Golden Harvest Savings Plan

Date of Enrollment in Golden Harvest Savings Plan ______________________
Day Month Year

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.