

SHORT FORM MEDICAL STATEMENT

COMPLETE SEPARATE STATEMENT FOR EACH PROPOSED INSURED.

PART A: TO BE COMPLETED BY AUTHORIZED REPRESENTATIVE OF THE SPONSOR, OR POLICYHOLDER.

Policy #: _____ Policyholder or Sponsor Name: _____ Occupation: _____

Proposed Insured's Name: _____ Employee's Salary: _____

The employee is actively at work or an active member of our organization and is to the best of our knowledge in good health.

Date: _____ Authorized Signature: _____ Date of Hire: _____

REASON FOR REQUEST: New Employee Late Applicant Open Enrollment Dependent: _____

COVERAGE DESIRED: (check one)	COMPLETE AMOUNT APPLIED FOR:
_____ BASIC LIFE IN EXCESS OF GUARANTEED ISSUE	_____
_____ SUPPLEMENTAL LIFE IN EXCESS OF GUARANTEED ISSUE	_____
_____ DEPENDENT LIFE	_____
_____ WEEKLY DISABILITY	_____
_____ LONG TERM DISABILITY	_____

Insurance will not be in force until Harleysville Life approves request and notifies policyholder.

PART B: TO BE COMPLETED BY APPLICANT.

PROPOSED INSURED STATEMENT

Last	First	MI	Gender	Date of Birth	Full time Student?
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#	Street	City	State	Zip
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Work Phone # ()	Home Phone # ()	Social Security Number	State or Country of Birth	Height	Weight
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|---|--|
| | CHECK CORRECT ANSWER |
| 1. Have you ever had life or disability coverage denied, rated, or postponed? | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 2. 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, sickle cell anemia or any disorder of the blood, kidneys, liver, lungs, stomach or intestines? | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 3. 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? | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 4. Do you regularly take prescription drugs or medications for any physical or mental condition? | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 5. Have you been diagnosed or treated for AIDS (Acquired Immune Deficiency Syndrome), or ARC (AIDS Related Complex); or ever been advised that you have tested HIV positive? | Yes <input type="checkbox"/> No <input type="checkbox"/> |

PLEASE EXPLAIN ALL "YES" ANSWERS FOR QUESTIONS 1 - 5. PROVIDE ALL DETAILS BELOW.

Question Number	Medical Condition	Date Condition		Name, Address, Phone # of Doctors and Hospitals
		Began	Ended	

PLEASE COMPLETE PAGE 2

APPLICANT'S STATEMENT: I have read the completed application. The above representations are true to the best of my knowledge and belief. I agree that policy shall not be in effect until it has been issued by the Company during the lifetime of the Proposed Insured. I understand the information on this application will be relied upon to determine insurability and that incorrect information may result in coverage being voided, subject to the policy incontestability provision. I understand that the agent has no authority to approve the application, change the policy, or waive any policy provisions. I understand no insurance will be effective until the date stated in the policy and all eligibility requirements are met.

MEDICAL AUTHORIZATION: I hereby authorize any licensed physician, medical practitioner, hospital, clinic, or other medical or medically related facility, insurance company, the Medical Information Bureau or to other organization, institution, or person, that has any record or knowledge of me or my health, to give Harleysville Life Insurance Company or its representatives or its reinsurers any such information. I understand that such information will be used to determine my insurability. A copy of this authorization shall be as valid as the original. I agree this authorization shall be valid for two years from the date signed, and that I may request a copy of it.

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

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 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.

Signed: _____ on: _____ ✓
Signature of Proposed Insured

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.