPT-001 (Ed. 07-10) Indiv Simplified Issue
Term Life Harleysville Life Ins Company

Date:

Satisfied - Item: Statement of Variability

Comments:

Attachments:

SOV Policy IPT-001 (Ed_ 07-10).PDF

SOV Application IA-012 (Ed_ 07-10).PDF

Item Status:

Status

Date:

Satisfied - Item: AR Guaranty Association Notice

Comments:

Attachment:

GAN-009 (AR) (Ed_ 01-04) Guaranty Assoc Notice - AR.PDF

Item Status:

Status

Date:

Satisfied - Item: AR Consumer Notice

Comments:

Attachment:

LFEA-138 (Ed_ 10-09) ARK Consumer Notice.PDF

Item Status:

Status

Date:

Satisfied - Item: 07.26.10 Marked Application IA-012
(Ed. 07-10)

Comments:

Attachment:

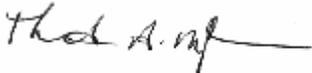
IA-012 (Ed_ 07-10) - SI Term App-07_26_10marked.PDF

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.

Form Number	Score
IPT-001 (AR) (Ed. 07-10)	64
IPT-001 (Ed. 07-10)	75
IA-012 (Ed. 07-10)	45

Signed: 
Name: Theodore A. Majewski
Title: President and Chief Operating Officer
Date: 7/22/10

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

Insurer: **HARLEYSVILLE LIFE INSURANCE COMPANY**

Form Number(s): **IPT-001 (AR) (Ed. 07-10) – Individual Term Life Policy**

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

7/22/10

Date

CERTIFICATE OF COMPLIANCE

Insurer: **HARLEYSVILLE LIFE INSURANCE COMPANY**

Form Numbers:

IPT-001 (AR) (Ed. 07-10) – Individual Term Life Policy

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

7/22/10

Date

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,

A handwritten signature in black ink that reads "Linda Boyce". The signature is written in a cursive, flowing style.

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 written in a cursive style with a long horizontal flourish at the end.

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

HARLEYSVILLE LIFE INSURANCE COMPANY
STATEMENT OF VARIABILITY

Form IPT-001 (AR) (Ed. 07-10), Individual Simplified-Issue Term Policy
Form IPT-001 (Ed. 07-10), Schedule of Benefits and Premiums

The following items on the Policy and Schedule of Benefits and Premiums pages are bracketed and considered variable. We have included an explanation for only those items that are not considered John Doe items.

Page 1

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

Company Telephone number for Inquiries, Information and Resolution of Complaints could change in the future.

State Insurance Department and Telephone Number will vary depending on the state where the policy is delivered or issued for delivery.

Company Officers could change in the future.

Page 3

Initial Term Period will be either 10, 15, 20 or 30 years as selected in the application.

Payment Mode may be either annual, semi-annual or quarterly as selected in the application.

All other bracketed items are John Doe items and will vary based on the insured's characteristics and selections.

Page 3A-1

All bracketed items are John Doe items and will vary based on the insured's characteristics and selections.

Page 3A-2

All bracketed items are John Doe items and will vary based on the insured's characteristics and selections.

Page 9

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

HARLEYSVILLE LIFE INSURANCE COMPANY
STATEMENT OF VARIABILITY

Form IA-012 (Ed. 07-10), Application for Simplified-Issue Term Policy

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

The following items on the Application are bracketed and considered variable.

Page 1

TITLE

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

Section TYPE OF PLAN / PREMIUM AND BILLING

We may add a "Credit Card" billing method 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: _____

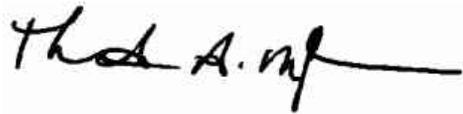
Telephone Number: _____

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



[P.O. Box 253
Harleysville, PA 19438
800.222.1981 www.harleysvillelife.com]

Harleysville Life Insurance Company
Simplified-Issue Term Life
Individual Life Insurance Application

1. Proposed Insured
Last Name, First Name, Middle Initial: _____
Residence Address/Phone #: _____
Date of Birth: _____ State of Birth: _____ Sex: M F Height/Weight: _____ Occupation: _____
Social Security Number: _____ Drivers License #/State: _____
Personal Care Physician Name/Address: _____

2. Do you currently or have you in the past 12 months used any form of tobacco or nicotine product more than 3 times/month – this includes cigarettes, cigars, pipes, chewing tobacco, snuff, nicotine patches or nicotine gum?
 Yes No

3. Owner Information (If other than Proposed Insured)
Last Name, First Name, Middle Initial: _____
Residence Address/Phone #: _____
Relationship to Proposed Insured: _____ SS#/Tax ID #: _____

4. Beneficiary Information (Name and Relationship, % share of proceeds, age if minor, SS # and/or Date of Birth)
Primary: _____ Contingent: _____

5. Type of Plan / Premium and Billing:
Term Period: 10 15 20 30
Amount: _____
Payment Mode: Annual Semi-Annual Quarterly
 9-Pay Pre-Authorized Check (PAC)
 Credit Card- except for first premium payment]

6. History – DO NOT Submit the application if any question is answered “Yes”.		
A. Have you ever had an application for Life Insurance Declined, Postponed, Rated above Table 4 or “D”, or Modified?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
B. Currently or in the past 2 years have you engaged in or do you plan to engage in: Skin/Scuba Diving (other than recreational), Mountain, Ice or Rock Climbing, Aviation Sports, Motor Sports, Parachuting, or have you flown as a pilot for other than a scheduled commercial airline?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
C. Have you, in the past 10 years, pled guilty or no contest or been convicted of a felony offense, or been on probation or parole for a felony offense or are felony charges currently outstanding against you?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
D. In the past 5 years have you pled guilty to or been convicted of reckless driving, driving while impaired or under the influence of alcohol or drugs, or have you had, or is your license suspended or revoked for reasons other than non-moving violations?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
E. Currently or in the past 12 months have you been hospitalized, confined to a nursing home, hospice, wheelchair or bed, or institutionalized, received home health care, or needed assistance with normal activities of daily living or have you been diagnosed as having a terminal medical condition that is expected to result in death within the next 12 months?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
F. In the past 10 years have you been diagnosed with or treated by a member of the medical profession for:		
1. Coronary Artery Disease, Heart Surgery, Valvular Heart Disease, Congestive Heart Failure, Heart Arrhythmia, Cardiomyopathy, Arteriosclerosis, Stroke, Cerebral Vascular Disease (TIA), Aneurysm, Peripheral Vascular Disease (PVD), Heart Attack, Angina or other Cardiovascular Disorder?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2. Chronic Bronchitis, Chronic Lung Disease, Chronic Obstructive Pulmonary Disease (COPD), Emphysema, Cystic Fibrosis or a Chronic Respiratory Disorder?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
3. Major Depression, Suicide Attempts, Bipolar, Schizophrenia, Alzheimer’s Disease, Dementia, Parkinson’s Disease, Demyelinating Disease including Multiple Sclerosis, Paraplegia, Quadriplegia?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
4. Diabetes (current age under 35, insulin dependent or uncontrolled), Chronic Kidney Disease or Chronic Liver Disease, Ulcerative Colitis, Hepatitis B or C, Crohn’s disease, Alcoholism, Alcohol Abuse, Illegal or Prescribed Drug Abuse?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
5. Cancer (other than Basal or Squamous Cell skin cancer), Hodgkin’s Disease, Lymphoma, Leukemia, Blood or Platelet Disorder, Muscle or Connective Tissue Disorder (including Lupus and Scleroderma or Sarcoidosis)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
G. 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 HIV (Human Immunodeficiency Virus) positive?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
H. In the past 12 months have you seen a physician or other medical provider or been hospitalized for more than 24 hours for any accident, illness, or medical condition, for which the diagnosis is still pending or for which further tests (excluding an HIV or AIDS test) or treatment are necessary?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

7. Other Insurance In Force / Replacement of Insurance

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

If Yes, please complete the following:

COMPANY AMOUNT POLICY # YEAR ISSUED PURPOSE

Is this insurance applied for intended to replace or change any existing life insurance policies or annuity contracts?

Yes No
 Yes No
 Yes No

If any of these questions are answered Yes, please complete a replacement form.

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.

APPLICANT'S STATEMENT / AGREEMENTS

I (We) have read the preceding questions and answers, and hereby represent to the best of my (our) knowledge and belief, that all 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 Harleysville Life Insurance 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 all delivery requirements have been properly completed and returned to Harleysville Life Insurance Company, and the first premium is paid in full while the proposed insured is alive.

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

I (We) authorize the Medical Information Bureau, governmental motor vehicle agencies and pharmaceutical databases to release to Harleysville Life Insurance Company and its reinsurers any of the following pertaining to me or my child: information relating to physical and mental condition; medical care, diagnosis or treatment; and avocation, insurance, aviation activity, criminal activity, financial information, occupation and driving record. This information will be used by Harleysville Life Insurance Company and its reinsurers to determine eligibility for insurance.

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; other persons or organizations performing business or legal services in connection with my application, including employees of Harleysville Insurance, or as may be otherwise lawfully required, or as I (We) further authorize.

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 in section 1 is/are true, correct and complete.

I (We) acknowledge receiving the Notice of Information Practices and authorize Harleysville Life Insurance Company to obtain and use the information as described above.

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 and amendments issued by Harleysville Life Insurance Company, will be attached to and made a part of the policy and delivered to the policy owner.

SIGNED AT: _____
City and State

P _____
Signature of Insured

DATED ON: _____
Month/Day/Year

P _____
Signature of Owner (if other than Insured)

AGENT CERTIFICATION

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.

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.

DATE: _____

P _____
Signature of Licensed Agent

Print Name of Licensed Agent

SERFF Tracking Number: MCHX-G126735753 State: Arkansas
 Filing Company: Harleysville Life Insurance Company State Tracking Number: 46298
 Company Tracking Number: IPT-001 (ED. 07-10)
 TOI: L041 Individual Life - Term Sub-TOI: L041.103 Renewable - Single Life -
 Fixed/Indeterminate Premium
 Product Name: IPT-001 (Ed. 07-10) Indiv Simplified Issue Term Li
 Project Name/Number: IPT-001 (Ed. 07-10) Indiv Simplified Issue Term Life Harleysville Life Ins Company /IPT-001 (Ed. 07-10) Indiv Simplified Issue
 Term Life Harleysville Life Ins Company

Superseded Schedule Items

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Creation Date:	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
07/22/2010	Form	Application for Simplified-Issue Term Policy	07/26/2010	IA-012 (Ed_ 07-10) - SITerm App 07_14_10.PDF (Superseded)



[P.O. Box 253
 Harleysville, PA 19438
 800.222.1981 www.harleysvillelife.com]

Harleysville Life Insurance Company
Simplified-Issue Term Life
Individual Life Insurance Application

1. Proposed Insured
 Last Name, First Name, Middle Initial: _____
 Residence Address/Phone #: _____
 Date of Birth: _____ State of Birth: _____ Sex: M / F Height/Weight: _____ Occupation: _____
 Social Security Number: _____ Drivers License #/State: _____
 Personal Care Physician Name/Address: _____

2. Do you currently or have you in the past 12 months used any form of tobacco or nicotine product more than 3 times/month – this includes cigarettes, cigars, pipes, chewing tobacco, snuff, nicotine patches or nicotine gum?
 Yes No

3. Owner Information (If other than Proposed Insured)
 Last Name, First Name, Middle Initial: _____
 Residence Address/Phone #: _____
 Relationship to Proposed Insured: _____ SS#/Tax ID #: _____

4. Beneficiary Information (Name and Relationship, % share of proceeds, age if minor, SS # and/or Date of Birth)
 Primary: _____ Contingent: _____

5. Type of Plan / Premium and Billing:
 Term Period: 10 15 20 30
 Amount: _____
 Payment Mode: Annual Semi-Annual Quarterly
 9-Pay Pre-Authorized Check (PAC)
 Credit Card- except for first premium payment]

6. History – DO NOT Submit the application if any question is answered “Yes”.		
A. Have you ever had an application for Life Insurance Declined, Postponed, Rated above Table 4 or “D”, or Modified?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
B. Currently or in the past 2 years have you engaged in or do you plan to engage in: Skin/Scuba Diving (other than recreational), Mountain, Ice or Rock Climbing, Aviation Sports, Motor Sports, Parachuting, or have you flown as a pilot for other than a scheduled commercial airline?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
C. Have you, in the past 10 years, pled guilty or no contest or been convicted of a felony offense, or been on probation or parole for a felony offense or are felony charges currently outstanding against you?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
D. In the past 5 years have you pled guilty to or been convicted of reckless driving, driving while impaired or under the influence of alcohol or drugs, or have you had, or is your license suspended or revoked for reasons other than non-moving violations?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
E. Currently or in the past 12 months have you been hospitalized, confined to a nursing home, hospice, wheelchair or bed, or institutionalized, received home health care, or needed assistance with normal activities of daily living or have you been diagnosed as having a terminal medical condition that is expected to result in death within the next 12 months?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
F. In the past 10 years have you been diagnosed with or treated by a member of the medical profession for:		
1. Coronary Artery Disease, Heart Surgery, Valvular Heart Disease, Congestive Heart Failure, Heart Arrhythmia, Cardiomyopathy, Arteriosclerosis, Stroke, Cerebral Vascular Disease (TIA), Aneurysm, Peripheral Vascular Disease (PVD), Heart Attack, Angina or other Cardiovascular Disorder?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2. Chronic Bronchitis, Chronic Lung Disease, Chronic Obstructive Pulmonary Disease (COPD), Emphysema, Cystic Fibrosis or a Chronic Respiratory Disorder?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
3. Major Depression, Suicide Attempts, Bipolar, Schizophrenia, Alzheimer’s Disease, Dementia, Parkinson’s Disease, Demyelinating Disease including Multiple Sclerosis, Paraplegia, Quadriplegia?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
4. Diabetes (current age under 35, insulin dependent or uncontrolled), Chronic Kidney Disease or Chronic Liver Disease, Ulcerative Colitis, Hepatitis B or C, Crohn’s disease, Alcoholism, Alcohol Abuse, Illegal or Prescribed Drug Abuse?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
5. Cancer (other than Basal or Squamous Cell skin cancer), Hodgkin’s Disease, Lymphoma, Leukemia, Blood or Platelet Disorder, Muscle or Connective Tissue Disorder (including Lupus and Scleroderma or Sarcoidosis)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
G. 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 HIV (Human Immunodeficiency Virus) positive?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
H. In the past 12 months have you seen a physician or other medical provider or been hospitalized for more than 24 hours for any accident, illness, or medical condition, for which the diagnosis is still pending or for which further tests (excluding an HIV or AIDS test) or treatment are necessary?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

7. Other Insurance In Force / Replacement of Insurance

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

If Yes, please complete the following:

COMPANY AMOUNT POLICY # YEAR ISSUED PURPOSE

Is this insurance applied for intended to replace or change any existing life insurance policies or annuity contracts?

Yes No
 Yes No
 Yes No

If any of these questions are answered Yes, please complete a replacement form.

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.

APPLICANT'S STATEMENT / AGREEMENTS

I (We) have read the preceding questions and answers, and hereby represent to the best of my (our) knowledge and belief, that all 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 Harleysville Life Insurance 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 all delivery requirements have been properly completed and returned to Harleysville Life Insurance Company, and the first premium is paid in full while the proposed insured is alive.

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I (We) authorize the Medical Information Bureau, governmental motor vehicle agencies and pharmaceutical databases to release to Harleysville Life Insurance Company and its reinsurers any of the following pertaining to me or my child: information relating to physical and mental condition; medical care, diagnosis or treatment; and avocation, insurance, aviation activity, criminal activity, financial information, occupation and driving record. This information will be used by Harleysville Life Insurance Company and its reinsurers to determine eligibility for insurance.

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; other persons or organizations performing business or legal services in connection with my application, including employees of Harleysville Insurance, or as may be otherwise lawfully required, or as I (We) further authorize.

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 in section 1 is/are true, correct and complete.

I (We) acknowledge receiving the Notice of Information Practices and authorize Harleysville Life Insurance Company to obtain and use the information as described above.

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 and amendments issued by Harleysville Life Insurance Company, will be attached to and made a part of the policy and delivered to the policy owner.

SIGNED AT: _____
City and State

P _____
Signature of Insured

DATED ON: _____
Month/Day/Year

P _____
Signature of Owner (if other than Insured)

AGENT CERTIFICATION

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.

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.

DATE: _____

P _____
Signature of Licensed Agent

Print Name of Licensed Agent