



MEMBER ENROLMENT FORM

| Street City Country | Date of Enrolment in Golden Harvest Savin | ngs Plan Month Day Year | |
|--|--|--|----------------------------------|
| Street City Country Telephone Date of Birth Month Day Year Age Month Day Year Designated Beneficiary First Name Last Name Golden Harvest Savings Plan Contract Savings Goal Monthly Deposit Required Term (in months) of Savings Contract Annual Interest Rate 1. (a) In the last five (5) years have you received any medical attention, advice, surgical procedure or be treated for any illness? Please tick the appropriate response. (Answering Yes to the above question makes the applicant subjected to underwriting approval) I understand that if I fail to make the contracted monthly savings goal deposits on a timely basis the contract will terminate, and total amount of any insurance premiums paid on this contract by the Policyholder may be deducted from my accumulated savibalance to date. No | Nama | | |
| Street City Country Telephone Date of Birth Month Day Year Age Month Day Year Month Day Year Membership Number Designated Beneficiary First Name Last Name Golden Harvest Savings Plan Contract Savings Goal Monthly Deposit Required Term (in months) of Savings Contract Annual Interest Rate 1. (a) In the last five (5) years have you received any medical attention, advice, surgical procedure or be treated for any illness? Please tick the appropriate response. Yes No (b) If yes, please provide details: (Answering Yes to the above question makes the applicant subjected to underwriting approval) Lunderstand that if I fall to make the contracted monthly savings goal deposits on a timely basis the contract will terminate, and total amount of any insurance premiums paid on this contract by the Policyholder may be deducted from my accumulated saving good health at this time. Member's Signature Date Month Day Year | | Middle | Last |
| Telephone | Address | | |
| Male Female | Street | City | Country |
| Male Female | Telephone | | Age |
| Membership Number Relationship to you Relationship to you Relationship to you First Name Last Name Relationship to you | ☐ Male ☐ Female | , | |
| Designated Beneficiary Relationship to you | Policyholder Name | | |
| Relationship to you | Membership Number | | Month Day Toda |
| Golden Harvest Savings Plan Contract Savings Goal Monthly Deposit Required Term (in months) of Savings Contract Annual Interest Rate 1. (a) In the last five (5) years have you received any medical attention, advice, surgical procedure or be treated for any illness? Please tick the appropriate response. | | Relationship to you | J |
| Savings Goal | | | |
| Term (in months) of Savings Contract Annual Interest Rate | Golden H | arvest Savings Plan Contract | |
| 1. (a) In the last five (5) years have you received any medical attention, advice, surgical procedure or be treated for any illness? Please tick the appropriate response. Yes No (b) If yes, please provide details: (Answering Yes to the above question makes the applicant subjected to underwriting approval) I understand that if I fail to make the contracted monthly savings goal deposits on a timely basis the contract will terminate, and total amount of any insurance premiums paid on this contract by the Policyholder may be deducted from my accumulated savin balance to date. I have provided the above information and acknowledge all statements to be correct to the best of my knowledge. I am i good health at this time. Member's Signature Date Month Day Year | Savings Goal | Monthly Deposit Required_ | |
| treated for any illness? Please tick the appropriate response. Yes No (b) If yes, please provide details: (Answering Yes to the above question makes the applicant subjected to underwriting approval) I understand that if I fail to make the contracted monthly savings goal deposits on a timely basis the contract will terminate, and total amount of any insurance premiums paid on this contract by the Policyholder may be deducted from my accumulated savin balance to date. I have provided the above information and acknowledge all statements to be correct to the best of my knowledge. I am i good health at this time. Date Month Day Year | Term (in months) of Savings Contract | Annual Interest Rate | |
| (Answering Yes to the above question makes the applicant subjected to underwriting approval) I understand that if I fail to make the contracted monthly savings goal deposits on a timely basis the contract will terminate, and total amount of any insurance premiums paid on this contract by the Policyholder may be deducted from my accumulated savin balance to date. I have provided the above information and acknowledge all statements to be correct to the best of my knowledge. I am i good health at this time. Member's Signature | | | ırgical procedure or beer |
| I understand that if I fail to make the contracted monthly savings goal deposits on a timely basis the contract will terminate, and total amount of any insurance premiums paid on this contract by the Policyholder may be deducted from my accumulated saving balance to date. I have provided the above information and acknowledge all statements to be correct to the best of my knowledge. I am it good health at this time. Member's Signature | (b) If yes , please provide details: | | |
| good health at this time. Member's Signature Date Month Day Year | I understand that if I fail to make the contracted mo total amount of any insurance premiums paid on the | onthly savings goal deposits on a timely basis the | contract will terminate, and the |
| Month Day Year | | owledge all statements to be correct to the bes | t of my knowledge. I am in |
| | Member's Signature | Date | Month Day Year |
| | To be com | npleted by Policyholder Personnel | Month Day Fear |
| Enrolment taken by: Signature: | Enrolment taken by:(Print Name | Signature: | |
| Insurance Coverage Signature: approved by: (Print Name) | | Signature: | |
| Insurance Coverage Golden Harvest Savings Plan Effective Date Account Number Assigned: (Month Day Year) | Effective Date | Account Number Assigned: | |