



Harleysville Life Insurance Company

1440 Pennbrook Parkway • Lansdale, PA 19446-3840
Tel (800) 222-1981 • www.harleysvillegroup.com

**GROUP LIFE INSURANCE PROCEEDS
VERIFICATION OF ELIGIBILITY
(to be completed by employer)**

Furnishing or retaining this completed form by Harleysville Life Insurance Company shall not operate as a waiver of any rights or defenses which Harleysville Life may have under any policy.

STATEMENT OF EMPLOYER

1. NAME OF EMPLOYEE/SPOUSE/DEPENDENT		DATE OF BIRTH	CERTIFICATE NUMBER (EMPLOYEES)
2. LEGAL RESIDENCE AT TIME OF DEATH			EMPLOYER'S POLICY NUMBER
3. EFFECTIVE DATE OF COVERAGE	AMOUNT OF INSURANCE	DATE EMPLOYEE FIRST ENTERED EMPLOY	EMPLOYEE'S OCCUPATION
4. DATE OF EMPLOYEE'S LAST ACTIVE SERVICE	REASON FOR EMPLOYEE'S LEAVING WORK	BASIC ANNUAL EARNINGS AT DEATH FOR EMPLOYEE	DATE OF DEATH
N/A FOR DEPENDENT LIFE			
5a. IS/WAS EMPLOYEE FULL TIME <input type="checkbox"/> YES <input type="checkbox"/> NO		B. PART-TIME <input type="checkbox"/> YES <input type="checkbox"/> NO	C. HOURS WORKED PER WEEK _____
5d. IF MORE THAN THIRTY-ONE DAYS ELAPSED BETWEEN DATE LAST WORKED AND DATE OF DEATH, DO YOU CONSIDER DEATH OCCURRED WHILE HE WAS <input type="checkbox"/> RETIRED EMPLOYEE <input type="checkbox"/> ABSENT ON SICK LEAVE <input type="checkbox"/> TOTALLY DISABLED <input type="checkbox"/> ABSENT BECAUSE OF TEMPORARY LAY-OFF <input type="checkbox"/> NO LONGER EMPLOYED			
6. NAME OF BENEFICIARY		RELATIONSHIP	DATE OF BIRTH OF BENEFICIARY
7. ADDRESS OF BENEFICIARY (STREET, CITY, STATE, ZIP CODE)			

FRAUD WARNINGS:

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.

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.

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.

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.

South Carolina: FRAUD STATEMENT: 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.

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.

Signature of Policyholder (please give title)

Name of Employer

Date

A Newspaper clipping of the death should also be sent on claims where accidental death coverage is involved.

If the insurance is payable to an executor, administrator or guardian, an official certificate of his appointment and qualification must accompany this form. If payment is affected by the prior death of a beneficiary, an official Death Certificate for such beneficiary must accompany this form.



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APPLICATION FOR LIFE INSURANCE PROCEEDS

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BENEFICIARY CLAIM STATEMENT

Page 1 of 2

BENEFICIARY	DECEASED
POLICY NO(S).	

Please attach a **certified death certificate**

INSURED INFORMATION *(please print)*

DATE OF DEATH	CAUSE OF DEATH	DATE OF BIRTH
PLACE OF DEATH (CITY & STATE)		
LEGAL RESIDENCE (STREET ADDRESS, CITY, STATE & ZIP)		

PAYMENT INFORMATION

1. If the Owner did not elect a payment plan and proceeds are \$10,000 or greater, funds are automatically available to you in your interest-bearing Bisys Retained Asset Account. Your proceeds will continue to earn interest or you can withdraw some or all of them at any time by writing a check(s). Signing this form constitutes your election of the Bisys Account. If no other payment plan has been elected, proceeds of less than \$10,000 will be sent to you via a one-sum check. Bisys customer service number 800-331-4631.
2. You may select a payment plan in lieu of or in addition to your Bisys Account. If you are interested in a payment plan, please indicate the type of plan in which you are interested and the form will be sent to you.

Check one: Interest Income Plan Installment Income Plan Life Income Plan Lump Sum

PAYEE INFORMATION *(Please Print) (One Person Per Form)*

FULL NAME	DAYTIME PHONE NO.		
STREET ADDRESS	CITY	STATE/ZIP	
RELATION TO DECEASED	BIRTHDATE		
TAXPAYER ID NO. (SOCIAL SECURITY NO.)			

SIGNATURE REQUIRED ON PAGE 2

See Page 2 for FRAUD WARNINGS as well as OTHER IMPORTANT INFORMATION AND SIGNATURE LINE

BENEFICIARY CLAIM STATEMENT

Page 2

Accidental Death – please attach a newspaper clipping reporting the accident, and an autopsy and police report if applicable.

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Certification – under the penalties of perjury, by signing below I certify (1) that the number shown on this form is my correct Taxpayer Identification Number, and (2) that I am not subject to backup withholding because (a) I have not been notified by the IRS that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (b) if I ever was so notified, the IRS has notified me that I am no longer subject to backup withholding. The Internal Revenue Service does not require your consent to any provisions of this document other than the certifications required to avoid backup withholding.

Signature

Date