



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

\_\_\_\_\_ City State Zip Code  
 Street and Number or Rural Route

#### 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 \*

\* 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 is over \$1,500,001 or more)

Riders: (choose all that are applicable)

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

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

Waiver of Premium

\* N/A in New Jersey

**b) Whole Life**

Amount of Insurance: \_\_\_\_\_ (Please complete the Financial Information Questionnaire if amount is \$1,500,001 or more)

Riders: (choose all that are applicable)

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

Automatic Premium Loan

Children's Benefit, Amount \$ \_\_\_\_\_ (Please complete the 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 is \$1,500,001 or more)

**Death Benefit Option** (choose one)

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 the 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?<br>If Yes, 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?<br>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:<br>(check all that apply) ___ skin/scuba diving ___ mountain, ice or rock climbing ___ aviation sports<br>___ 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?<br>If Yes, Please complete an appropriate Aviation Questionnaire                      | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 5. In the past 5 years have you pled guilty to or been convicted of driving while impaired or under the influence of drugs or alcohol? If Yes, 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, 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 |

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an insurance application may be guilty of a criminal offense and subject to penalties under state law.

**APPLICANT'S STATEMENT**

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

**AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION**

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

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

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

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

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

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

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

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

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

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

✓ \_\_\_\_\_  
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

A completed Disclosure Statement (applicable in Pennsylvania) was given to the applicant.  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



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 P.O. Box 253, Harleysville, PA 19438-0253

## Part II Medical Information

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

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

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

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

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



**AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION**

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

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

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

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

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

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

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

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

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

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

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

✓ \_\_\_\_\_  
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

A completed Disclosure Statement (applicable in Pennsylvania) was given to the applicant.  Yes  No

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

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

✓ \_\_\_\_\_  
Signature of Licensed Agent

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



Harleysville Life Insurance Company  
355 Maple Avenue, Harleysville, PA 19438-2297

Please mail forms to the administrative address:  
Harleysville Life Insurance Company  
P.O. Box 253, Harleysville, PA 19438-0253  
Tel 800.222.1981 www.harleysvillife.com

EXAMINER: \_\_\_\_\_  
ADDRESS: \_\_\_\_\_

## NOTICE AND CONSENT FOR BLOOD TESTING

### WHICH MAY INCLUDE AIDS VIRUS (HIV) ANTIBODY/ANTIGEN TESTING

To determine your insurability, the insurer named above ("the insurer") has requested that you provide a sample of your blood for testing and analysis. All tests will be performed by a licensed laboratory.

Tests may be performed to determine the presence of antibodies or antigens to the Human Immunodeficiency Virus (HIV), also known as the AIDS virus. The HIV antibody test is actually a series of tests done by a medically accepted procedure. These tests are extremely reliable. Other tests which may be performed include determinations of blood cholesterol and related lipids (fats) and screening for liver or kidney disorders, diabetes, and immune disorders.

All test results will be treated confidentially. They will be reported by the laboratory to the insurer. When necessary for business reasons in connection with insurance you have or have applied for with the insurer, the insurer may disclose test results to others such as its affiliates, reinsurers, independent contractors, and its employees to whom disclosure is required. If the insurer is a member of the Medical Information Bureau ("MIB, Inc."), and if the test results for HIV antibodies/antigens are other than normal, the insurer will report to the MIB, Inc. a generic code which signifies only a nonspecific blood test abnormality. The test results may also be disclosed to any member company that receives an application for health or life insurance on your life. If your HIV test is normal, no report will be made about it to the MIB, Inc. Other test results may be reported to the MIB, Inc., in a more specific manner. The organization described in this paragraph may maintain the test results in a file or data bank. There will be no other disclosure of test results or even that the tests have been done except as may be required or permitted by law or as authorized by you.

If your HIV test results are normal, no routine notification will be sent to you unless required by state law. If the HIV test results are other than normal, the insurer will contact you. The insurer may also contact you if there are other abnormal test results which, in the insurer's opinion, are significant. The insurer may ask you for the name of a physician or other health care provider to whom you may authorize disclosure and with whom you may wish to discuss the results.

Positive HIV antibody/antigen test results do not mean that you have AIDS, but that you are at significantly increased risk of developing AIDS or AIDS-related conditions. Federal authorities say that persons who are HIV antibody/antigen positive should be considered infected with the AIDS virus and capable of infecting others.

Positive HIV antibody or antigen test results or other significant blood abnormalities will adversely affect your application for insurance. This means that your application may be declined, that an increased premium may be charged, or that other policy changes may be necessary.

I have read and I understand this Notice and Consent for Blood Testing Which May Include HIV Antibody/Antigen Testing. I voluntarily consent to the withdrawal of blood from me by needle, the testing of blood, and the disclosure of the test results as described above. I understand that this consent shall be valid for thirty (30) months following the date shown below. I understand that I have the right to request and receive a copy of this authorization. A photocopy or transmitted facsimile of this form will be as valid as the original. I also have the right, upon written request, to an insurance institution (insurers), agent, or insurance support organization for access to recorded personal information and a copy of same within thirty (30) business days from the date such request is received. I have the right to request, in writing, that any recorded personal information be corrected, amended, or deleted within thirty (30) business days from the date of receipt of my written request by an insurance institution, agent, or insurance support organization. If my request is not honored, I have the right to file a concise statement of the correct, relevant or fair information; and the reasons why I disagree with such refusal to correct, amend, or delete recorded personal information.

\_\_\_\_\_  
Full Name of Proposed Insured

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Signature of Proposed Insured or Parent/Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
State of Residence

## HARLEYSVILLE LIFE INSURANCE COMPANY

355 Maple Avenue  
Harleysville, PA 19438

### IT IS REQUIRED THAT YOU BE GIVEN THIS IMPORTANT NOTICE NOTICE OF INFORMATION PRACTICES

**APPLICATION AND MEDICAL RECORDS:** Your application, including the medical history, is the prime source of information in the evaluation process. Therefore, we ask that you make sure the information is accurate and complete. In addition to the application, we may ask you to take a physical examination or other special test such as an electrocardiogram. We may also ask for a report from your doctor or your children's doctor, or hospital, another insurance company or the Medical Information Bureau (MIB, Inc.). When we do so, we will use the authorization form you signed.

**UNDERWRITING:** The underwriting process begins when your application is received. After reviewing your application and information from the outside sources mentioned in this notice, we determine if coverage is available and what rate class you qualify for. It is possible for underwriting to determine you are not eligible for coverage. If so, we will notify you in writing.

You are required to let us know if there is a change to any answer on your application before accepting the policy, as a change may affect the underwriting process and approved rate class.

**CONTESTABILITY:** The policy issued will contain language that describes when and what circumstances coverage may be contested. Remember, your application represents material information used to determine your insurability. The policy may be void or a claim may be denied if the application contains false information.

**REPLACEMENT OF EXISTING COVERAGE:** If you are thinking about, or have decided to, replace existing coverage with a new policy, state law may require your agent to provide additional replacement information that will help you compare policies to make an informed decision. In some states, this additional replacement information is required if you have existing coverage and are purchasing a new policy, regardless of whether you will be replacing the existing coverage with the new policy. Please review this replacement information carefully.

**FAIR CREDIT REPORTING ACT:** An investigative consumer report may be obtained during the underwriting process of your application. It provides information such as, your character, general reputation, personal characteristics and mode of living. No information collected concerning the sexual orientation of the proposed insured will be used to determine his or her eligibility for insurance. The information is obtained through personal interviews with your friends, neighbors and associates. Upon written request from you, received within a reasonable time, additional detailed information concerning the nature and scope of this investigation will be provided.

**MEDICAL INFORMATION BUREAU:** Information you provide will be treated as confidential, except that Harleysville Life Insurance Company or its reinsurer(s) may make a brief report thereon to the Medical Information Bureau (MIB, Inc.). The MIB, Inc. is a non-profit membership organization of life insurance companies which operates an information exchange on behalf of its members. Upon request by another member insurance company to which you or your minor children have applied for life or health insurance coverage or to which a claim is submitted, the MIB, Inc. will supply such company with the information it may have in its files.

Upon receipt of a request from you, the MIB, Inc. will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the Bureau's Information Office is: 50 Braintree Hill, Suite 400, Braintree, MA 02184-8734. Toll Free Number: 866-692-6901.

The Harleysville Life Insurance Company or its reinsurer(s) may also release information in its file to other life insurance companies to whom you or your minor children may apply for life or health insurance, or to whom a claim for benefits may be submitted.

**INSURANCE INFORMATION PRACTICES:** We will rely primarily on information provided by you. We may supplement that information from other sources such as medical professionals who have treated you. In some cases, we may ask a consumer reporting agency to collect information and submit an investigative consumer report to us as explained in this Notice under **Fair Credit Reporting Act**. You may request to be interviewed in connection with the preparation of this report.

In certain limited situations, we are allowed by law to disclose necessary items of personal information to third parties without your specific authorization. In general, you have the right to obtain access to any personal information about you or your minor children in our file upon written request. *Medical record information, however, will be given only to a licensed medical practitioner of your choice.* You have the right to be told about, and to see a copy if you wish, items of personal information about you that appear in our files, including information contained in investigative consumer reports. To obtain access to personal information about you or your minor children in our file, please write to the Vice President of Marketing & Life Operations, Harleysville Life Insurance Company, 355 Maple Avenue, Harleysville, PA 19438-2297. Indicate your full name, address, telephone number and policy number.

You also have the right to seek correction, amendment or deletion of information you believe to be inaccurate. Send your request for correction, amendment or deletion to the Vice President of Marketing & Life Operations at the address specified above. Your comments will be carefully considered and corrections made where justified. If we do not make the correction or deletion, you may file with us a brief statement setting forth what you believe to be correct information. This statement will become a part of your permanent file.

## A Summary of Your Rights Under the Fair Credit Reporting Act

The federal Fair Credit Reporting Act (FCRA) is designed to promote accuracy, fairness, and privacy of information in the files of every "consumer reporting agency" (CRA). Most CRAs are credit bureaus that gather and sell information about you – such as if you pay your bills on time or have filed bankruptcy – to creditors, employers, landlords, and other businesses. You can find the complete text of the FCRA, 15 U.S.C. 1681-1681u, at the Federal Trade Commission's web site (<http://www.ftc.gov>). The FCRA gives you specific rights, as outlined below. You may have additional rights under state law. You may contact a state or local consumer protection agency or a state attorney general to learn those rights.

- **You must be told if information in your file has been used against you.** Anyone who uses information from a CRA to take action against you – such as denying an application for credit, insurance, or employment – must tell you, and give you the name, address, and phone number of the CRA that provided the consumer report.
- **You can find out what is in your file.** At your request, a CRA must give you the information in your file, and a list of everyone who has requested it recently. There is no charge for the report if a person has taken action against you because of information supplied by the CRA, if you request the report within 60 days of receiving notice of the action. You also are entitled to one free report every twelve months upon request if you certify that (1) you are unemployed and plan to seek employment within 60 days, (2) you are on welfare, or (3) your report is inaccurate due to fraud. Otherwise, a CRA may charge you up to eight dollars.
- **You can dispute inaccurate information with the CRA.** If you tell a CRA that your file contains inaccurate information, the CRA must investigate the items (usually within 30 days) by presenting to its information source all relevant evidence you submit, unless your dispute is frivolous. The source must review your evidence and report its findings to the CRA. (The source also must advise national CRAs – to which it has provided the data – of any error.) The CRA must give you a written report of the investigation, and a copy of your report if the investigation results in any change. If the CRA's investigation does not resolve the dispute, you may add a brief statement to your file. The CRA must normally include a summary of your statement in future reports. If an item is deleted or a dispute statement is filed, you may ask that anyone who has recently received your report be notified of the change.
- **Inaccurate information must be corrected or deleted.** A CRA must remove or correct inaccurate or unverified information from its files, usually within 30 days after you dispute it. **However, the CRA is not required to remove accurate data from your file unless it is outdated (as described below) or cannot be verified.** If your dispute results in any change to your report, the CRA cannot reinsert into your file a disputed item unless the information source verifies its accuracy and completeness. In addition, the CRA must give you a written notice telling you it has reinserted the item. The notice must include the name, address and phone number of the information source.
- **You can dispute inaccurate items with the source of the information.** If you tell anyone – such as a creditor who reports to a CRA – that you dispute an item, they may not then report the information to a CRA without including a notice of your dispute. In addition, once you've notified the source of the error in writing, it may not continue to report the information if it is, in fact, an error.
- **Outdated information may not be reported.** In most cases, a CRA may not report negative information that is more than seven years old; ten years for bankruptcies.
- **Access to your file is limited.** A CRA may provide information about you only to people with a need recognized by the FCRA – usually to consider an application with a creditor, insurer, employer, landlord, or other business.

**Agent:** If an **inspection report** will be ordered on the applicant as part of the underwriting process, a copy of this form must be given to the applicant.

- **Your consent is required for reports that are provided to employers, or reports that contain medical information.** A CRA may not give out information about you to your employer, or prospective employer, without your written consent. A CRA may not report medical information about you to creditors, insurers, or employers without your permission.
- **You may choose to exclude your name from CRA lists for unsolicited credit and insurance offers.** Creditors and insurers may use file information as the basis for sending you unsolicited offers of credit or insurance. Such offers must include a toll-free phone number for you to call if you want your name and address removed from future lists. If you call, you must be kept off the lists for two years. If you request, complete and return the CRA form provided for this purpose, you must be taken off the lists indefinitely.
- **You may seek damages from violators.** If a CRA, a user or (in some cases) a provider of CRA data, violates the FCRA, you may sue them in state or federal court.

The FCRA gives several different federal agencies authority to enforce the FCRA:

| <b>FOR QUESTIONS OR CONCERNS REGARDING:</b>   | <b>PLEASE CONTACT:</b>   |
|---|--|
| CRAs, creditors and others not listed below   | Federal Trade Commission Consumer Response Center – FCRA<br>Washington, DC 20580<br>(202) 326-3761                           |
| National banks, federal branches/agencies of foreign banks (word "National" or initials "N.A." appear in or after bank's name)        | Office of the Comptroller of the Currency Compliance Management, Mail Stop 6-6<br>Washington, DC 20219<br>(800) 613-6743     |
| Federal Reserve System member banks (except National banks and federal branches/agencies of foreign banks)                            | Federal Reserve Board<br>Division of Consumer & Community Affairs<br>Washington, DC 20551<br>(202) 452-3693                  |
| Savings associations and federally chartered savings Banks (word "Federal" or initials "F.S.B." appear in federal institution's name) | Office of Thrift Supervision<br>Consumer Programs<br>Washington, DC 20552<br>(800) 842-6929                                  |
| Federal credit unions (words "Federal Credit Union" appear in institution's name)   | National Credit Union Administration<br>1775 Duke Street<br>Alexandria, VA 22314<br>(703) 518-6360                           |
| State-chartered banks that are not members of the Federal Reserve System  | Federal Deposit Insurance Corporation<br>Division of Compliance & Consumer Affairs<br>Washington, DC 20429<br>(800) 934-FDIC |
| Air, surface, or rail common carriers regulated by former Civil Aeronautics Board or Interstate Commerce Commission                   | Department of Transportation<br>Office of Financial Management<br>Washington, DC 20590<br>(202) 366-1306                     |
| Activities subject to the Packers and Stockyards Act, 1921  | Department of Agriculture<br>Office of Deputy Administrator – GIPSA<br>Washington, DC 20250<br>(202) 720-7051                |



**Harleysville Life Insurance Company**  
355 Maple Avenue, Harleysville, PA 19438-2297

Please mail forms to the administrative address:  
**Harleysville Life Insurance Company**  
P.O. Box 253, Harleysville, PA 19438-0253  
Tel 800.222.1981 www.harleysvillelife.com



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

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

## HARLEYSVILLE LIFE INSURANCE COMPANY TEMPORARY LIFE INSURANCE AGREEMENT

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

### Date Coverage Begins

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

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

### Terms and Conditions

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

### Date Agreement Terminates

This Agreement will automatically terminate:

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

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

**Eligibility Questions**

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

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

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

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

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

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

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

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

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

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

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



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

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

## HARLEYSVILLE LIFE INSURANCE COMPANY TEMPORARY LIFE INSURANCE AGREEMENT

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### Date Coverage Begins

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1. The date of this Agreement, but only if Part 1 of the Application has been completed, signed and dated on the same date as the date this Agreement is signed, and
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### Terms and Conditions

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

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This Agreement will automatically terminate:

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

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

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

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

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

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

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

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

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

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

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



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

Please mail forms to the  
 Administrative Address:  
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 P.O. Box 253, Harleysville, PA 19438-0253

**PREAUTHORIZED CHECK (PAC) INFORMATION FORM**

**HARLEYSVILLE LIFE INSURANCE COMPANY**

The company above will withdraw the premiums from the specified account. This company will be referred to hereafter as "Company". "You", "your", "I" and "me" refer to the bank account owner whose name appears below.

**How automatic bank draft works:** Automatic bank draft is a debit service that offers a convenient way to pay life insurance premiums. The company will collect the life insurance premiums from your bank account electronically—you do not need to write checks or mail in any payments. Premium withdrawals will appear on your bank statement, and your statements will be your receipts for payment of your premium. **[Draft date will be 7-10 days from the date the application is received by Harleysville Life Insurance Company.]**

**Automatic Bank Draft Agreement**

I hereby authorize and request the company to initiate electronic or other commercially accepted-type debits against the indicated bank account in the financial institution named for the payment of monthly premiums and other indicated charges due on the insurance policy, and to continue to initiate such debits in the event of a conversion, renewal, or other change to any such contract(s). I hereby agree to indemnify and hold the Company harmless from any loss, claim or liability of any kind by reason or dishonor of any debit.

I understand that this authorization will not affect the terms of the contract(s), other than the mode of payment, and that if premiums are not paid within the applicable grace period, the contract(s) will terminate, subject to any applicable nonforfeiture provision. I acknowledge that the debit appearing on my bank statement shall constitute my receipt of payment, but no payment is deemed made until the Company receives actual payment.

I agree that this authorization may be terminated by me or the Company at any time and for any reason by providing written notice of such termination to the non-terminating party and may be terminated by the Company immediately if any debit is not honored by the financial institution named for any reason. This must be dated and signed by the bank account owner(s) as his/her name appears on the bank records for the account provided on this authorization.

Financial Institution Name: \_\_\_\_\_

Financial Institution Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Routing Number:

Account Number:

This agreement authorizes:  A new monthly transfer  
 A change in existing transfer amount  
 A change in financial institution

Type of Account:  Checking  Savings Credit Union  Yes  No

Name of Primary Insured: \_\_\_\_\_ Policy Number(s): \_\_\_\_\_

Preferred Monthly Withdrawal Date (1<sup>st</sup> – 28<sup>th</sup>): \_\_\_\_\_ Universal Life, Term Only\*

Preferred Monthly Withdrawal Date (10<sup>th</sup> or 25<sup>th</sup>): \_\_\_\_\_ Whole Life, Annuities Only

Print Bank Account Owner(s) Name: \_\_\_\_\_

Insured's Relationship to Bank Account Owner(s): \_\_\_\_\_

**NOTE:** As part of HLIC's money laundering prevention program, a Bank Account Owner must have a specific relationship to the insured/policyowner, such as a parent, grandparent, spouse, guardian, child or employer. If this relationship does not exist, HLIC may refuse to establish the Bank Draft or may terminate the payment of funds to the policy.

Signature(s) of Bank Account Owner(s): \_\_\_\_\_

\* If changing PAC information on a Universal Life or Term six digit policy number, a withdrawal date of the 10<sup>th</sup> or 25<sup>th</sup> is only available. **FORM MUST BE COMPLETED IN FULL, ACCOMPANIED BY A VOIDED CHECK AND SENT TO HARLEYSVILLE LIFE INSURANCE COMPANY AT THE ADDRESS ABOVE.**



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 355 Maple Avenue, Harleysville, PA 19438  
 Tel 800.222.1981 www.harleysvillegroup.com

Please mail forms to the  
 Administrative Address:  
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 P.O. Box 253, Harleysville, PA 19438-0253

**AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS  
 PURSUANT TO 45 CFR 164.508 (HIPAA)**

**Patient Name:**  
**DOB:**

**Application or Claim Number:**  
**Dates of Information Requested:** \_\_\_\_ through \_\_\_\_

TO: Any physician, surgeon, dentist, hospital, rehabilitation/convalescent/custodial facility, ambulance, nurse, other health care provider or insurance company.

The undersigned authorizes you to disclose and release the following protected health information:

**Any and all inpatient admissions, all ER visits, outpatient clinic notes, diagnostic testing, radiology films, consults, doctors orders, progress notes (excluding psychotherapy notes), nurses notes, laboratory testing, prescription and pharmacology records, social service records, reports, correspondence, consultations, memoranda, treatment plans, admission records, discharge summaries, medical summaries, diagnoses, and/or any writing of any kind. These records should also include drug and alcohol records, HIV and AIDS records, and mental health records.**

This protected health information is disclosed for the following purposes: verifying, evaluating, negotiating and or other pertinent legal uses, with respect to the patient's insurance application or claim made to Harleysville Insurance.

You are authorized to release the above records, or copies thereof, to any representative of Harleysville Life Insurance at the following address:

**Harleysville Life Insurance  
 P.O. Box 253  
 Harleysville, PA 19438-0253**

This authorization shall be in force and effect until 24 months from the date signed. **I further agree that a photocopy or facsimile copy of this Authorization shall be valid and effective just as the original.**

I have the right to revoke this authorization, in writing, by sending written notification to Harleysville Life Insurance Company at the above address. I understand that a revocation is not effective to the extent that you have relied on my authorization to disclose protected health information.

I acknowledge that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by Subpart E of the Regulations promulgated by the U.S. Department of Health and Human Services pursuant to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") relating to the privacy of individually identifiable health information.

I understand that I have the right to:

- Inspect or copy the individually identifiable health information to be disclosed.
- Refuse to sign this authorization and that my treatment is not conditioned upon my signature hereon. I further understand that if I refuse to sign this authorization to release medical records, Harleysville Life Insurance, its reinsurers and representatives, may not be able to process my application or claim for benefits.
- Receive a copy of this Authorization upon request.

**Signature of Patient or Personal Representative** \_\_\_\_\_ **Dated** \_\_\_\_\_

**Name of Patient or Personal Representative** \_\_\_\_\_

**Description of Personal Representative's Authority to sign for Patient (if applicable)** \_\_\_\_\_



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P.O. Box 253, Harleysville, PA 19438-0253

## REQUIRED DISCLOSURE STATEMENT FOR ACCELERATED BENEFITS

**This disclosure statement is provided to the Owner  
at the time of Application for Accelerated Benefit**

### Limitations of the Accelerated Benefit:

The accelerated benefit in this life insurance product may provide benefits to pay for long-term care services, but it is NOT part of a long-term care or nursing home insurance policy and the amount this product pays you may not be enough to cover your medical, nursing home or other bills. You may use the money you receive from this product for any purpose. Unlike conventional life insurance proceeds, accelerated benefits payable under this product rider **COULD BE TAXABLE IN SOME CIRCUMSTANCES**. We recommend that you contact a tax advisor when making tax-related decisions about electing to receive and use benefits from an accelerated benefit product.

### Consequences of this Benefit:

Receipt of accelerated benefits MAY AFFECT MEDICAID and SUPPLEMENTAL SECURITY INCOME (“SSI”) ELIGIBILITY. The mere fact that you own a policy with an accelerated benefit product may affect your eligibility for these government programs. In addition, exercising the option to accelerate living benefits and receiving those benefits before you apply for these programs, or while you are receiving government benefits, may affect your initial or continued eligibility. Contact the Medicaid Unit of your local Division of Medical Assistance and the Social Security Administration for more information.

### Medical Conditions enabling accelerating of life benefit:

- Terminally Ill is an illness, which, in the medical judgment of a Physician approved by Us will directly result in a life expectancy of 12 months or less.

### Benefit Payment:

Accelerated Living Benefit Payment is the lesser of a percentage of the Insured’s death benefit or a stated maximum, to be paid if the Insured is eligible under the Accelerated Living Benefit rider.

### Premium:

If the accelerated living benefit is paid, subsequent premiums for the Insured’s life insurance under this Policy will continue to be due unless waived under a waiver benefit elected under this policy.

### Administrative Expense Charge:

There is no administrative expense charge for exercising this benefit.

\_\_\_\_\_  
Signature of Owner

\_\_\_\_\_  
Signature of Agent

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date



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**NOTICE TO APPLICANTS REGARDING REPLACEMENT OF LIFE INSURANCE**

**THIS NOTICE IS FOR YOUR PROTECTION AND IS REQUIRED BY REGULATIONS OF THE MICHIGAN COMMISSIONER OF INSURANCE. PLEASE READ IT CAREFULLY**

Dropping or changing your existing life insurance to replace it with a new life insurance policy may be disadvantageous because:

A company can deny a claim during the first two years if it can be shown that you withheld information from your application which was important to the decision of whether to insure you. This is called the "CONTESTABLE PERIOD." If you drop or change policies, you may have to go through the two year period again.

You may pay HIGHER RATES for identical coverage because of your age. Life insurance rates go up as you get older.

BEFORE YOU DROP, CHANGE OR CASH IN YOUR PRESENT INSURANCE and apply for new insurance, you should:

1. Compare the policy BENEFITS and OPTIONS. The agent is required by law to provide you with all pertinent facts of the change and the insurance company you are considering must notify the company that issued your existing policy.
2. Be aware that you may be required to provide EVIDENCE OF INSURABILITY. If your health condition has changed since the application was taken on your present policy, you may be required to pay additional premiums under the new policy, or be denied coverage.
3. Compare the LOAN INTEREST RATE. The interest rate for new policies is probably higher than for the existing policy. Therefore, you will pay more when you want to borrow the cash value. If you are considering borrowing against your existing policy to pay the premiums on the proposed policy, you should understand that in the event of your death, the amount of any unpaid loan, including unpaid interest, will be deducted from the benefits of your existing policy.
4. Find out if the existing policy and/or the proposed policy offers DIVIDENDS OR EXCESS INTEREST. Dividends or excess interest can have a significant impact on net policy cost. Remember that no company can guarantee the amount of dividends it will pay in the future, nor can excess interest projections be presented as to imply a guarantee.
5. CONTACT THE AGENT OF YOUR PRESENT COMPANY. Your present company can often make changes in your existing insurance on terms which are more favorable to you than can another company.
6. Find out if there are income or estate tax consequences if you drop or change your present policy.

You should not drop or change your existing life insurance coverage until after you have been issued the new policy, examined it and found it to be acceptable to you. REMEMBER YOU HAVE TEN (10) DAYS AFTER RECEIPT OF THE POLICY TO CANCEL AND OBTAIN A FULL REFUND.

I \_\_\_ have \_\_\_ have not received a copy of all sales material presented to me.

Applicant's Signature \_\_\_\_\_



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 P.O. Box 253, Harleysville, PA 19438-0253

### INFORMATION STATEMENT

THE LIFE INSURANCE I INTEND TO PURCHASE FROM HARLEYSVILLE LIFE INSURANCE COMPANY MAY REPLACE OR ALTER EXISTING LIFE INSURANCE.

The following policy(ies) may be replaced as a result of this transaction:

| Insurer<br>(As it appears on the policy) | Insured<br>(As it appears on the policy) | Policy<br>Number |
|--|--|------------------|
| _____                                    | _____                                    | _____            |
| _____                                    | _____                                    | _____            |
| _____                                    | _____                                    | _____            |
| _____                                    | _____                                    | _____            |

The proposed policy is

\_\_\_\_\_ \$ \_\_\_\_\_  
 Type of Policy – Generic Name Face Amount

\_\_\_\_\_ Date  
 Signature of Applicant

\_\_\_\_\_ City State  
 Address of Applicant

I certify that this form and the Notice to Applicants Regarding Replacement of Life Insurance was given to and signed by:

\_\_\_\_\_  
 (Applicant – Please print or type)

prior to taking an application and that I am leaving a signed copy for the applicant.

A sales illustration \_\_\_ was \_\_\_ was not used in this presentation. A copy of the sales illustration must be submitted with this form.

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

\_\_\_\_\_ Address

\_\_\_\_\_ City State



## BASIC ILLUSTRATION REQUIREMENT

This is to acknowledge that a basic illustration conforming to the policy as applied for has not been provided. I understand that a basic illustration which conforms to the policy as issued will be provided no later than at the time of policy delivery.

Printed Name of Applicant \_\_\_\_\_

Applicant's Signature \_\_\_\_\_ Date \_\_\_\_\_

Printed Name of Agent \_\_\_\_\_ Date \_\_\_\_\_

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