



Harleysville Life Insurance Company

355 Maple Avenue • Harleysville, PA 19438-2297
Tel 800.222.1981 • www.harleysvillegroup.com

**APPLICATION FOR
VOLUNTARY GROUP TERM LIFE**
Please print or type all information requested.
All applications missing information will be returned.

Group Policy Number: _____ Name of Sponsoring Organization:
Pennsylvania Middle School Association

PART I – TO BE COMPLETED BY ALL APPLICANTS

Name of Applicant (Last, First, MI): _____

Address (No., Street, City, State, ZIP Code): _____

Social Security Number: _____ Date of Birth: _____ Birthplace: _____ Sex: Male Female Marital Status: Married Single Work Phone #: () _____
Home Phone #: () _____

Beneficiary Designation: _____ Relationship: _____

Coverage Requested: Participant only For Participant and Spouse For Participant and Children For Participant and Eligible Dependents Applying for Reinstatement
If electing Dependent Coverage:
Number of Unmarried Children ages 18 and under: _____
Number of Unmarried Children 19-25 in College: _____

Name of Spouse (Last, First, MI): _____

Address of Spouse, if different (No., Street, City, State, ZIP Code): _____

Social Security Number: _____ Date of Birth: _____ Birthplace: _____ Occupation: _____

Amount of Insurance Requested:

PARTICIPANT: \$ _____ Minimum of \$20,000, maximum of \$300,000 available in \$10,000 increments
SPOUSE: \$ _____ Minimum of \$10,000, maximum of \$150,000 available in \$10,000 increments up to 50%
of Participant's amount
ELIGIBLE CHILDREN: \$ _____ Minimum of \$1,000, maximum of \$10,000 available in \$1,000 increments

Billing Mode: Quarterly Semi-Annual Annual **(A \$2.00 administration fee will be added to each bill.)**

Please answer the following questions.

Have you used nicotine products in the past 12 months? PARTICIPANT: Yes No SPOUSE: Yes No

What is your Height and Weight? PARTICIPANT: Height _____ Weight _____ (lbs) SPOUSE: Height _____ Weight _____ (lbs)

PART II- COMPLETE THE FOLLOWING QUESTIONS IF THE AMOUNT REQUESTED IS ABOVE THE PLAN GUARANTEED ISSUE LIMITS:

- | | | |
|--|--|--|
| | CHECK CORRECT ANSWER | |
| | PARTICIPANT | SPOUSE |
| 1. Have you been hospitalized within the last 90 days?..... | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 2. Have you ever been diagnosed or treated for Acquired Immune Deficiency (AIDS), Aids Related Complex (ARC), been tested positive for antibodies for the Human Immunodeficiency Virus (HIV)?..... | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 3. Have you ever had life or disability coverage denied, rated, or postponed?..... | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 4. Have you ever been diagnosed or treated for any disease of the heart or blood vessels; high blood pressure; diabetes; cancer; drug or alcohol abuse; any disorder of the immune system; mental or nervous disorder or any disorder of the blood, kidneys, liver, lungs, stomach or intestines?..... | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 5. Within the past 5 years, have you consulted a physician or practitioner for or been diagnosed as having any injury, medical or surgical condition not stated above?..... | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 6. Do you regularly take prescription drugs or medicines for any physical or mental condition? | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |

Please provide details to any "yes" answers in Part IV on the next page.

FOR HOME OFFICE USE ONLY

Coverage For:	Guar Issue Life Amount:	Effective Date:	Medically Underwritten Life Amount:	Effective Date:
PARTICIPANT				
SPOUSE				
CHILD				

Home Office Amendments: _____

THIS APPLICATION IS NOT COMPLETE WITHOUT SIGNATURE(S) ON PAGE 3

PART III - COMPLETE THE FOLLOWING QUESTIONS IF THE AMOUNT REQUESTED IS ABOVE \$100,000 FOR THE PARTICIPANT AND/THE SPOUSE:

7. Name and Address of personal physician:
 PARTICIPANT _____ SPOUSE _____

 Date and Reason of Last Visit:
 PARTICIPANT _____ SPOUSE _____
8. Please provide the following:
 Weight change in last 12 months: PARTICIPANT _____ SPOUSE _____
9. Have you ever used nicotine products?
 PARTICIPANT: Yes No If yes, when did you last use nicotine products? _____
 SPOUSE: Yes No If yes, when did you last use nicotine products? _____
10. Please provide the following:
 PARTICIPANT: Driver license number: _____ State of Issue: _____
 SPOUSE: Driver license number: _____ State of Issue: _____

CHECK THE CORRECT ANSWER FOR THE PARTICIPANT AND/OR THE SPOUSE:

- | | PARTICIPANT | SPOUSE |
|---|--|--|
| 11. Have you, within the past 3 years been sited for a moving violation or had your license revoked?..... | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 12. Do you participate in recreational activities involving: | | |
| a. Aeronautics (including hang gliding, soaring, skydiving, ballooning)?..... | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| b. Powered racing or competitive vehicles (including motorcycles, automobiles, and motorboats)?..... | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| c. Recreational vehicles over open terrain, trails, sand, snow or ice (including snowmobiles, dirt bikes, and dune buggies)?..... | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| d. Skin or scuba diving, mountain climbing, rodeos or competitive skiing?..... | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 13. Are you presently taking any medications? (if "yes" indicate below)..... | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 14. Has any member of your immediate family had cancer, diabetes, or nervous or mental abnormality?..... | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 15. To the best of your knowledge have you ever been told you had: | | |
| a. Epilepsy, fainting spell, nervous or mental conditions, neuritis, paralysis, or any disease or abnormality of the brain or nervous system?..... | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| b. Heart attack, murmur, palpitation, or high blood pressure, anemia, or any disease or abnormality of the heart, blood or blood vessels?..... | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| c. Tuberculosis, asthma, pleurisy, or any disease or abnormality of the lungs, bronchial tubes, throat or respiratory system? | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| e. Ulcer, pancreas or any disease or abnormality of the stomach, intestines, rectum, gallbladder or liver?..... | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| f. Urinary sugar, albumin or stone, syphilis, menstrual disorder, or disease or abnormality of the breasts, kidneys, prostate, urinary or genital system? | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| g. Diabetes, gout, or other disease or abnormality of the thyroid or other glands? | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| h. Arthritis, rheumatic fever, back ailment, or any disease or abnormality of the joints, muscles or bones?..... | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| h. Any disease or abnormality of the eyes ears or skin? | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| i. Cancer or tumor?..... | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| j. Any physical deformity or defect?..... | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 16. Have you ever: | | |
| a. Used amphetamines, barbiturates, hallucinogens, marijuana or narcotics?..... | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| b. Been counseled or treated for use of drugs?..... | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| c. Been advised by a doctor to discontinue or reduce use of alcohol? | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| d. Been counseled or treated for use of alcohol? | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |

PART IV - PLEASE EXPLAIN ALL "YES" ANSWERS FOR QUESTIONS 1-16. PROVIDE ALL DETAILS BELOW.

Question Number	Medical Condition	Date Condition Began	Condition Ended	Name and Addresses of Medications, Doctors, and Hospitals

THIS APPLICATION IS NOT COMPLETE WITHOUT SIGNATURE(S) ON PAGE 3

PART V

AUTHORIZATION FOR EMPLOYER-SPONSORED PAYROLL DEDUCTION ONLY PLANS

I hereby authorize by Employer to deduct from my salary whatever premiums are due for the Life Insurance under this group policy. This authorization will remain in force until revoked by me by written notice addressed to my Employer. I understand that the insurance requested in the application will not be effective until approved by Harleystown Life Insurance Company.

AUTHORIZATION TO OBTAIN INFORMATION

I have read the above questions and answers, and hereby declare that to the best of my knowledge and belief, they are complete and true, and that the Company may rely on the statements in the issuance of insurance coverage. I agree that this application and any other required parts will be the basis for, and an integral part of any certificate 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; and that no insurance will take effect unless and until the certificate has been manually delivered to and received and accepted by me and the full first premium paid during the lifetime and continued insurability as described in the application of each person on whom insurance is requested.

I authorize any licensed physician, medical practitioner, hospital, clinic, dispensary, sanitarium, or other medically related facility, insurance company, the Veteran's Administration or Medical Information bureau, consumer reporting agency or employer to release to the Harleystown Life Insurance Company and its reinsurers any of the following pertaining to me 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, criminal activity, financial information, occupation, habits, driving record and general character. This information will be used by Harleystown Life Insurance Company and its reinsurers to determine eligibility for insurance.

To facilitate rapid transmission of such information, I authorize all such sources to provide such records or information to any of Harleystown's legal representatives. I understand that Harleystown Life Insurance Company will not release this information to any person or organization except its reinsurer(s); the Medical Information Bureau; 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 person organizations performing business or legal services in connection with my application including group plan administrators; or as may be otherwise lawfully required, or as I further authorize.

I understand that I or my 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 also understand that this authorization will be valid for two and one-half years from the date shown below.

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

For Applications signed in the District of Columbia: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim is provided by the applicant.

For Applications signed in Maryland: FRAUD WARNING: Any person who either intends to defraud or knows that he is facilitating a fraud against an insurer and submits an application or files a claim containing a false or deceptive statement may be guilty of fraud, as determined by a court of competent jurisdiction.

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

For Applications signed in South Carolina: FRAUD WARNING: Any person who either intends to defraud or knows that he is facilitating a fraud against an insurer and submits an application or files a claim containing a false or deceptive statement is guilty of fraud.

For Applications signed in Virginia: Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated the state law.

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

Is the insurance applied for to replace any existing insurance or annuity policy?

PARTICIPANT: Yes No If "Yes," please provide the name of company and the policy number: _____

SPOUSE: Yes No If "Yes," please provide the name of company and the policy number: _____

Dated at _____ (on) _____ 20_____

Dated at _____ (on) _____ 20_____

Signature of Participant Applicant

Signature of Spouse, if applying for insurance

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. In addition, we may ask you or your minor children 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. When we do so, we use the authorization form signed.

FAIR CREDIT REPORTING ACT: In connection with your application for insurance, an investigative consumer report may be obtained, including if applicable, information as to your character, general reputation, personal characteristics and mode of living. This 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 (M.I.B.). The M.I.B. 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 M.I.B. will supply such company with the information it may have in its files.

Upon receipt of a request from you, the M.I.B. 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: Post Office Box 105, Essex Station, Boston, Massachusetts 02112. Telephone Number: (617) 426-3660.

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 underwriting and New Business, Harleysville Life Insurance Company, Harleysville, Pennsylvania 19438-9989. Indicate your full name, address, telephone number and policy or certificate 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 Underwriting and New Business 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 part of your permanent file.