Harleysville
Good people to know®

Harleysville Life Insurance Company
355 Maple Avenue
Harleysville, PA 19438-2297
800.222.1981
www.harleysvillelife.com

Group Insurance Enrollment Form

IMPORTANT: Submitting this form does not automatically entitle you and/or your dependent(s) to coverage. Your plan administrator is responsible for establishing eligibility and submitting any additional documentation. Please check with your plan administrator to confirm that you and/or your dependent(s) are eligible based on the provisions of the group policy(ies) issued by Harleysville Life Insurance Company.

Please Print All Answers

Employer or Sponsor Name: _____

Group Policy #: G-_____Sub Acct #_____Marital Status ☐ M, ☐ S, ☐ W, ☐ D, ☐ Legally Separated

Applicant Name (Last/First/Middle): _____

Date of Birth: _____ ☐ Male ☐ Female Social Security #: _____

Home Address: _____ Home Pho ne Number: _____

_____ Work Phone Number: _____

EMPLOYEE INFORMATION

Occupation: _____

Class Description: _____

Date of Hire or Membership: _____

☐ Full Time ☐ Part Time ☐ Retired

Earnings: $_____ ☐ Annual ☐ Hourly

☐ Other _____

Are you now actively at work and performing all duties of your regular occupation? ☐ Yes ☐ No

If Yes, number of regular hours worked per week:_____

BENEFIT INFORMATION (the elections only need to be made if the employee pays all or part of the premium)

Select coverage(s) available under group plan	Coverage Amount $	Voluntary Coverage Amount $
☐ Life		
☐ Accidental Death and Dismemberment		
☐ Short Term Disability		
☐ Long Term Disability		
☐ Dependent's Insurance Spouse*Name: _____ Gender:____ DOB:_____		
☐ Dependent's Insurance - Child*		

***DEPENDENT LIFE INSURANCE**

An eligible Dependent does not include dependents who are confined in a hospital, clinic, nursing home, rest home, rehabilitation center, or similar establishment or receiving hospice care on the date the insurance would otherwise become effective. Such insurance will not be effective until the date the dependent is no longer confined and not in a period of continued limited activity.

REQUIRED SIGNATURE

I have read the above questions and answers, and hereby represent that the information provided is complete and true, and that the Company may rely on the statements in the issuance of insurance coverage. I agree that this Group Insurance Enrollment Form and other required parts will be the basis for determining eligibility for coverage and that incomplete or inaccurate information contained on this form may result in the denial of eligibility and/or coverage. If I am required to pay for all or part of this insurance, I hereby authorize, until further notice, that my employer may deduct from my wages, amounts equal to the contributions required for the premium for group insurance under policies issued to my employer by Harleysville Life Insurance Company.

Date _____ ✍ _____
Employee/Member Signature

IF ENROLLING FOR GROUP LIFE INSURANCE BENEFITS, PLEASE COMPLETE THE BENEFICIARY DESIGNATION ON REVERSE SIDE.

Employee or Member Name (Last/First/Middle): _____ **G-**_____

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. **Florida:** Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree. **Maryland:** Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. **New Mexico:** Any person who knowingly presents a false or fraudulent claim for payment of loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties. **Ohio:** Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud. **Pennsylvania:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties. **Tennessee and Virginia:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

PRIMARY BENEFICIARY DESIGNATION	**CONTINGENT BENEFICIARY DESIGNATION**
Name: _____ Social Security Number: _____ Date of Birth: _____ Relationship to Applicant:_____ Home Address: _____ _____ Beneficiary Phone #: _____ Percentage Share: _____% *(Total for all primary beneficiaries must equal 100%)*	Name: _____ Social Security Number: _____ Date of Birth: _____ Relationship to Applicant: _____ Home Address: _____ _____ Beneficiary Phone #: _____ Percentage Share: _____% *(Total for all contingent beneficiaries must equal 100%)*
Name: _____ Social Security Number: _____ Date of Birth: _____ Relationship to Applicant:_____ Home Address: _____ _____ Beneficiary Phone #: _____ Percentage Share: _____% *(Total for all primary beneficiaries must equal 100%)*	Name: _____ Social Security Number: _____ Date of Birth: _____ Relationship to Applicant: _____ Home Address: _____ _____ Beneficiary Phone #: _____ Percentage Share: _____% *(Total for all contingent beneficiaries must equal 100%)*

REQUIRED SIGNATURES FOR BENEFICIARY DESIGNATION

I acknowledge that the information contained above for beneficiary designations is true and accurate.

Date _____ ✍ _____

Employee/Member Signature