

SERFF Tracking Number: MCHX-G127309107 State: Arkansas  
 Filing Company: Harleysville Life Insurance Company State Tracking Number: 49281  
 Company Tracking Number: GMA-002 (Ed. 06-11)  
 TOI: L04G Group Life - Term Sub-TOI: L04G.500 Other  
 Product Name: GMA-002 (Ed. 06-11) Group Master Application - Har  
 Project Name/Number: GMA-002 (Ed. 06-11) Group Master Application - Harleysville Life Insurance Company /GMA-002 (Ed. 06-11) Group Master Application - Harleysville Life Insurance Company

## Filing at a Glance

Company: Harleysville Life Insurance Company

Product Name: GMA-002 (Ed. 06-11) Group Master Application - Har  
 SERFF Tr Num: MCHX-G127309107 State: Arkansas  
 TOI: L04G Group Life - Term SERFF Status: Closed-Approved-Closed State Tr Num: 49281

Sub-TOI: L04G.500 Other Co Tr Num: GMA-002 (ED. 06-11) State Status: Approved-Closed  
 Filing Type: Form Reviewer(s): Linda Bird  
 Author: SPI McHughConsulting Disposition Date: 07/14/2011  
 Date Submitted: 07/12/2011 Disposition Status: Approved-Closed

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

## General Information

Project Name: GMA-002 (Ed. 06-11) Group Master Application - Harleysville Life Insurance Company Status of Filing in Domicile: Not Filed  
 Project Number: GMA-002 (Ed. 06-11) Group Master Application - Harleysville Life Insurance Company Date Approved in Domicile:  
 Requested Filing Mode: Review & Approval Domicile Status Comments:  
 Explanation for Combination/Other: Market Type: Group  
 Submission Type: New Submission Group Market Size: Small and Large  
 Group Market Type: Association, Employer Overall Rate Impact:  
 Filing Status Changed: 07/14/2011  
 State Status Changed: 07/14/2011 Deemer Date:  
 Created By: SPI McHughConsulting Submitted By: SPI McHughConsulting  
 Corresponding Filing Tracking Number:  
 Filing Description:  
 HARLEYSVILLE LIFE INSURANCE COMPANY  
 NAIC # 64327, FEIN # 23-1580983

Group Life Form Filing  
 GMA-002 (Ed. 06-11) - True Group/Voluntary Master Application

SERFF Tracking Number: MCHX-G127309107 State: Arkansas  
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**GMA-003 (Ed. 06-11) - Group Application Supplement Voluntary Life & Short-Term Disability**

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 forms 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.

These forms will be used in conjunction with all previously approved group life and disability products for Harleysville's true group and voluntary programs where applicable.

This filing is exempt from prior approval in Harleysville's domicile state of Pennsylvania.

These forms are in final printed form subject only to changes in font style, margins, page numbers, positioning and format. For example, formatting may change slightly when the document is assembled through an automated document assembly system. Printing standards will not be lower than those required under your law.

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

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-G127309107 State: Arkansas  
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## Company and Contact

### Filing Contact Information

Jackie Tootchen, Compliance Project Team Leader 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  
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## Filing Fees

Fee Required? Yes  
 Fee Amount: \$100.00  
 Retaliatory? No  
 Fee Explanation:  
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Harleysville Life Insurance Company	\$100.00	07/12/2011	49694153

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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	07/14/2011	07/14/2011

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## **Disposition**

Disposition Date: 07/14/2011

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		No
Supporting Document	Application		Yes
Supporting Document	Authorization Letter		Yes
Supporting Document	Statement of Variability		Yes
Supporting Document	AR Cert of Compliance		Yes
Form	True Group/Voluntary Master Application		Yes
Form	Group Application Supplement Voluntary Life & Short-Term		Yes

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## Form Schedule

### Lead Form Number:

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	GMA-002 (Ed. 06-11)	Application/True Enrollment Form	Group/Voluntary Master Application	Initial		0.000	GMA-002 (Ed_06-11) TRUE GROUP- VOLUNTARY MASTER APPLICATIO N- Final 6_23_11 Bracketed.PD F
	GMA-003 (Ed. 06-11)	Application/Group Enrollment Form	Group Application Supplement Voluntary Life & Short-Term	Initial		0.000	GMA-003 (Ed_06-11) GROUP APP SUPPLEMEN T- VOLUNTARY LIFE & STD- Final 6_23_11.PDF

**TRUE GROUP/VOLUNTARY  
 MASTER APPLICATION**

**Requested Effective Date:** \_\_\_\_\_  **New Plan**  **Amendment** **Policy Number:** \_\_\_\_\_

**Is this Application Replacing Existing Coverage?**  Yes  No If Yes, please **DO NOT CANCEL** your current group plan until this application has been approved, in writing, by the home office.

**I. Applicant Information ( Please type or print all information)**

1. Corporate/Legal Name of Policyholder or Sponsor: \_\_\_\_\_ 2. Tax ID Number: \_\_\_\_\_

3. Street Address, City, State, Zip: \_\_\_\_\_

Mailing/Billing Address, City, State, Zip:  same as street address

4. Group Administrator: \_\_\_\_\_ Title: \_\_\_\_\_  
 E-Mail Address: \_\_\_\_\_ Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_  
 Billing Contact Person: \_\_\_\_\_ Title: \_\_\_\_\_  
 E-Mail Address: \_\_\_\_\_ Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

5. Nature of Business: (specify) \_\_\_\_\_ 6. SIC code: \_\_\_\_\_ 7. Length of Time in Business: \_\_\_\_\_

8. Type of Business:  Sole Proprietor  Partnership  C-Corp  S-Corp  LLC  Non-Profit  Other \_\_\_\_\_

9. Are the Employees of any affiliates, subsidiaries or branches to be covered?  Yes  No If Yes, Please list details below.

Name of Company and Full Address	Separate Billing	If Separate Bill, List Contact Person	Tax ID # (if different than above)	Nature of Business	# of Employees Insured	% Owned by Parent Company
	<input type="checkbox"/> Y <input type="checkbox"/> N					
	<input type="checkbox"/> Y <input type="checkbox"/> N					
	<input type="checkbox"/> Y <input type="checkbox"/> N					
	<input type="checkbox"/> Y <input type="checkbox"/> N					

\*Attach separate sheet if additional affiliates, subsidiaries or branches

10. Have you ever applied or been insured for group insurance with Harleysville Life?  Yes  No If Yes, complete below:  
 Group Policy Number(s) \_\_\_\_\_  
 Date Insurance Ended/Declined \_\_\_\_\_ Effective Date (if still insured) \_\_\_\_\_

11. Does the applicant have any other coverage with the Harleysville Group of Insurance Companies (including property and casualty insurance) ? If Yes, please list policy number and type of coverage: \_\_\_\_\_

12. Name of Present Group Carrier for:

Life/AD&D: _____	Cancellation Date: _____	<input type="checkbox"/> No Current Coverage
Short-Term Disability: _____	Cancellation Date: _____	<input type="checkbox"/> No Current Coverage
Long-Term Disability: _____	Cancellation Date: _____	<input type="checkbox"/> No Current Coverage
Voluntary Life: _____	Cancellation Date: _____	<input type="checkbox"/> No Current Coverage

**\* Attach a copy of the present carrier's last bill, the insurance certificate, and the group policy (if applicable).**  
**\*\*Are there other Group Life Insurance plans in force which you are not replacing or currently applying for with another carrier?**  Yes  No If Yes, please indicate the benefit amount of each plan.  
 \_\_\_\_\_  
 \_\_\_\_\_

**II. General and Eligibility Information**

13. Eligible Insureds:  All Full-Time Employees  All Full-Time & Part-Time Employees  
 Other (include description): \_\_\_\_\_

14. Are Retirees eligible for Benefits?  Yes  No (If Yes, please define retiree eligibility including any years of service or age requirements): \_\_\_\_\_  
 Are future retirees eligible for benefits?  Yes  No Does an age reduction apply to retirees?  Yes  No  
 Is coverage paid for by the retiree?  Yes  No If Yes, what % is paid by the retiree: \_\_\_\_\_%

15. **Number of Employees (Eligible vs. Enrolled)**  
 Total Number Full Time Employed \_\_\_\_\_ Total Number Full Time Insured \_\_\_\_\_  
 Total Number Part Time Employed \_\_\_\_\_ Total Number Part Time Insured \_\_\_\_\_

16. **Earnings Definition:**  
 Includes Commission, excludes Bonuses and Overtime  
 Other: \_\_\_\_\_  
 \* If commissions or bonuses are included, please include these amounts in the salary information provided for employees.

17. **Redetermination** (when salary based benefits should be adjusted to reflect salary changes):  
 Immediately  Anniversary Date of the plan  1<sup>st</sup> of the month following date of salary change  
 Other \_\_\_\_\_

18. **Lay-off or Leave of Absence Provision** (period of time where coverage will continue with premium payment-not including FMLA):  Not Included  3 months  6 months  Other \_\_\_\_\_

19. **Rehire Provision** (For employees who are terminated from the plan and later rehired; what is the time frame an employee must return to work in order to not have to satisfy the service waiting period):  
 12 months  6 months  3 months  Other \_\_\_\_\_  
 No Rehire Provision- All rehired employees must satisfy a waiting period.

20. Employees must be Actively at Work on a full-time basis for coverage to become effective. As of the proposed effective date, are any of your employees currently: **Disabled?**  Yes  No  
**On Waiver of Premium?**  Yes  No  
**Receiving Disability Benefits from any source?**  Yes  No  
**Not Actively at Work for any reason?**  Yes  No

If Yes to any of the above, please list details:

Employee Name	Date of Disability/ Last Worked	Cause of Disability	Expected Return to work date	Benefit Amount	Reason for Not Actively at Work
					<input type="checkbox"/> Disability <input type="checkbox"/> Leave of Absence <input type="checkbox"/> Other _____
					<input type="checkbox"/> Disability <input type="checkbox"/> Leave of Absence <input type="checkbox"/> Other _____
					<input type="checkbox"/> Disability <input type="checkbox"/> Leave of Absence <input type="checkbox"/> Other _____

21. **Billing Type Requested:**  List Bill  Self-Administered Bill  Direct Bill (voluntary life only-contact Home Office)  
**Billing Mode:**  Monthly  Quarterly  Semi-Annual  Annual  
**Deposit of \$\_\_\_\_\_ to apply to the first premium**

22. **Initial Rate Guarantee:**  
 Life/AD&D  24 months  \_\_\_\_\_ months  
 Voluntary Life/AD&D  24 months  \_\_\_\_\_ months  
 Short-term Disability  24 months  \_\_\_\_\_ months  
 Long-Term Disability  24 months  \_\_\_\_\_ months

Premium rates were quoted based on the data submitted to the Company. Final premium rates will be determined based on the information provided in this Application and the employee/participant information provided at final enrollment.

23. If employees will be required to contribute to the cost of insurance, please indicate:  
**STD**  Pre-tax or  Post-tax  
**LTD**  Pre-tax or  Post-tax

**III. Class Description and Schedule**

24. **Class 1 Description:** \_\_\_\_\_

**Minimum number of hours worked for Eligible Employees:** \_\_\_\_\_ **hours**

(Please check all that apply for this class)

Life Coverage  STD Coverage  LTD Coverage  Voluntary Life

If employees will be required to contribute to the cost of insurance, please indicate the % of the cost the employee will pay:  
Life \_\_\_\_\_% STD \_\_\_\_\_% LTD \_\_\_\_\_% Dependent Life \_\_\_\_\_%

**Eligible Waiting Period**

A. Present Employees (employees hired on or before the effective date of this plan) \_\_\_\_\_

B. Future Employees (employees hired after the effective date of this plan) \_\_\_\_\_

**Class 2 Description:** \_\_\_\_\_

**Minimum number of hours worked for Eligible Employees:** \_\_\_\_\_ **hours**

(Please check all that apply for this class)

Life Coverage  STD Coverage  LTD Coverage  Voluntary Life

If employees will be required to contribute to the cost of insurance, please indicate the % of the cost the employee will pay:  
Life \_\_\_\_\_% STD \_\_\_\_\_% LTD \_\_\_\_\_% Dependent Life \_\_\_\_\_%

**Eligible Waiting Period**

A. Present Employees (employees hired on or before the effective date of this plan) \_\_\_\_\_

B. Future Employees (employees hired after the effective date of this plan) \_\_\_\_\_

**Class 3 Description:** \_\_\_\_\_

**Minimum number of hours worked for Eligible Employees:** \_\_\_\_\_ **hours**

(Please check all that apply for this class)

Life Coverage  STD Coverage  LTD Coverage  Voluntary Life

If employees will be required to contribute to the cost of insurance, please indicate the % of the cost the employee will pay:  
Life \_\_\_\_\_% STD \_\_\_\_\_% LTD \_\_\_\_\_% Dependent Life \_\_\_\_\_%

**Eligible Waiting Period**

A. Present Employees (employees hired on or before the effective date of this plan) \_\_\_\_\_

B. Future Employees (employees hired after the effective date of this plan) \_\_\_\_\_

**Class 4 Description:** \_\_\_\_\_

**Minimum number of hours worked for Eligible Employees:** \_\_\_\_\_ **hours**

(Please check all that apply for this class)

Life Coverage  STD Coverage  LTD Coverage  Voluntary Life

If employees will be required to contribute to the cost of insurance, please indicate the % of the cost the employee will pay:  
Life \_\_\_\_\_% STD \_\_\_\_\_% LTD \_\_\_\_\_% Dependent Life \_\_\_\_\_%

**Eligible Waiting Period**

A. Present Employees (employees hired on or before the effective date of this plan) \_\_\_\_\_

B. Future Employees (employees hired after the effective date of this plan) \_\_\_\_\_

**Class 5 Description:** \_\_\_\_\_

**Minimum number of hours worked for Eligible Employees:** \_\_\_\_\_ **hours**

(Please check all that apply for this class)

Life Coverage  STD Coverage  LTD Coverage  Voluntary Life

If employees will be required to contribute to the cost of insurance, please indicate the % of the cost the employee will pay:  
Life \_\_\_\_\_% STD \_\_\_\_\_% LTD \_\_\_\_\_% Dependent Life \_\_\_\_\_%

**Eligible Waiting Period**

A. Present Employees (employees hired on or before the effective date of this plan) \_\_\_\_\_

B. Future Employees (employees hired after the effective date of this plan) \_\_\_\_\_

25. **Plan Design** [ As per the attached proposal OR  As defined below] Please complete the benefits for each class:

Class	* Voluntary Life- complete section VI				(AD&D) (check if included)	Short Term Disability		Long Term Disability	
	Salary Multiple	Min Benefit	Max Benefit	Flat Amount		Benefit %	Max	Benefit %	Max
1					<input type="checkbox"/>				
2					<input type="checkbox"/>				
3					<input type="checkbox"/>				
4					<input type="checkbox"/>				
5					<input type="checkbox"/>				

Comments (Please note any additional class or benefit details here):

**IV. Basic Life Insurance Benefits**  As per the attached proposal OR  As defined below

27. Base Life and AD&D benefits will reduce:  
 by 35% at ages 65, 70, 75, 80 and 85 with a minimum benefit of \$1,000  
 by 35% at age 65, further reducing to 50% of the original amount at age 70  
 Other: \_\_\_\_\_  
\*If age reduction varies by class, please attach a separate sheet with reduction choice for each class.

28. Waiver of Premium:  Included  Excluded  
 All Classes  Select Classes (please list class #(s): \_\_\_\_\_  
Total Disability must begin before:  Age 60  Other: \_\_\_\_\_  
Total Disability Waiting Period:  9 months  Other: \_\_\_\_\_  
Termination Age if Approved for Waiver of Premium Benefit:  Age 65  Other \_\_\_\_\_

29. Dependent Life:  Included  Excluded  
Benefit amounts for Spouse \_\_\_\_\_ and Child \_\_\_\_\_ (Where required by law spouse includes civil union partners)  
Are any insured dependents confined in a hospital, clinic, nursing home, rest home, rehabilitation center, or similar establishment or receiving hospice care on the proposed effective date of this plan?  Yes  No  
If Yes, such insurance will not be effective until the date the Dependent is no longer confined and not in a period of continued limited activity. (Note: insurance for newborns will be effective on the date the child is 14 days of age provided that the employee elected dependent coverage prior to birth.) **Name(s) of Confined dependent(s):** \_\_\_\_\_

**V. Voluntary Life/AD&D Benefits**  As per the attached proposal OR  As defined below

30. Employee/Participant Coverage Increments of \$ _____ OR Salary multiple amount _____	Minimum Benefit \$ _____ Maximum Benefit \$ _____
Spouse Coverage: <input type="checkbox"/> Included <input type="checkbox"/> Excluded Increments of \$ _____ (Where required by law spouse includes civil union partners)	Minimum Benefit \$ _____ Maximum Benefit \$ _____

31. Child Coverage:  Included  Excluded  
Enter up to 3 amounts: \$ \_\_\_\_\_, \$ \_\_\_\_\_, \$ \_\_\_\_\_

32. Are any insured dependents confined in a hospital, clinic, nursing home, rest home, rehabilitation center, or similar establishment or receiving hospice care on the proposed effective date of this plan?  Yes  No  
If Yes, such insurance will not be effective until the date the Dependent is no longer confined and not in a period of continued limited activity. (Note: insurance for newborns will be effective on the date the child is 14 days of age provided that the employee elected dependent coverage prior to birth.) **Name(s) of Confined Dependent(s):** \_\_\_\_\_

33. Voluntary Life and AD&D benefits will reduce:  
 by 35% at ages 65, 70, 75, minimum \$1,000  
 by 35% at age 65, further reducing to 50% of the original amount at age 70  
 Other: \_\_\_\_\_  
\*If age reduction varies by class, please attach a separate sheet with reduction choice for each class.

34. Termination Ages:  
Employee:  Age 80  Age: \_\_\_\_\_  
Spouse:  Age 75  Age: \_\_\_\_\_  
Child:  Age 19, or 25 if a full-time student  Age \_\_\_\_\_, or \_\_\_\_\_ if a full-time student

35. Include AD&D for Employee and Spouse or Civil Union Partners:  Yes  No

36. Waiver of Premium:  Included  Excluded  
 All Classes  Select Classes (please list class # (s): \_\_\_\_\_  
Total Disability must begin before:  Age 60  Other: \_\_\_\_\_  
Total Disability Waiting Period:  9 months  Other: \_\_\_\_\_  
Termination Age if Approved for Waiver of Premium Benefit:  Age 65  Other \_\_\_\_\_

Annual Enrollment Period Effective Date: \_\_\_\_\_

**VI. Short-Term Disability Benefits**  As per the attached proposal OR  As defined below

37. Benefits Begin: \_\_\_\_\_ Day for Accident and \_\_\_\_\_ Day for Sickness  
 \*If benefit period varies by class please attach a separate sheet showing benefit period for each class.

38. 1<sup>st</sup> day Hospitalization:  Included  Excluded

39. Maximum benefit duration for accident and sickness: \_\_\_\_\_ weeks  
 \* If maximum benefit duration varies by class, please attach a separate sheet showing duration for each class.

40. Minimum Benefit:  \$15  Other: \_\_\_\_\_

41. Pre-Existing Condition Exclusion:  Included  Excluded  
 If Included, Please include prior carrier booklet, select one:  3/12  12/12  Other: \_\_\_\_\_  
 If Included, Please select all that apply:  Employees not covered by prior plan (late entrants)  
 Future employees hired on or after the effective date of this plan  
 All employees

42. Will employees be required to exhaust sick leave benefits (if applicable) before they become eligible for disability benefits?  
 Yes  No

**VII. STD Buy-Up Plan Benefits**  As per the attached proposal OR  As defined below

43. Buy-Up Plan applies to:  All Classes  Select Classes (list class # (s): \_\_\_\_\_)

44. Benefit Percentage: \_\_\_\_\_%

45. Maximum Benefit Amount (combined with the base benefit): \_\_\_\_\_

46. Benefits Begin: \_\_\_\_\_ Day for Accident and \_\_\_\_\_ Days for Sickness

47. Maximum benefit duration for accident and sickness: \_\_\_\_\_ weeks

**VIII. Long-Term Disability Benefits**  As per the attached proposal OR  As defined below

<p>48. Elimination Period:</p> <p><input type="checkbox"/> 90 days Class # (s) _____</p> <p><input type="checkbox"/> 180 days Class # (s) _____</p> <p><input type="checkbox"/> Other _____ Class # (s) _____</p>	<p>49. Own Occupation:</p> <p><input type="checkbox"/> 24 months Class #(s) _____</p> <p><input type="checkbox"/> 36 months Class #(s) _____</p> <p><input type="checkbox"/> 60 months Class #(s) _____</p> <p><input type="checkbox"/> Extended Own Occupation Class #(s) _____</p> <p><input type="checkbox"/> Other _____ Class #(s) _____</p>	
<p>50. Benefit Duration:</p> <p><input type="checkbox"/> Social Security Normal Retirement Age Class # (s) _____</p> <p><input type="checkbox"/> To Age 65 Reducing Benefit Duration Class # (s) _____</p> <p><input type="checkbox"/> To Age 65/5/70 Class # (s) _____</p> <p><input type="checkbox"/> 2 years Class # (s) _____</p> <p><input type="checkbox"/> 5 years Class # (s) _____</p> <p><input type="checkbox"/> Other: _____ Class # (s) _____</p>	<p>51. Minimum Benefit:</p> <p><input type="checkbox"/> \$50.00</p> <p><input type="checkbox"/> \$100.00</p> <p><input type="checkbox"/> \$100.00 or 10%</p> <p><input type="checkbox"/> Other: _____</p>	<p>52. Integration:</p> <p><input type="checkbox"/> Full Family</p> <p><input type="checkbox"/> Primary Only</p> <p><input type="checkbox"/> All Sources _____%</p> <p><input type="checkbox"/> Other: _____</p>

53. Mental Illness and Substance Abuse Limitation:  12 months  24 months  Unlimited  Other: \_\_\_\_\_

54. Pre-Existing Condition Exclusion (includes continuity of coverage for employees covered by a prior plan):  
 3/12  6/12  12/12  12/24  3/6/12  6/12/24  Other: \_\_\_\_\_

55. Return to Work Incentive:  12 months  24 months  Other: \_\_\_\_\_

56. Survivor Benefit: Lump Sum Equal to:  3 months  6 months  12 months  Other: \_\_\_\_\_

57. Optional Riders (check all that apply):

<input type="checkbox"/> Work Place Modification Benefit	<input type="checkbox"/> Conversion Benefit
<input type="checkbox"/> Cost of Living Adjustment or Escalation Benefit: Benefits Percentage: _____ Number of Adjustments: <input type="checkbox"/> 5 <input type="checkbox"/> 10 <input type="checkbox"/> unlimited <input type="checkbox"/> Other	<input type="checkbox"/> 401(k) Contribution Benefit
<input type="checkbox"/> Pension Contribution Benefit	<input type="checkbox"/> Activities of Daily Living Benefit
<input type="checkbox"/> Spousal Disability Benefit: Monthly Benefit Amount: <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$2,000	<input type="checkbox"/> Education Benefit
	<input type="checkbox"/> Family Care Credit Benefit

**IX. LTD Buy-Up Plan Benefits**  As per the attached proposal OR  As defined below

58. Buy-Up Plan applies to:  All Classes  Select Classes (list class # (s): \_\_\_\_\_)

59. Benefit Percentage: \_\_\_\_\_%

60. Maximum Monthly Benefit Amount: \_\_\_\_\_

61. Elimination Period: \_\_\_\_\_

62. Maximum benefit duration: \_\_\_\_\_

The laws of some states require us to furnish you with the following notice:

**Florida**

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

**Maryland**

Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully 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.

**Ohio**

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

**Pennsylvania**

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

**Tennessee and Virginia**

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

**All Other States**

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.

**Agent's Information and Certification (Please Print)**

I certify that I personally completed this application in the company of an authorized representative of the group.  Yes  No  
 I certify that I have no knowledge of any information which might affect the eligibility of any person proposed for insurance that has not been fully disclosed in this Application.  Yes  No

Writing Agent's Name: \_\_\_\_\_ Agent's Code Number: \_\_\_\_\_

Agency: \_\_\_\_\_

Agent's Address: \_\_\_\_\_

General Agency (if applicable): \_\_\_\_\_ Florida Agent's License #: \_\_\_\_\_

**AGREEMENT:** Group insurance at the Insurance Company's rates and under the terms of the Policy(s) applied for will take effect on the Requested Effective Date if all requested information is received on a timely basis and if the Application is accepted by an approved letter from the Home Office of the Harleysville Life Insurance Company. If eligible employees/participants are required to contribute to the cost of the group insurance, such group insurance will take effect only if the required number have enrolled. **DO NOT CANCEL YOUR CURRENT GROUP INSURANCE POLICY(S) UNTIL THIS APPLICATION HAS BEEN APPROVED, IN WRITING, BY THE HOME OFFICE.** If this Application is not accepted, no insurance will become effective and any deposit premium advanced by the Applicant will be refunded.

It is understood that:

1. no individual shall become insured while not actively at work on a full-time basis unless agreed to in writing by Harleysville Life Insurance Company, and only eligible employees/participants as defined in this Application and Policy(s) issued shall be insured;
2. if eligible employees/participants are required to contribute to the cost of the Group Insurance that a minimum participation rate, as defined in this Application, will be maintained;
3. the Applicant will maintain accurate employee records of all beneficiaries, changes of beneficiary or assignment, and that the Insurance Company may rely on this information in adjudicating any claim under the policy;
4. the Applicant agrees to accept certificates in electronic format for delivery to persons covered under the group Policy(s);
5. no agent has power on behalf of the Harleysville Life Insurance Company to make or modify any request or application for insurance, or to bind said Insurance Company by making any promise or representation; and

If the Policyholder is a Trust, the Applicant (Sponsor) applies for membership in the Trust, including group insurance provided by the Policy issued to the Trust. Our Organization hereby applies for coverage under the Voluntary Group Term Life Insurance Policy issued to the HLIC Trust. We understand that our Organization or the Trustee may terminate our participation in the Trust by written notice.

**APPLICANT STATEMENT:** I have read and understand the preceding application in its entirety including the questions and answers, and hereby represent to the best of my (our) knowledge and belief that the statements and answers are complete and true. The Applicant agrees: (1) that this Application is offered as an inducement for the group insurance applied for; (2) that this Application will form a part of any policy or policies issued and (3) that no waiver or change will bind the Insurance Company unless signed by the President, Vice President or Secretary of the Harleysville Life Insurance Company.

Signed at (City,State): \_\_\_\_\_ Date: \_\_\_\_\_

Authorized Signature of Applicant: \_\_\_\_\_

Print Name: \_\_\_\_\_ Title: \_\_\_\_\_

Agent's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

General Agent Signature (if applicable): \_\_\_\_\_

**FOR HOME OFFICE USE ONLY**

Products	Guaranteed Issue	Participation Level (Actual)	Participation Level (Required)	Sold Rate/Rate Table
Life	\$	%	%	
AD&D	\$	%	%	
Dependent Life	\$	%	%	
STD	\$	%	%	
LTD	\$	%	%	
STD Buy-Up	\$	%	%	
LTD Buy-Up	\$	%	%	
Voluntary Life/AD&D (Employee)	\$	%	%	
Voluntary Life/AD&D (Spouse)	\$	%	%	
Voluntary Life (Child)	\$	%	%	

Age Reduction Code: Life/AD&D \_\_\_\_\_ Voluntary Life/AD&D \_\_\_\_\_

Spouse Benefit cannot exceed \_\_\_\_\_% of the employee's approved benefit (\*Voluntary Life Only)



Harleysville Life Insurance Company

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

**GROUP APPLICATION SUPPLEMENT  
VOLUNTARY LIFE & SHORT-TERM DISABILITY**  
(for groups with less than 10 employees)

This application supplement is made part of Harleysville Life Insurance Company Application for Participation (form LFJA-101).

**Requested Effective Date:** \_\_\_\_\_  **New Plan**  **Amendment** **Policy Number:** \_\_\_\_\_

**Is this Application Replacing Existing Coverage?**  Yes  No If Yes, please **DO NOT CANCEL** your current group plan until this application has been approved, in writing, by the home office.

**I. Applicant Information** ( Please type or print all information)

1. Corporate/Legal Name of Policyholder or Sponsor: \_\_\_\_\_ 2. Tax ID Number: \_\_\_\_\_

2. Name of Present Group Carrier for:  
Voluntary Short-Term Disability: \_\_\_\_\_ Cancellation Date: \_\_\_\_\_  No Current Coverage  
Voluntary Life: \_\_\_\_\_ Cancellation Date: \_\_\_\_\_  No Current Coverage  
**\* Attach a copy of the present carrier's last bill, the insurance certificate, and the group policy (if applicable).**

**II. General and Eligibility Information**

3. Eligible Insureds:  All Full-Time Employees  All Full-Time & Part-time Employees  
 Other (include description): \_\_\_\_\_

4. **Number of Employees (Eligible vs. Enrolled)**  
Total Number Full Time Employed \_\_\_\_\_ Total Number Full Time Insured \_\_\_\_\_  
Total Number Part Time Employed \_\_\_\_\_ Total Number Part Time Insured \_\_\_\_\_

5. **Billing Type Requested:**  List Bill  Self-Administered Bill  Direct Bill (voluntary life only-contact Home Office)  
**Billing Mode:**  Monthly  Quarterly  Semi-Annual  Annual  
**Deposit of \$** \_\_\_\_\_ **to apply to the first premium**

6. **Initial Rate Guarantee:**  
Voluntary Life/AD&D  24 months  \_\_\_\_\_ months  
Voluntary Short-term Disability  24 months  \_\_\_\_\_ months

Premium rates were quoted based on the data submitted to the Company. Final premium rates will be determined based on the information provided in this Application and the employee/participant information provided at final enrollment.

7. **Minimum number of hours worked for Eligible Employees:** \_\_\_\_\_ **hours**  
(Please check all that apply for this class)  
 Voluntary Life  Voluntary STD  
**Eligible Waiting Period**  
A. Present Employees (employees hired on or before the effective date of this plan) \_\_\_\_\_  
B. Future Employees (employees hired after the effective date of this plan) \_\_\_\_\_

Comments (Please note any additional class or benefit details here): \_\_\_\_\_  
\_\_\_\_\_

8. Annual Enrollment Period Effective Date: \_\_\_\_\_

**VI. Voluntary Life/AD&D Benefits** [ As per the attached proposal OR  As defined below]

9. Employee/Participant Coverage  
Increments of \$ \_\_\_\_\_ OR Salary multiple amount \_\_\_\_\_ Minimum Benefit \$ \_\_\_\_\_  
Maximum Benefit \$ \_\_\_\_\_

Spouse Coverage:  Included  Excluded Minimum Benefit \$ \_\_\_\_\_  
Increments of \$ \_\_\_\_\_ (Where required by law spouse includes civil union partners) Maximum Benefit \$ \_\_\_\_\_

10. Child Coverage:  Included  Excluded Enter up to 3 amounts: \$ \_\_\_\_\_, \$ \_\_\_\_\_, \$ \_\_\_\_\_

11. Are any insured dependents confined in a hospital, clinic, nursing home, rest home, rehabilitation center, or similar establishment or receiving hospice care on the proposed effective date of this plan?  Yes  No  
If Yes, such insurance will not be effective until the date the Dependent is no longer confined and not in a period of continued limited activity. (Note: insurance for newborns will be effective on the date the child is 14 days of age provided that the employee elected dependent coverage prior to birth.) **Name(s) of Confined Dependent(s):** \_\_\_\_\_  
\_\_\_\_\_

12. Voluntary Life and AD&D benefits will reduce:  
 by 35% at ages 65, 70, 75, minimum \$1,000  
 by 35% at age 65, further reducing to 50% of the original amount at age 70  
 Other: \_\_\_\_\_  
 \*If age reduction varies by class, please attach a separate sheet with reduction choice for each class.

13. Termination Ages:  
 Employee:  Age 80  Age: \_\_\_\_\_  
 Spouse:  Age 75  Age: \_\_\_\_\_  
 Child:  Age 19, or 25 if a full-time student  Age \_\_\_\_\_, or \_\_\_\_\_ if a full-time student

14. Include AD&D for Employee and Spouse:  Yes  No (Where required by law spouse includes civil union partners)

15. Waiver of Premium:  Included  Excluded  
 All Classes  Select Classes (please list class # (s): \_\_\_\_\_)  
 Total Disability must begin before:  Age 60  Other: \_\_\_\_\_  
 Total Disability Waiting Period:  9 months  Other: \_\_\_\_\_  
 Termination Age if Approved for Waiver of Premium Benefit:  Age 65  Other \_\_\_\_\_  
 Annual Enrollment Period Effective Date: \_\_\_\_\_

**VII. Voluntary Short-Term Disability Benefits** [ As per the attached proposal OR  As defined below]

16. Benefits Begin: \_\_\_\_\_ Day for Accident and \_\_\_\_\_ Day for Sickness  
 \*If benefit period varies by class please attach a separate sheet showing benefit period for each class.

17. Redetermination (when salary based benefits should be adjusted to reflect salary changes):  
 Immediately  Anniversary Date of the plan  1<sup>st</sup> of the month following date of salary change  
 Other: \_\_\_\_\_

17. 1<sup>st</sup> day Hospitalization:  Included  Excluded

18. Maximum benefit duration for accident and sickness: \_\_\_\_\_ weeks  
 \* If maximum benefit duration varies by class, please attach a separate sheet showing duration for each class.

19. Minimum Benefit:  \$15  Other: \_\_\_\_\_

20. Benefit Percentage: \_\_\_\_\_ % Weekly Minimum: \$ \_\_\_\_\_

21. Pre-Existing Condition Exclusion:  Included  Excluded  
 If Included, Please include prior carrier booklet, select one:  3/12  12/12  Other \_\_\_\_\_  
 If Included, Please select all that apply:  Employees not covered by prior plan (late entrants)  
 Future employees hired on or after the effective date of this plan  
 All employees

22. Will employees be required to exhaust sick leave benefits (if applicable) before they become eligible for disability benefits?  
 Yes  No

**Fraud Notices** The laws of some states require us to furnish you with the following notice:

**Florida**  
 Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

**Maryland**  
 Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully 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.

**Ohio**  
 Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

**Pennsylvania**  
 Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

**Tennessee and Virginia**  
 It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

**All Other States**  
 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.

**Agent's Information and Certification (Please Print)**

I certify that I personally completed this application in the company of an authorized representative of the group.  Yes  No  
 I certify that I have no knowledge of any information which might affect the eligibility of any person proposed for insurance that has not been fully disclosed in this Application.  Yes  No

Writing Agent's Name: \_\_\_\_\_ Agent's Code Number: \_\_\_\_\_

Agency: \_\_\_\_\_

Agent's Address: \_\_\_\_\_

General Agency (if applicable): \_\_\_\_\_ Florida Agent's License #: \_\_\_\_\_

**AGREEMENT:** Group insurance at the Insurance Company's rates and under the terms of the Policy(s) applied for will take effect on the Requested Effective Date if all requested information is received on a timely basis and if the Application is accepted by an approved letter from the Home Office of the Harleysville Life Insurance Company. If eligible employees/participants are required to contribute to the cost of the group insurance, such group insurance will take effect only if the required number have enrolled. **DO NOT CANCEL YOUR CURRENT GROUP INSURANCE POLICY(S) UNTIL THIS APPLICATION HAS BEEN APPROVED, IN WRITING, BY THE HOME OFFICE.** If this Application is not accepted, no insurance will become effective and any deposit premium advanced by the Applicant will be refunded.

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3. the Applicant will maintain accurate employee records of all beneficiaries, changes of beneficiary or assignment, and that the Insurance Company may rely on this information in adjudicating any claim under the policy;
4. the Applicant agrees to accept certificates in electronic format for delivery to persons covered under the group Policy(s);
5. no agent has power on behalf of the Harleysville Life Insurance Company to make or modify any request or application for insurance, or to bind said Insurance Company by making any promise or representation; and

If the Policyholder is a Trust, the Applicant (Sponsor) applies for membership in the Trust, including group insurance provided by the Policy issued to the Trust. Our Organization hereby applies for coverage under the Voluntary Group Term Life Insurance Policy issued to the HLIC Trust. We understand that our Organization or the Trustee may terminate our participation in the Trust by written notice.

**APPLICANT STATEMENT:** I have read and understand the preceding application in its entirety including the questions and answers, and hereby represent to the best of my (our) knowledge and belief that the statements and answers are complete and true. The Applicant agrees: (1) that this Application is offered as an inducement for the group insurance applied for; (2) that this Application will form a part of any policy or policies issued and (3) that no waiver or change will bind the Insurance Company unless signed by the President, Vice President or Secretary of the Harleysville Life Insurance Company.

Signed at (City, State): \_\_\_\_\_ Date: \_\_\_\_\_

Authorized Signature of Applicant: \_\_\_\_\_

Print Name: \_\_\_\_\_ Title: \_\_\_\_\_

Agent's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

General Agent Signature (if applicable): \_\_\_\_\_

**FOR HOME OFFICE USE ONLY**

Products	Guaranteed Issue	Participation Level (Actual)	Participation Level (Required)	Sold Rate/Rate Table
STD	\$	%	%	
Voluntary Life/AD&D (Employee)	\$	%	%	
Voluntary Life/AD&D (Spouse)	\$	%	%	
Voluntary Life (Child)	\$	%	%	

Age Reduction Code: Voluntary Life/AD&D \_\_\_\_\_

Spouse Benefit cannot exceed \_\_\_\_\_% of the employee's approved benefit (\*Voluntary Life Only)

SERFF Tracking Number: MCHX-G127309107 State: Arkansas  
 Filing Company: Harleysville Life Insurance Company State Tracking Number: 49281  
 Company Tracking Number: GMA-002 (ED. 06-11)  
 TOI: L04G Group Life - Term Sub-TOI: L04G.500 Other  
 Product Name: GMA-002 (Ed. 06-11) Group Master Application - Har  
 Project Name/Number: GMA-002 (Ed. 06-11) Group Master Application - Harleysville Life Insurance Company /GMA-002 (Ed. 06-11) Group Master Application - Harleysville Life Insurance Company

## Supporting Document Schedules

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Bypassed - Item:</b> Flesch Certification		
<b>Bypass Reason:</b> n/a to this filing		
<b>Comments:</b>		

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Application		
<b>Comments:</b> see forms tab		

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Authorization Letter		
<b>Comments:</b>		
<b>Attachment:</b> 2011 Harleysville Third Party Authorization Letter.PDF		

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Statement of Variability		
<b>Comments:</b>		
<b>Attachment:</b> GMA Variable Memorandum.PDF		

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> AR Cert of Compliance		
<b>Comments:</b>		
<b>Attachment:</b>		

*SERFF Tracking Number:* MCHX-G127309107 *State:* Arkansas  
*Filing Company:* Harleysville Life Insurance Company *State Tracking Number:* 49281  
*Company Tracking Number:* GMA-002 (ED. 06-11)  
*TOI:* L04G Group Life - Term *Sub-TOI:* L04G.500 Other  
*Product Name:* GMA-002 (Ed. 06-11) Group Master Application - Har  
*Project Name/Number:* GMA-002 (Ed. 06-11) Group Master Application - Harleysville Life Insurance Company /GMA-002 (Ed. 06-11) Group Master Application - Harleysville Life Insurance Company

**AR Cert of Compliance with Rule 19.PDF**

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

Tel 800.222.1981  
215.513.6400  
Fax 215.513.6410



January 3, 2011

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,



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

## **Harleysville Life Insurance Company Variability Memorandum**

**GMA-002 (Ed. 06-11) – True Group/Voluntary Master Application**

**GMA-003 (Ed. 06-11) – Group Application Supplement Voluntary Life & Short-Term Disability**

*The following items in the Applications are bracketed and considered variable.*

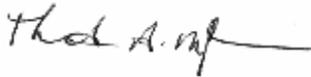
- There may be a change, in the future, to the company address, telephone number and website.
  
- Under Plan Design, Basic Life Insurance Benefits, Voluntary Life/AD&D Benefits, Short-Term Disability Benefits, STD Buy-Up Plan Benefits, Long-Term Disability Benefits, Voluntary Short-Term Disability Benefits - [ As per the attached proposal OR  As defined below] may or may not be included depending upon whether Harleysville is getting the information they need based on giving them the option of attaching a proposal, if not, they will remove the bracketed information and make all the information on the application be required to be completed.

## Certificate of Compliance with Arkansas Rule and Regulation 19

Insurer: Harleysville Life Insurance Company

Form Number(s): GMA-002 (Ed. 06-11) - True Group/Voluntary Master Application  
GMA-003 (Ed. 06-11) - Group Application Supplement Voluntary Life & Short-Term  
Disability

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



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Signature of Company Officer

Theodore A. Majewski

---

Name

President and Chief Operating Officer

---

Title

7/12/11

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Date