

SERFF Tracking Number: HRLM-128209058 State: Arkansas
Filing Company: Harleysville Life Insurance Company State Tracking Number:
Company Tracking Number: 2012-10
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
Product Name: IA-006 (AR) (Ed. 03-12), Application for Individual Life Insurance
Project Name/Number: IA-006 (Ed. 03-12), Application for Individual Life Insurance/2012-10

Filing at a Glance

Company: Harleysville Life Insurance Company

Product Name: IA-006 (AR) (Ed. 03-12), SERFF Tr Num: HRLM-128209058 State: Arkansas

Application for Individual Life Insurance

TOI: L08 Life - Other

SERFF Status: Closed-Approved- State Tr Num:
Closed

Sub-TOI: L08.000 Life - Other

Co Tr Num: 2012-10

State Status: Approved-Closed

Filing Type: Form

Reviewer(s): Linda Bird

Authors: Kristen Moyer, Larissa
Noto

Disposition Date: 04/09/2012

Date Submitted: 04/02/2012

Disposition Status: Approved-
Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: IA-006 (Ed. 03-12), Application for Individual Life
Insurance

Status of Filing in Domicile: Authorized

Project Number: 2012-10

Date Approved in Domicile: 11/22/2012

Requested Filing Mode: Review & Approval

Domicile Status Comments: SERFF Tracking
Number #MCHU-127625088

Explanation for Combination/Other:

Market Type: Individual

Submission Type: New Submission

Individual Market Type:

Overall Rate Impact:

Filing Status Changed: 04/09/2012

Deemer Date:

State Status Changed: 04/09/2012

Submitted By: Kristen Moyer

Created By: Larissa Noto

Filing Description:

Corresponding Filing Tracking Number:

March 29, 2012

Re: HARLEYSVILLE LIFE INSURANCE COMPANY

NAIC # 64327, FEIN # 23-1580983

Individual Life Insurance Application Filing

SERFF Tracking Number: HRLM-128209058 State: Arkansas
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Form IA-006 (Ed. 03-12), Application for Individual Life Insurance
Form IA-007 (Ed. 03-12), Proposed Other Insured Supplement
Form IA-008 (Ed. 03-12), Children's Insurance Supplement

We are attaching the above-captioned filing for your review and approval for Harleysville Life Insurance Company. The forms are being submitted in final printed form in which they will be distributed to Insureds. These forms were previously approved by the Arkansas Department of Insurance on October 07, 2011.

Forms IA-006 (Ed. 03-12), IA-007 (Ed. 03-12) and IA-008 (Ed. 03-12) will respectively replace forms IA-006 (Ed. 09-11), IA-007 (Ed. 09-11) and IA-008 (Ed. 09-11) which were previously approved as stated above under SERFF Tracking Number MCHX-G127678771.

We are submitting these forms because there were minor adjustments made to all three forms that were intended to clarify and simplify the medical and lifestyle questions. Highlighted copies of the revisions to the forms are attached as supporting documentation.

Currently these forms will only be used in paper format. If, in the future, Harleysville decides to use these forms in either an electronic format or telephonic, they will file the procedures and necessary documentation with the respective State Department of Insurance.

Attached are Statement of Variability's, Compliance Rule 49 Certification, Compliance Rule/Reg 19 Certification and Readability Certification.

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.

State Narrative:

Company and Contact

Filing Contact Information

Sue Carbutt, Life Product Specialist

scarbutt@harleysvillegroup.com

SERFF Tracking Number: HRLM-128209058 State: Arkansas
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355 Maple Avenue 215-513-6420 [Phone]
 Harleysville, PA 19438 215-513-6410 [FAX]

Filing Company Information

Harleysville Life Insurance Company CoCode: 64327 State of Domicile: Pennsylvania
 355 Maple Avenue Group Code: 253 Company Type:
 Harleysville, PA 19438 Group Name: State ID Number:
 (800) 222-1981 ext. [Phone] FEIN Number: 23-1580983

Filing Fees

Fee Required? Yes
 Fee Amount: \$150.00
 Retaliatory? No
 Fee Explanation:
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Harleysville Life Insurance Company	\$150.00	04/02/2012	57646127

SERFF Tracking Number: HRLM-128209058 State: Arkansas
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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	04/09/2012	04/09/2012

SERFF Tracking Number: *HRLM-128209058* *State:* *Arkansas*
Filing Company: *Harleysville Life Insurance Company* *State Tracking Number:*
Company Tracking Number: *2012-10*
TOI: *L08 Life - Other* *Sub-TOI:* *L08.000 Life - Other*
Product Name: *IA-006 (AR) (Ed. 03-12), Application for Individual Life Insurance*
Project Name/Number: *IA-006 (Ed. 03-12), Application for Individual Life Insurance/2012-10*

Disposition

Disposition Date: 04/09/2012

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: *HRLM-128209058* State: *Arkansas*
 Filing Company: *Harleysville Life Insurance Company* State Tracking Number:
 Company Tracking Number: *2012-10*
 TOI: *L08 Life - Other* Sub-TOI: *L08.000 Life - Other*
 Product Name: *IA-006 (AR) (Ed. 03-12), Application for Individual Life Insurance*
 Project Name/Number: *IA-006 (Ed. 03-12), Application for Individual Life Insurance/2012-10*

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		No
Supporting Document	Statement of Variability		Yes
Form	Application for Individual Life Insurance		Yes
Form	Proposed Other Insured Supplement		Yes
Form	Children's Insurance Supplement		Yes

SERFF Tracking Number: HRLM-128209058 State: Arkansas
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 TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
 Product Name: IA-006 (AR) (Ed. 03-12), Application for Individual Life Insurance
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Form Schedule

Lead Form Number: Form IA-006 (Ed. 03-12), Application for Individual Life Insurance

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	Form IA-006 (Ed. 03-12)	Application/ Enrollment Form	Application for Individual Life Insurance	Initial			IA-006 (Ed. 03-12) App for Life Ins - Basic-Redline-3.15.pdf
	Form IA-007 (Ed. 03-12)	Application/ Enrollment Form	Proposed Other Insured Supplement	Initial			IA-007 (Ed. 03-12) Prop Other Ins Supp- Basic - Redline 3.15.pdf
	Form IA-008 (Ed. 03-12)	Application/ Enrollment Form	Children's Insurance Supplement	Initial			IA-008 (Ed. 03-12) Child Ins Supp- Basic - Redline-3.15.pdf



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

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

Part I APPLICATION FOR INDIVIDUAL LIFE INSURANCE

Section I Proposed Primary Insured

1. Full Name:

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

2. Occupation: _____

Work Phone Number: _____

Employer: _____

Type of Business: _____

Annual Income: \$ _____

Total Net Worth: \$ _____

3. U. S. Citizen Yes No

If No, Date of Entry to U.S. _____

Visa Type _____

Country of Citizenship _____

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

If Yes, please provide details:

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

Section II Beneficiary Information

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

Primary: _____ Contingent: _____

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

1. Name of Owner: _____

Owner's Social Security Number or Tax ID #: _____

Proposed Primary Insured becomes Owner at age 21. (check if applicable)

Owner's Address: _____

Street and Number or Rural Route

City State Zip Code

2. Trust Information (Please complete if policy owner is a trust.)

Name of Trust: _____ Name of Trustee: _____

Date of Trust: _____ Trust Identification Number: _____

Section IV Payment

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

2. Billing Address: Residence Business Owner

Street and Number or Rural Route

City

State

Zip Code

3. Premiums are to be Paid (choose one) Planned Premium \$ _____

Annually Semi-Annually Quarterly Single Premium (UL and WL only) 9-Pay (Term only)

PAC * [Credit Card- except for first premium payment]

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

Section V Plan of Insurance

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

a) Term Life

Level Term: Length of Term 10 15 20 30

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

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

Children's Benefit, Amount \$ _____ (Please complete the Children's Insurance Supplement)

Other Insured, Amount \$ _____ (Please complete the Proposed Other Insured Supplement)

Waiver of Premium]

b) Whole Life

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

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

[Accidental Death Benefit, Amount \$ _____

Automatic Premium Loan

Children's Benefit, Amount \$ _____ (Please complete Children's Insurance Supplement)

Guaranteed Insurability Benefit, Amount \$ _____

Payor Benefit (Please complete Payor Benefit Supplement)

Waiver of Premium]

c) Universal Life

Plan of Insurance: _____

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

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

Option 1: Death Benefit equals Specified Amount

Option 2: Death Benefit equals Specified Amount + Cash Value

No-Lapse Guarantee Minimum Premium Option (choose one)

10 Years

20 Years

30 yr NLG

NLG to 100

Maturity

Other: _____]

Riders: (choose all that are applicable)

Accidental Death Benefit, Amount \$ _____

Children's Term Insurance, Amount \$ _____ (Please complete Children's Insurance Supplement)

Other Insured, Amount \$ _____ All Years Number of Years _____ (Please complete Proposed Other Insured Supplement)

Accidental Death Benefit - Other Insured, Amount \$ _____

Primary Insured, Amount \$ _____ All Years Number of Years _____

Scheduled Increase Option, Amount \$ _____

Total Disability Premium Payment

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

Other _____]

Section VI Pending Life Applications

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

Name of Company

Amount of Coverage

Purpose

Which pending applications do you intend to accept? _____

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

If Yes, please provide details: _____

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

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

Section VII Other Insurance In Force

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

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

If Yes, Please complete the following:

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

Yes No
 Yes No
 Yes No

2. Harleysville Life Policy to be converted:

Existing policy # _____ Conversion Amount Full Partial \$ _____

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

Section VIII General Information

1. In the past/next 2 years have you or do you intend to travel to a foreign country for reasons other than vacation? If Yes, please complete Foreign Travel Questionnaire	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. In the past/next 2 years, have you or do you have plans to reside in a foreign country for 90 days or longer? If Yes, please complete Foreign Residence Questionnaire	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. In the past/next 2 years have you engaged in or do you intend to engage in any of the following: (check all that apply) ___ skin/scuba diving ___ mountain, ice or rock climbing ___ aviation sports ___ parachuting ___ motor sports If Yes, please complete the appropriate questionnaire(s)	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. In the past 5 years have you flown or do you intend to fly within the next 2 years as a pilot, copilot or crew member for other than a scheduled commercial airline, or do you hold a current pilot's license? If Yes, please complete an appropriate Aviation Questionnaire	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. In the past <u>7.5</u> years have you pled guilty to or been convicted of driving while impaired or under the Influence of drugs or alcohol? If Yes, please complete the appropriate Alcohol or Drug Questionnaire	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. In the past 7 years, have you filed for bankruptcy? If Yes, please provide details including chapter filed, date, reason and if discharged _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. Have you been placed on current active status in the Armed Forces, or entered into a written agreement to have active status in the near future? If Yes, please complete the Military Status Questionnaire	<input type="checkbox"/> Yes <input type="checkbox"/> No
8. In the past 5 years have you pled guilty to or been convicted of any moving violations, or had your license suspended or revoked? If Yes, please provide details: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
9. Have you ever been convicted of, or are you currently charged with, a felony or misdemeanor, or are you currently on probation or parole? If Yes, please provide details: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No

Details to questions above: _____

Part II Medical Information

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

 Telephone Number: _____
 Specialty Physician(s) Yes No (Please provide physician(s) information to the detail section on the next page.)

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

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

3. Have you ever been diagnosed with, been treated for or consulted a physician been given medical advice by a member of the medical profession for: (If Yes, please provide full details)

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

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

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

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

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

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

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

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

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

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

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

SIGNED AT: _____
City and State

✓ _____
Signature of Insured

DATED ON: _____
Month/Day/Year

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

✓ _____
Signature of Owner (if other than Insured)

✓ _____
Signature of Applicant (if other than Insured)

AGENT CERTIFICATION

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

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

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

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

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

Signed at: _____

✓ _____
Signature of Licensed Agent

Dated on: _____

✓ _____
Print Name of Licensed Agent



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

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

Proposed Other Insured Supplement

Section I Proposed Other Insured

1. Relationship to Proposed Insured: _____

Full Name:

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

Former name if changed in the last 5 years:

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

Residence: Same as Primary Insured

 Street and Number or Rural Route Telephone # Cell Phone #

 City State Zip Code Email Address

2. Occupation: _____

Work Phone Number: _____

Employer: _____

Type of Business: _____

Annual Income: \$ _____

Net Worth \$ _____

3. U. S. Citizen Yes No

If No, Date of Entry to U.S. _____

Visa Type _____

Country of Citizenship _____

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

If Yes, please provide details:

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

Section II Beneficiary Information

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

Primary: _____ Contingent: _____

Section III Other Insurance In Force

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

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

Which pending applications do you intend to accept? _____

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

If Yes, please provide details _____

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

If Yes, please complete the following:

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

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

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

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

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

Section V Medical Information	
1. Name of Proposed Other Insured _____ Date of Birth _____	
Height _____ Weight _____ Weight change (> 10 lbs) in last 12 months _____ Reason for weight change _____	
Personal Primary Physician: Name: _____	
Address: _____	
Telephone Number: _____	
Specialty Physician(s) <input type="checkbox"/> Yes <input type="checkbox"/> No (Please provide physician(s) information in the details section on the next page.)	

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

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

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

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

Details to any above questions answered Yes.

Question #	Date(s)	Physician(s)	Details

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

APPLICANT'S STATEMENT

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

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

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

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

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

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

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

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

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

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

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

SIGNED AT: _____
City and State

DATED ON: _____
Month/Day/Year

✓ _____
Signature of Owner (if other than Insured)

✓ _____
Signature of Insured

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

✓ _____
Signature of Applicant (if other than Insured)

AGENT CERTIFICATION

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

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

Signed at: _____

✓ _____
Signature of Licensed Agent

Dated on: _____

Print Name of Licensed Agent



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

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

Children's Insurance Supplement

Section I

1. List all children to be covered:

Name	Sex	Date of Birth	Height	Weight

Section II

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

Section III General Information

1. In the past/next 2 years have you or do you intend to travel to a foreign country for reasons other than vacation? If Yes, please complete Foreign Travel Questionnaire	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. In the past/next 2 years, have you or do you have plans to reside in a foreign country for 90 days or longer? If Yes, please complete Foreign Residence Questionnaire	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. In the past/next 2 years have you engaged in or do you intend to engage in any of the following: (check all that apply) ___ skin/scuba diving ___ mountain, ice or rock climbing ___ aviation sports ___ parachuting ___ motor sports If Yes, please complete the appropriate questionnaire(s)	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. In the past 5 years have you flown or do you intend to fly within the next 2 years as a pilot, copilot or crew member for other than a scheduled commercial airline, or do you hold a current pilot's license? If Yes, please complete an appropriate Aviation Questionnaire	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. In the past <u>57</u> years have you pled guilty to or been convicted of driving while impaired or under the influence of drugs or alcohol? If Yes, please complete the appropriate Alcohol or Drug Questionnaire	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Have you been placed on current active status in the Armed Forces, or entered into a written agreement to have active status in the near future? If Yes, please complete the Military Questionnaire	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. In the past 5 years have you pled guilty to or been convicted of any moving violations, or had your license suspended or revoked? If Yes, please provide details: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
8. Have you ever been convicted of, or currently charged with, a felony or misdemeanor, or are you currently on probation or parole? If Yes, please provide details: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No

Section IV Medical Information

1. Child's Personal Primary Physician: Name: _____
 Address: _____
 Telephone Number: _____
 Specialty Physician(s) Yes No (Please provide physician(s) information in the details section on the next page.)

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

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

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

SIGNED AT: _____
City and State

✓ _____
Signature of Insured

DATED ON: _____
Month/Day/Year

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

✓ _____
Signature of Owner (if other than Insured)

✓ _____
Signature of Applicant (if other than Insured)

AGENT CERTIFICATION

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

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

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

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

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

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

SIGNED AT: _____

✓ _____
Signature of Licensed Agent

DATED ON: _____

Print Name of Licensed Agent

SERFF Tracking Number: HRLM-128209058 State: Arkansas
Filing Company: Harleysville Life Insurance Company State Tracking Number:
Company Tracking Number: 2012-10
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
Product Name: IA-006 (AR) (Ed. 03-12), Application for Individual Life Insurance
Project Name/Number: IA-006 (Ed. 03-12), Application for Individual Life Insurance/2012-10

Supporting Document Schedules

	Item Status:	Status Date:
Satisfied - Item: Flesch Certification Comments: Attachments: AR Compliance Rule 19.pdf AR Compliance Rule 49.pdf Readability Cert 3.12.pdf LFEA-138.pdf		
Bypassed - Item: Application Bypass Reason: N/A to this filing Comments:		
Satisfied - Item: Statement of Variability Comments: Attachment: Generic Statement of Variability.pdf		

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

Insurer: **HARLEYSVILLE LIFE INSURANCE COMPANY**

Form Number(s): **IA-006 (Ed. 03-12), et al. – Application for Individual Life Insurance**

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



Signature of Company Officer

Theodore A. Majewski

Name

President and Chief Operating Officer

Title

3/29/12

Date

CERTIFICATE OF COMPLIANCE

Insurer: **HARLEYSVILLE LIFE INSURANCE COMPANY**

Form Numbers:

IA-006 (Ed. 03-12), et al. – Application for Individual Life Insurance

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



Signature of Company Officer

Theodore A. Majewski

Name

President and Chief Operating Officer

Title

3/29/12

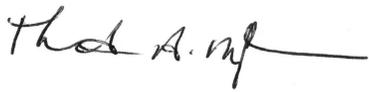
Date

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
IA-006 (Ed. 03-12)	51
IA-007 (Ed. 03-12)	50
IA-008 (Ed. 03-12)	48

Signed: 
Name: Theodore A. Majewski
Title: President and Chief Operating Officer
Date: 3/29/12

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: _____

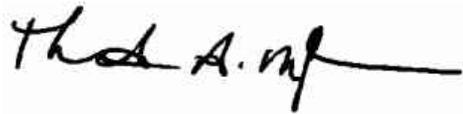
Telephone Number: _____

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

**HARLEYSVILLE LIFE INSURANCE COMPANY
STATEMENT OF VARIABILITY**

IA-006 (Ed. 03-12)

IA-007 (Ed. 03-12)

IA-008 (Ed. 03-12)

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

All Forms

Page 1

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

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

Form IA-006 (Ed. 03-12), Application for Individual Life Insurance

Section IV Payment

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

Page 2

Section V Plan of Insurance

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