

Golden Harvest Savings Plan

Date of Enrollment in Golden Harvest Savings Plan

Name _____
Last First

Address _____
Street City Country

Telephone _____ Date of Birth _____ Age _____
Day Month Year

☐ Male ☐ Female

Organization Name _____ Date of Membership _____
Day Month Year

Membership Number _____

Designated Beneficiary _____ Relationship to you _____

Golden Harvest Savings Plan Contract

Savings Goal _____

Monthly Deposit Required _____

Initial Deposit \$ _____

Term (in months) of Savings Contract _____

Annual Interest Rate _____

Within the last five years have you ever been treated for or been advised that you have any of the following conditions: diabetes, heart disorders, any cancer, acquired immune deficiency syndrome (AIDS), HIV infection or AIDS related complex? ☐ Yes ☐ No

(Answering Yes to the above question makes the applicant ineligible for insurance under the Golden Harvest Savings Plan.)

I understand that if I fail to make the contracted monthly saving goal deposit on a timely basis the contract will be terminated, and the total amount of any insurance premium paid on this contract by the Organization may be deducted from my accumulated savings balance to date.

I have provided the above information and acknowledge all statements to be correct to the best of my knowledge. I am in good health at this time.

Member's Signature _____

Date _____
Day Month Year

To be completed by Organization Personnel

Enrollment taken by _____ Insurance Coverage approved by _____
Organization Officer Organization Officer

Insurance Coverage Effective Date _____
Day Month Year

Golden Harvest Savings Plan Account Number Assigned _____

This Enrollment Form should be made in 3 copies, the write (original copy) is for the office administering the insurance, the yellow copy is for the Organization, and the pink copy is for the Member.