GUARDIAN®

☐ **Berkshire Life Insurance Company of America**
Home Office: 700 South Street, Pittsfield, MA 01201
A wholly owned stock subsidiary of The Guardian Life Insurance Company of America, New York, NY

☐ **The Guardian Life Insurance Company of America**
Administrative Office: 700 South Street, Pittsfield, MA 01201

(Please check appropriate company(ies). Any insurer checked above is herein referred to as the "Company.")

Application for Disability Insurance

I. Proposed Insured Information

a. Name (First, Middle Initial, Last) Suffix Previous Last Name, if applicable

b. Gender: ☐ Male ☐ Female

c. Social Security #: _____

d. Residence Address (Street, City, State, Zip):

_____

_____

How long at this address? _____

e. Date of Birth (mm/dd/yyyy): _____

f. Place of Birth: _____

g. Telephone: Home _____

Cell _____

E-mail Address: _____

h. Are you a U.S. citizen ☐ Yes ☐ No

If no, please provide: Visa Type _____ Visa Duration _____

How long have you lived in the U.S. on a full-time basis? _____

(If residence has not been continuous, give dates, and explain in Remarks and Special Requests section 10)

_____

2. Business Information

a. Current Employer: _____

Number of years with current employer _____

b. Business Address (Street, City, State, Zip):

_____

_____

c. Business Telephone: _____

Business Website: _____

d. Nature of Business:

_____

e. Occupation: _____

Number of years in this occupation _____

f. Job Title (if medical or dental occupation, state specialty):

_____

g. Professional licenses and designations held (if none, so state):

_____

3. Occupational Information

a. Describe all activities performed in connection with the duties of your occupation, including but not limited to invasive surgical, travel, sales and supervisory duties. If the space provided is not adequate, provide additional details in Remarks & Special Requests section 10.

Description of Specific Duties	% of Time Devoted to Each Duty

b. Describe exact physical duties of your occupation (lifting, climbing, driving, etc.). If none, so state.

_____

c. Describe any tools or equipment you use to perform the duties of your occupation. If none, so state.

_____

d. Is this a home-based occupation? ☐ Yes ☐ No If yes, what percentage of time do you spend working outside the home? _____%

e. How many hours per week are you at work in this occupation? _____ hours

f. Have you been continuously at work full time performing the usual duties of your occupation for the past six months? ☐ Yes ☐ No
If no, explain in section 10 Remarks and Special Requests.

g. Do you supervise any employees? ☐ Yes ☐ No If yes, how many? _____

h. Employment Status: ☐ Employee (no ownership) ☐ Sole Proprietor ☐ Partner _____% ownership
☐ S-Corporation Shareholder _____% ownership ☐ C-Corporation Shareholder _____% ownership

i. Do you plan to change your occupation, job or employment within the next six months? ☐ Yes ☐ No If yes, provide details:

j. Do you have any other part- or full-time occupations, jobs or employment? ☐ Yes ☐ No If yes, provide details:

4. Other Insurance Coverage of the Proposed Insured

a. Do you have disability insurance in force or applied for, or are you eligible for disability insurance within the next 12 months with any company, including Guardian or Berkshire? ☐ Yes ☐ No

b. Do you plan to apply for or are you currently applying for any other life, long-term care, disability or accident insurance? (In Remarks and Special Requests section 10, include amount applying for and company applying with, and whether this other insurance will be in addition to or in lieu of insurance with Berkshire or Guardian.) ☐ Yes ☐ No

c. Describe all disability income pending and in force coverage. If none, check here ☐

Type of Insurance: Individual (IDI), Group (G), Group with Conversion Option (GC), Overhead Expense (OE), Disability Buy-Out (DBO), Retirement Protection (RP), Association (A), Other (O – Explain)

Status: I = In Force, P = Pending, E = Eligible For

Company Name	Type	Status	Benefit Amount	Benefit Period	Social Insurance Benefit	Catastrophic Benefit	Employer paid? (Y/N)	Is coverage being replaced? (Y/N)	Amount to be Replaced?	Date to be Replaced?
1.										
2.										
3.										
4.										

5. Personal Financial Information of the Proposed Insured

For purposes of this section, Earned Income and Unearned Income mean the income you are required to report for federal income tax purposes. Earned Income includes W-2 wages, salary, tips, fees, bonuses, your share of the distribution of the owners actively involved in a business, net business income, and other sources of revenue. Unearned income includes passive income, income from dividends, capital gains, interest (including tax exempt interest), rentals, royalties, retirement plans, alimony, investments, and business interests as an inactive owner. Fill in the income amounts below using your individual and/or business tax returns and supporting schedules. "Actual filed" means the amount of income disclosed in your filed federal income tax return for the requested year. Explain in Section 10 Remarks and Special Requests, any significant fluctuations between years or changes since the end of the most recent calendar year. Show loss amounts in parentheses.

a. Earned Income 1. Year-To-Date This Calendar Year $_____ 2. Actual Filed Last Calendar Year $_____ 3. Actual Filed Two Calendar Years Ago $_____

b. Unearned Income 1. Actual Filed Last Calendar Year $_____ 2. Actual Filed Two Calendar Years Ago $_____
Sources: _____

c. Do you participate in a qualified retirement plan such as a 401(k), 403(b), SIMPLE, IRA or profit sharing? ☐ Yes ☐ No

d. Total Annual Retirement Contribution (including your contribution and employer contributions):
1. Year-To-Date This Calendar Year $_____ 2. Actual Last Calendar Year $_____ 3. Actual Two Calendar Years Ago $_____

e. Do you wish to have this retirement contribution considered as part of your earned income? ☐ Yes ☐ No

f. Total Net Worth if 6 million dollars or more (assets minus liabilities, excluding primary residence) $_____
Sources: _____

g. Have you ever filed bankruptcy? ☐ Yes ☐ No
If yes, Type: ☐ Personal ☐ Business Date Filed: _____ Date Discharged: _____

6. Additional Information of the Proposed Insured

(Please provide details in Section 10 Remarks and Special Requests to all "Yes" answers)

a. Do you currently have plans to reside or travel outside of the U.S. within the next 12 months? (If yes, indicate location, frequency, for work or pleasure, date of departure, length of stay.) ☐ Yes ☐ No

b. Do you drive a motor vehicle? _____ Driver's License State _____ Driver's License # ☐ Yes ☐ No

c. Within the past five years, have you been convicted of any motor vehicle moving violations or had your driver's license suspended or revoked? (If yes, details must include date of violation, description of violation and penalty.) ☐ Yes ☐ No

d. Within the last 10 years, have you been convicted of a felony? ☐ Yes ☐ No

e. Indicate "yes" if any apply: 1) within the last 10 years your professional license has been suspended or revoked; 2) you have ever been disbarred; or 3) within the last 10 years you have been fined or sanctioned by an entity that oversees your profession. ☐ Yes ☐ No

f. Within the last three years, have you participated, or do you plan to participate in any of the following activities: piloting any type of aircraft; mountain or rock climbing; scuba diving; hang gliding; parachuting or skydiving; motor vehicle racing? (If yes to any, complete Aviation and/or Avocation Supplement.) ☐ Yes ☐ No

g. Within the past five years, have you had any application for insurance declined, modified, rated, cancelled, rescinded, or have you withdrawn a pending application, or had a renewal or reinstatement request refused? ☐ Yes ☐ No

h. Have you used tobacco, nicotine, or any nicotine delivery system such as the nicotine patch, nicotine gum, nicotine lozenges, nicotine inhaler or nicotine tablets in any form in the last 12 months? (If you have quit, date last used: _____) ☐ Yes ☐ No

i. Are you currently a member of, or do you currently have plans to join any branch of the United States Military, including the Army, Navy, Air Force, Marine Corps, Coast Guard, National Guard, or any reserve military unit? ☐ Yes ☐ No

j. Are you currently employed by, or seeking employment with, any company or entity which provides military, paramilitary, or security services outside of the United States? ☐ Yes ☐ No

k. Have you been alerted to or received orders for an overseas assignment or active service with any branch of the United States Military, including the Army, Navy, Air Force, Marine Corps, Coast Guard, National Guard, or any reserve military unit? ☐ Yes ☐ No

7. Health Information of the Proposed Insured

☐ This Section 7 is left intentionally blank. Information pertaining to my health and medical history will be provided by me in a separate Guardian or Berkshire form or forms which become part of my application. Additional questioning of your health and medical history may be required even when Section 7 is completed.

a. Name of your primary care physician: If none, check here ☐ Address of primary care physician (Street, City, State, Zip): _____

b. Date and reason last consulted? _____

c. What treatment or medication was given or recommended? Primary care physician telephone: _____

d. Height _____ feet _____ inches Current Weight _____ lbs.

e. Weight change past year: ☐ None ☐ Gain*: _____ lbs. ☐ Loss*: _____ lbs. *Reason for change: _____

(Please provide details to all "Yes" answers in Section 10 Remarks and Special Requests. If any part of questions 7f through 7n is left blank or answered "Yes", no prepayment should be taken and no Conditional Receipt issued.)

f. Have you been diagnosed as having or been treated for cancer, heart attack, stroke, diabetes, or chronic fatigue syndrome? ☐ Yes ☐ No

g. Are you currently receiving any medical advice, counseling or treatment for any medical, surgical, psychological or psychiatric condition? ☐ Yes ☐ No

h. Within the past 10 years, have you been diagnosed by or received treatment from a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), Human Immunodeficiency Virus (HIV), or any deficiency of the immune system? ☐ Yes ☐ No

i. Within the past 10 years, have you had, been treated for or received a consultation or counseling for cardiac arrhythmia, mitral valve prolapse, chest pain, or any disease or disorder of the heart?	☐ Yes ☐ No
j. Within the past 10 years, have you had, been treated for or received a consultation or counseling for hepatitis, fatty liver disease, cirrhosis, Jaundice, or any disease or disorder of the liver?	☐ Yes ☐ No
k. Within the past 10 years, have you had, been treated for or received a consultation or counseling for sciatica, whiplash, spinal disc disease, spondylosis, scoliosis, ankylosing spondylitis, spondylolisthesis or any disease, disorder or condition of the back, neck or spine?	☐ Yes ☐ No
l. Within the past 10 years, have you had, been treated for or received a consultation or counseling for chronic obstructive pulmonary disease, pneumonia, pleurisy or any disease or disorder of the lungs?	☐ Yes ☐ No
m. Within the past 10 years, have you had, been treated for or received a consultation or counseling for polycystic kidney disease, nephritis, pylonephritis or any disease or disorder of the kidneys?	☐ Yes ☐ No
n. Are you now pregnant? If yes, expected delivery date: _____	☐ Yes ☐ No
o. Are you currently taking prescription medication, or have you been prescribed any medication within the last six months?	☐ Yes ☐ No
p. In the last 10 years, have you had, been treated for or received a consultation or counseling for:	
1. high blood pressure, peripheral vascular disease, atherosclerosis, or any disease or disorder of the circulatory system?	☐ Yes ☐ No
2. hyperthyroidism, hyperparathyroidism, Cushing's syndrome or any disease or disorder of the glands?	☐ Yes ☐ No
3. osteoporosis, osteomyelitis, osteochondritis, fracture or any disease or disorder of the bones?	☐ Yes ☐ No
4. psoriasis, urticaria, dermatitis, or any disease or disorder of the skin?	☐ Yes ☐ No
5. arthritis, osteoarthritis, rheumatism, arthralgia, myalgia, fibromyalgia, dystonia, muscular dystrophy, muscle weakness, temporomandibular joint syndrome, overuse syndrome, repetitive motion disorder, tendonitis or any disease or disorder of the joints, tendons, ligaments, or muscles?	☐ Yes ☐ No
6. multiple sclerosis, neuropathy, neuritis, neuralgia, trigeminal neuralgia or any disease or disorder of the nerves?	☐ Yes ☐ No
7. cataracts, glaucoma, keratoconus, macular degeneration, optic neuritis or any disease or disorder of the eyes or vision?	☐ Yes ☐ No
8. cholesteatoma, tinnitus, vertigo, Meniere's disease, otosclerosis, or any disease or disorder of the ears, hearing or balance?	☐ Yes ☐ No
9. sinusitis, nasal polyps, rhinitis or any disease or disorder of the nasal sinuses?	☐ Yes ☐ No
10. hoarseness, laryngitis, vocal cord polyps, vocal cord paralysis, or any disease or disorder of the vocal cords or speech?	☐ Yes ☐ No
11. cholecystitis, cholelithiasis, biliary cirrhosis, or any disease or disorder of the gall bladder or bile ducts?	☐ Yes ☐ No
12. Barrett's esophagus, esophagitis, gastroesophageal reflux disease, esophageal stricture or any disease or disorder of the esophagus?	☐ Yes ☐ No
13. gastritis, peptic ulcer disease, or any disease or disorder of the stomach?	☐ Yes ☐ No
14. pancreatitis, pancreatic cyst, spenomegaly, hypersplenism or any disease or disorder of the pancreas or spleen?	☐ Yes ☐ No
15. ulcerative colitis, Crohn's disease, diverticulitis, colon polyps, irritable bowel syndrome, proctitis, anal fissure, or any disease or disorder of the intestines, colon, or rectum?	☐ Yes ☐ No
16. epilepsy, stroke, dizziness, headache, migraines, attention deficit hyperactivity disorder, cognitive impairment or any disease or disorder of the brain?	☐ Yes ☐ No
17. allergy, asthma, bronchitis, emphysema or any disease or disorder of the respiratory system?	☐ Yes ☐ No
18. polycystic ovary syndrome, complications of pregnancy, infertility, endometriosis, or any disease or disorder of the reproductive or genital organs?	☐ Yes ☐ No
19. prostatitis, benign prostatic hypertrophy, or any disease or disorder of the prostate?	☐ Yes ☐ No
20. neurogenic bladder, urethritis, urethral stricture, urinary incontinence, interstitial cystitis or any disease or disorder of the urinary system?	☐ Yes ☐ No
21. fibrocystic breast disease, gynecomastia, mastitis, breast cancer, or any disease or disorder of the	☐ Yes ☐ No

breasts?

22. anxiety, depression, nervousness, stress, mental or nervous disorder, or other emotional disorder? ☐ Yes ☐ No

23. insomnia, narcolepsy, hernia, sleep apnea, restless leg syndrome, tremor, Epstein Barr virus, tumor, or Lyme disease? ☐ Yes ☐ No

q. Do you have, or in the last 10 years have you had, any loss of hearing or sight? ☐ Yes ☐ No

r. Do you have an amputation of any kind, or any physical deformity, impairment, or handicap? ☐ Yes ☐ No

s. Have you ever used stimulants, hallucinogens, narcotics or any other controlled substance, or been advised to have counseling or treatment for alcohol or drug use? (If yes, complete the Alcohol and Drug Usage Supplement.) ☐ Yes ☐ No

t. Within the past five years, have you made a claim for disability benefits from any insurer, or from any state or federal program providing disability benefits? ☐ Yes ☐ No

u. Within the past five years, have you had a physical exam or check-up of any kind? ☐ Yes ☐ No

v. Within the past five years, have you been advised to have surgery or any diagnostic tests that were not performed, except for HIV tests? ☐ Yes ☐ No

w. Other than previously stated on this application, in the last five years have you received medical advice or counseling from physician(s), medical or mental health professional(s), counselor(s), psychotherapist(s), chiropractor(s), or other practitioner(s), or have you been a patient in a hospital, clinic, sanatorium, or other medical facility? ☐ Yes ☐ No

x. Within the past 12 months, have you had symptoms of any medical, psychological, or psychiatric disease or illness for which you have not sought treatment? ☐ Yes ☐ No

y. Do either of your parents have a history of: diabetes; cancer; high blood pressure; heart disease; Huntington's Disease or mental illness? ☐ Yes ☐ No

	Age if Living	Age at Death	Cause of Death
FATHER			
MOTHER			

8. Premium Information

a. What percentage of the premium for the coverage you are applying for will be paid by your employer? ☐ None ☐ 100% ☐ Other _____%

b. If your employer will pay any part of the premium, will it be reportable by you as taxable income? ☐ Yes ☐ No

c. If paid by the proposed insured, is it paid by: ☐ Pre-tax dollars ☐ After-tax dollars

d. Premium Mode: ☐ Annual ☐ Semiannual ☐ Quarterly ☐ Monthly – *available with Group Bill and Automatic Bank Draft only*

e. Billing Type: ☐ Paper Bill
☐ Automatic Bank Draft: ☐ New service ☐ Add to my existing Guardian or Berkshire service
☐ Group Bill: ☐ Existing Account # _____
☐ New – Billing Name _____ Common Billing Day _____

f. Send premium notices to: ☐ Residence ☐ Owner's Address ☐ Business ☐ Other _____

g. Prepayment of Premium – *A prepayment must be accompanied by a signed Conditional Receipt and section 7 must be completed.*
☐ No money has been submitted with this application.
☐ $_____ has been submitted with this application for proposed insurance.

9. Coverage Applied For

Indicate all insurance applied for with this application and specify coverage desired. Complete the appropriate product supplement for Overhead Expense, Disability Buy-Out and Income ProVider. Complete column A and question h when applying for ProVider Plus, column B and question i for Retirement Protection as a stand-alone policy, and column C and questions j through n for Reducing Term.

	Column A	Column B	Column C	Column D	Column E
	Disability Income	Disability Income – Retirement Protection	Reducing Term	Overhead Expense	Disability Buy-Out
a. Indemnity/Benefit Amount	$	$	$	$	Complete Supplement
b. Policy Form Number					
c. Own Occupation Definition of Disability	☐ True ☐ Modified	Modified	Modified	True	True
d. Premium Structure	☐ Level ☐ Graded	☐ Level ☐ Graded	Level	Level	Level
e. Elimination Period		☐ 180 days ☐ 360 days			
f. Benefit Period/Term		To Age 65			
g. Occupation Class					
Supplemental Benefits	Complete question h	Complete question i	Complete questions j – n	Complete Supplement	Complete Supplement

Complete the Following When Applying for Disability Income

h. Supplemental Benefits – ProVider Plus

	ProVider Plus	ProVider Plus Limited
Partial Disability Benefits	☐ Partial Disability ☐ Residual Disability	☐ Basic Partial Disability
Cost of Living Adjustments	☐ 3% Compound ☐ 6% Maximum ☐ Four-Year Delayed	☐ 3% Maximum (CPI-Tied)
Extended Benefits	☐ Lump Sum Disability Benefit	
	☐ Future Increase Option $_____	
Benefits listed at right are available with both ProVider Plus and ProVider Plus Limited	☐ Retirement Protection Plus: *Monthly Indemnity* $_____ *Elimination Period* ☐ 180 days ☐ 360 days ☐ Social Insurance Substitute $_____ ☐ Unemployment Waiver of Premium ☐ Other_____ ☐ Other_____	

Complete the Following When Applying for Retirement Protection (separate policy)

i. Supplemental Benefits – ProVider Plus: Retirement Protection

☐ Cost of Living Adjustment: ☐ 3% Compound ☐ 6% Maximum

☐ Future Increase Option $_____

☐ Other_____

Complete the Following When Applying for Reducing Term Insurance

j. Loss Payee Name: _____

(Must be the individual or entity that the money is owed to.)

Loss Payee Tax ID #:_____

Business Address (Street, City, State, Zip):

_____

_____

Owner Name: _____

Owner Tax ID #:_____

k. Provide type and reason that the obligation was incurred:

☐ Business Loan

☐ Purchase Agreement

☐ Employment Contract

☐ Student Loan – Have you deferred payments of this loan or do you intend to do so?

☐ Yes ☐ No If yes, describe how long below.

*Details:*_____

☐ Other _____

l. Date obligation took effect (mm/dd/yyyy): _____

m. Names of all debtors or guarantors:

_____

_____

_____

n. Periodic payment in the amount of $_____ is to be made each month for _____ months

Periodic payment in the amount of $_____ is to be made each month for _____ months

Periodic payment in the amount of $_____ is to be made each month for _____ months

I am responsible for payments for a total of _____ months

10. Remarks and Special Requests

Provide details to any "yes" answers, identifying each detail by question number. Include, if applicable, diagnosis or symptoms, tests performed, dates, types and amounts of medication, length of disability, degree of recovery, and names and addresses of all physicians, medical or mental health professionals, counselors, psychotherapists, chiropractors, practitioners or hospitals. Also include in this section any special policy requests such as specific policy date other than as provided by the terms of this application. For additional space use the Supplement to the Application for Insurance (C-APP-SUPP).

11. Amendments or Corrections (For Home Office Use Only)

12. Representations of the Proposed Insured and Owner

Those parties who sign below, agree that:

1. This Application for Disability Insurance, any required Representations to the Medical Examiner, and any other supplements or amendments to this Application for Insurance will form the basis for, and become part of and attached to any policy or coverage issued and is herein referred to as the "Application."
2. All of the statements that are part of this Application are correctly recorded, and are complete and true to the best of the knowledge and belief of those persons who made them.
3. No agent, broker or medical examiner has any right to accept risks, make or change contracts, or to waive or modify any of the Company's rights or requirements.
4. Any misrepresentation or omission, if found to be material, may adversely affect acceptance of the risk, claims payment, or may lead to rescission of any policy that is issued based on this Application.
5. All coverage shown to be replaced in answer to Question 4c of this application will be permanently terminated on or before the date(s) indicated. If not, it is understood and agreed that the Company reserves all rights outlined in any policy issued and those available by law. Further, benefits under any policy or coverage issued based on this application may be reduced by the amount payable under such existing policies.
6. The policy date is the date from which premiums are calculated and become due. Except as provided in the Conditional Receipt (if an advance payment has been made and acknowledged and such Receipt issued), no insurance shall take effect unless and until the policy is delivered, the first premium is paid, and there has been no change in the health, the income level, status of employment or occupation of the proposed insured. If disability insurance becomes effective in the manner stated in the Conditional Receipt, the amount of such insurance shall not exceed the limits set forth in such Receipt. If a request is made for coverage to commence as of a specified date, it is understood and agreed that certain rights under the conditional receipt may be waived.
7. Changes or corrections made by the Company and noted in the "Amendments or Corrections" section are ratified by the owner upon acceptance of a policy containing this Application with the noted changes or corrections. In those states where written consent is required by statute or State Insurance Department regulation for amendments as to plan, amount, classification, age at issue, or benefits, such changes will be made only with the owner's written consent.
8. By paying premiums on a basis more frequently than annually, the total premium payable during one year's time will be greater than if the premium were paid annually. That is, the cost of paying annualized periodic premiums will be more than the cost of paying one annual premium.
9. If applying for Disability Buy-Out insurance, if no written buy-sell agreement is in place, one must be executed before a disability occurs that would qualify for benefits under the policy. Otherwise, the Company will have no liability other than to refund premiums. We will require a written assurance within one year of the policy date that an agreement is in place. If no assurance is received, the policy will be voided and the premiums refunded.

Any person who knowingly, and with intent to defraud any insurance company or other person, files an application of 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 may also be subject to civil penalties.

Signed at _____ this _____ day of _____, _____.
City and State Day Month Year

_____
Signature of Proposed Insured

_____
Signature of Applicant/Owner if Other than Proposed Insured

_____
Witness

Life Customer Service Office
3900 Burgess Place
Bethlehem, PA 18017

Disability Customer Service Office
700 South Street
Pittsfield, MA 01201

☐ **THE GUARDIAN LIFE INSURANCE COMPANY OF AMERICA**
☐ **THE GUARDIAN INSURANCE & ANNUITY COMPANY, INC.**
☐ **BERKSHIRE LIFE INSURANCE COMPANY OF AMERICA**

(Please check appropriate company(ies). Any insurer checked above is herein referred to as the "Company.")

Insurance Information Practices

The notification below must be completed and given to the Proposed Insured before the application is completed

Notice to _____
Proposed Insured

Thank you for your interest in insurance with our Company. This notice is given to you at the time you apply for life or disability insurance to tell you about the kinds of information we may obtain in connection with your application. Only qualified members of our Company's staff or its legal representatives will have access to your medical file to evaluate your eligibility for insurance or to service your claim for benefits under a policy. Your authorization will govern our request for information and any later disclosure of that information. We will treat all personal information about you as confidential. You have a right of access and correction with respect to this information. If you wish a more detailed explanation of our Information Practices, please send your written request to the Privacy Office of the Guardian Corporate Family at 7 Hanover Square, New York, NY 10004-2616.

Fair Credit Reporting Act Pre-Notice

When we begin to process your application, we may ask for a consumer report from a consumer reporting agency. All or part of that report may be an investigative consumer report. Such a report will include information about your character, general reputation, personal characteristics or mode of living, except as may be related directly or indirectly to your sexual orientation. It will be obtained through personal interviews with people who know you. You may ask to be interviewed in connection with this report. We may request later consumer reports, other than an investigative consumer report, at a future update, renewal or extension of the insurance for which you have applied. At your request, we will tell you if we have asked for a consumer report or an investigative consumer report in the initial processing of your application. If we have, we will tell you the name and address of the consumer reporting agency to which we have made our request for a report. You can obtain a copy of this report by contacting this consumer reporting agency. At your written request, we will give you more detailed information about the nature and scope of this kind of investigation.

Medical Information Bureau Pre-Notice

The Medical Information Bureau is a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another Bureau Member company for life or disability insurance, or if a claim for benefits is submitted to such company, the Bureau, upon request, will supply such company with the information in its files. Our Company, its legal representatives, or its reinsurers may make a brief report of objective findings about you to the Bureau.

If you so request of the Bureau, it will arrange to disclose the information it may have in your file. If you question the accuracy of the information in the Bureau's file, you may contact the Bureau and seek to correct the information according to procedures set forth in the Federal Fair Credit Reporting Act. The Bureau's address is 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734, and its telephone number is 866-692-6901 (TTY 866-346-3642 for hearing impaired). Information for consumers about MIB may be obtained on its website at www.mib.com.

Medical Records

We may request information from health care providers or others who have records of your medical history, mental or physical condition, or treatment. Only qualified members of our Company's staff or its legal representatives will have access to your medical file to evaluate your eligibility for insurance or to service your claim for benefits under a policy. Your authorization will govern our request for information and any later disclosure of that information.

Personal Information Telephone Interview

We may phone you to verify or supplement information you have given us on your application. The call will be made from our underwriting office or from a consumer reporting agency acting for us.

Life Customer Service Office
[3900 Burgess Place
Bethlehem, PA 18017]

Disability Customer Service Office
[700 South Street
Pittsfield, MA 01201]

☐ **The Guardian Life Insurance Company of America**
☐ **The Guardian Insurance & Annuity Company, Inc.**
☐ **Berkshire Life Insurance Company of America**

(Please check appropriate company(ies). Any insurer checked above is herein referred to as the "Company.")

Authorization to Obtain and Release Information

Name of Proposed Insured_____ Date of Birth_____

Address of Proposed Insured_____

_____

This Authorization Is Designed To Comply With The HIPAA Privacy Rule

This Authorization applies to the Proposed Insured named above. It can only be signed by the Proposed Insured, or the parent or legal guardian of the Proposed Insured in the case of a minor under the age of 18.

Investigative consumer report. I authorize the Company or its legal representatives to obtain or have prepared an investigative consumer report as described in the notice given to me.

Medical Records and other information. I authorize any physician, medical or mental health professional, practitioner, hospital, clinic, preferred provider organization, health maintenance organization, point of service health care coverage or pharmacy, pharmacy benefit manager, consumer reporting agency, MIB, Inc., insurance or reinsurance company, employer or laboratory that has any records or information of the Proposed Insured or his/her health to release medical and non-medical information in its possession about the Proposed Insured, to the Company or its legal representatives. Non-medical information shall include data about my driving record; civil action or bankruptcy court records; hazardous sport or aviation activity; use of alcohol or drugs; employment information, business pursuits, documentation of earned and unearned income; any claim of eligibility for disability income benefits; and other applications for insurance. Medical information means all information in the possession of or derived from providers of health care regarding the medical history, pharmaceutical history, mental or physical condition, or treatment of the Proposed Insured. I understand that the information released may relate to the symptoms, evaluation, diagnosis, examination, treatment or prognosis of any mental or physical condition, including psychiatric and psychological conditions, and drug or alcohol abuse or the diagnosis and treatment of Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) by a medical professional. Medical information does not include information about prior testing for Human Immunodeficiency Virus (HIV).

I agree that for purposes of collecting information in connection with an application for insurance, this authorization shall be valid for two years from the date shown below and that a copy of the authorization shall be as valid as the original. For the purpose of collecting information in connection with a claim for benefits under an accident and sickness insurance policy, this authorization will be valid for the duration of the claim. For the purpose of collecting information in connection with a claim for benefits under a life insurance policy, the authorization is valid for the duration of the claim. I agree that if I sign this authorization electronically, that it will be equally as effective and valid as if I signed the form through traditional means. I understand, however, that I am under no obligation to sign this document electronically.

I know that I may revoke this authorization in writing, at any time, by sending a written request for revocation to the Guardian Corporate Secretary at [7 Hanover Square, New York, NY 10004-2616], or the Berkshire Corporate Secretary at [700 South Street, Pittsfield, MA 01201]. I understand that a revocation is not effective to the extent that the Company and/or any of the entities listed above has already relied on this authorization, or to the extent that the Company has a legal right to contest a claim under an insurance policy or to contest the policy itself.

I understand that the Company or its legal representatives will use the information obtained by this authorization to determine eligibility for insurance or eligibility for benefits under an existing policy. I further understand that if I refuse to sign this authorization, the Company may not be able to process my application, or pay a claim in the case of coverage which is already in force. The Company or its legal representatives will not release any information obtained to any person or organization except to reinsurance companies, MIB, Inc., Innovative Underwriters Services (a subsidiary of The Guardian Life Insurance Company of America), or other persons or organizations performing business or legal services in connection with an application, claim, or as may be lawfully permitted or required, or as I may further authorize. I understand that any information disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal regulations governing privacy (such as the HIPAA Privacy Rule).

I authorize the Company or its legal representatives to make a brief report of my personal health information to the MIB, Inc.

I acknowledge that I have been given a copy of this authorization and also acknowledge receipt of the Notice of Insurance Information Practices, which includes the Fair Credit Reporting Act Pre-Notice, the Medical Information Bureau Pre-Notice, and Medical Records.

Signed at _____ this _____ day of _____ , _____

City and State | Day | Month | Year

_____ _____

Signature of Proposed Insured or Parent/Legal Guardian | Witness Signature

*IMNB000000004

Producer's Certification (Complete in all cases.)

This Producer's Certification is to be used with the application for insurance on:

First Middle Initial Last Name

1. How well do you know the proposed insured?
   ☐ Known well for ___ years ☐ Known slightly for ___ years
   ☐ Met very recently ☐ Relative? _____

2. a. Do you have knowledge or reason to believe that this application involves a replacement as defined under applicable state law or Company procedure? ☐ Yes ☐ No

   b. If "Yes," did you deliver appropriate Notice Regarding Replacement, where applicable? ☐ Yes ☐ No

3. Did you deliver to the proposed insured the notice of Insurance Information Practices, which includes the Fair Credit Reporting Act Disclosure, the Medical Information Bureau Pre-Notice, and Medical Records? ☐ Yes ☐ No

4. Have you suggested the possibility of an extra premium for any reason? ☐ Yes ☐ No

5. Have you suggested the possibility of an exclusion rider for any reason? ☐ Yes ☐ No

6. If submitting under a discount program, please provide the following details.

   Program type: ☐ Resident/student ☐ Association ☐ QSPP ☐ VIP ☐ Professional Group ☐ Group Conversion

   Program status: ☐ New ☐ Existing If existing, provide program name and code: _____

Remarks (and additional instructions)

7. Commissions

Producer's Name	Producer's code	Last 4 Digits of Producer's SSN	Servicing Producer (Check Only One)	Percentage	DIS Code (list once)
			☐	%	
			☐	%	
			☐	%	
			☐	%	
			☐	%	
			☐	%	

I represent that, to the best of my knowledge and belief, the information provided in this report by the proposed insured and/or owner in the application is complete, accurate and correctly recorded, and there is nothing adversely affecting the insurability of the proposed insured other than as indicated in the application. I also represent that I gave all required forms on or before the date the application was taken. I represent that I am duly licensed in the state in which this application was signed.

Any person who knowingly, and with intent to defraud any insurance company or other person, files an application of 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 may also be subject to civil penalties.

Signed at _____ this _____ day of _____, _____.
City and State Day Month Year

_____ _____
Type or Print Producer's Name Signature of Soliciting Producer

_____
State(s) Where Licensed

I have reviewed this application and determined that all the required answers and statements have been made.

_____ Signed _____
Date Submitted (Agency Personnel)

Berkshire Life Insurance Company of America
Home Office: 700 South Street, Pittsfield, MA 01201
Berkshire Life Insurance Company of America is a wholly owned stock subsidiary of
The Guardian Life Insurance Company of America, New York, NY

GUARDIAN®

Student Loan Protection Rider Insurance Supplement

1. Please check the application you are supplementing:

- ☐ Application for Disability Insurance
- ☐ Application for Disability Insurance Option Exercises
- ☐ Other
- ☐ Application for Disability Insurance Simplified Reinstatement (complete only sections 2 and 5)
- ☐ Application for Disability Insurance Reinstatement (complete only sections 2 and 5)

2. Proposed Insured Information

a. Name (First, Middle Initial, Last)

b. Date of Birth (mm/dd/yyyy)

c. Original Policy # (if applicable)

d. Have you received a graduate degree? ☐ Yes ☐ No
If no, are you currently enrolled in a graduate degree program? ☐ Yes ☐ No

3. Coverage Applied For

a. Monthly Benefit Amount	$	b. Premium Structure	Level
c. Elimination Period	☐ 90 days ☐ 180 days	d. Benefit Term	☐ 10 years ☐ 15 years

4. Other Student Loan Coverage

a. Other than coverage requested by this application, describe all disability insurance for your student loan(s) in force, applied for, or for which you are eligible within the next 12 months with any company: If none, check here ☐

Status: I = In Force, P = Pending, E = Eligible For

Company Name	Status	Monthly Benefit Amount	Benefit Term/ Period	Is coverage being replaced? (Y/N)	Amount to be Replaced?	Date to be Replaced?
1.						
2.						
3.						

5. Student Loan Information

The following questions pertain to the student loan(s) that you are seeking to cover by this application.

a. Is your student loan(s) a legally binding loan agreement(s) that includes the terms of your financial obligation and establishes your personal responsibility for loan repayment over a fixed period of time? ☐ Yes ☐ No

b. Is your student loan(s) a legally binding loan agreement(s) that is signed by you as a borrower? ☐ Yes ☐ No

c. Was your student loan(s) established solely for the purpose of paying education-related expenses while you attend or attended a degree-granting institution? ☐ Yes ☐ No

d. Was your student loan(s) secured from a chartered bank, lending institution and/or government program, or their lawful successor(s) or assigns? ☐ Yes ☐ No

e. Is your student loan commingled with obligations which are separate and distinct from your obligation to pay education-related expenses? ☐ Yes ☐ No

BERKSHIRE LIFE INSURANCE COMPANY OF AMERICA
Home Office: 700 South Street, Pittsfield, MA 01201
Berkshire Life Insurance Company of America is a wholly owned stock subsidiary of and an administrator for The Guardian Life Insurance Company of America, New York, NY

Student Loan Protection Rider Disclosure

Important information about the Student Loan Protection Rider for which You have applied

Thank you for applying for a Student Loan Protection Rider ("the Rider") offered by Berkshire Life Insurance Company of America, Pittsfield, Massachusetts ("Berkshire"). The Rider provides disability coverage with respect to a Student Loan Obligation for which you are obligated to repay, according to the terms and conditions stated in the Rider. Because the Rider contains some unique features, we have provided this form to ensure that you have an understanding of some of its benefits, features and limitations, including:

- This is a reimbursement benefit, so it is important that the Student Loan Protection Maximum Monthly Benefit amount you select is appropriate for your student loan monthly obligations. The monthly benefit payable under the Rider is based on the monthly amount You incur and pay for a claimed month as a result of a Student Loan Obligation.
- The Rider terminates at the end of the benefit term You select in the application for this rider, even if no benefits have been paid and/or the Policy remains in force. The date of termination will show on Your Schedule Page as the Student Loan Protection Termination Date.
- Coverage under this Rider ends when You no longer have a Student Loan Obligation. Therefore, it is important for You to contact Us if You no longer have a Student Loan Obligation. We will refund any premium paid for the Rider as of the date the Student Loan Obligation ends upon receipt of proof of the termination in Our Home Office. However, in no case will We refund more than 12 months of premium paid for this rider.
- A Student Loan Obligation is defined as a legally binding loan agreement that:
  - includes the terms of Your financial obligation and establishes Your personal responsibility for loan repayment over a fixed period of time; and
  - is signed by You as a borrower; and
  - is established solely for the purpose of paying education related expenses while You attend a degree-granting institution; and
  - is secured from a chartered bank, lending institution and/or government program, or their lawful successor(s) or assigns; and
  - is not commingled with obligations which are separate and distinct from Your obligation to pay education related expenses.

If you have any questions or concerns regarding the coverage provided by the Rider, please contact your agent or broker. This Student Loan Protection Rider Disclosure Form does not alter the terms, conditions, limitations, or exclusion(s) (if any), of any policy and/or rider that may be issued.

By signing this form, I acknowledge that I have read this form.

Signed this _____day of _____, _____ (month, year).

_____
(Applicant Signature)

Berkshire Life Insurance Company of America
Home Office: 700 South Street, Pittsfield, MA 01201
Berkshire Life Insurance Company of America is a wholly owned stock subsidiary of
The Guardian Life Insurance Company of America, New York, NY

Application for Disability Insurance –
Overhead Expense Insurance Supplement

I. Proposed Insured Information

a. Name (First, Middle Initial, Last)

b. Date of Birth (mm/dd/yyyy)

2. Overhead Expense Insurance

a. Supplemental Benefits ☐ Future Increase Option $_____
☐ Supplemental Overhead Expense Benefit ☐ Other _____

b. Your share of covered expenses? $_____ and _____% of total.

c. Are there other employees in the firm who generate revenue? ☐ Yes* ☐ No

*If yes, what is the compensation for these employees, their title(s) and the percentage of gross revenue they generate? Provide details in the Application for Disability Insurance, Section 10 Remarks and Special Requests.

d. Owner Information (if other than the Proposed Insured)

Name of Owner (First, Middle Initial, Last) or name of trust or company: _____

Relationship to the Proposed _____ Owner's Address (Street, City, State, Zip): _____

Tax ID or Social Security #: _____ _____

e. Monthly Expenses of the Business Entity – What are the current average monthly overhead expenses incurred for the items shown? (If responsible for expenses shared jointly with others, include only the portion for which the proposed insured is responsible.)

Advertising	$_____
Car and Truck Expenses	_____
Commissions and Fees	_____
Contract Labor	_____
Depreciation and Section 179 Expense Deduction	_____
Employee Benefit Programs	_____
Insurance	_____
Mortgage Interest (Paid to Banks, etc.)	_____
Other Interest	_____
Legal and Professional Services	_____
Office Expenses	_____
Pension and Profit Sharing Plans	_____
Rent or Lease (Other Business Property)	_____
Repairs and Maintenance	_____
Taxes and Licenses	_____
Utilities	_____
Wages (exclude compensation for members of insured's profession)	_____
Other Expenses (itemized):	
_____	_____
_____	_____
TOTAL (Should agree with 2b.)	$_____
Proposed Insured Monthly Earned Income*	$_____

*Earned income is considered for and in accordance with Salary Replacement guidelines of 50% of the Proposed Insured's Earned Income not to exceed one-half of the total monthly overhead expense benefit or $10,000, whichever is less. Available with policy form 4200 Salary Replacement.

Berkshire Life Insurance Company of America
Home Office: 700 South Street, Pittsfield, MA 01201
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The Guardian Life Insurance Company of America, New York, NY

GUARDIAN®

Application for Disability Insurance –
Disability Buy-Out Insurance Supplement

1. Proposed Insured Information

a. Name (First, Middle Initial, Last)

b. Date of Birth (mm/dd/yyyy)

2. Disability Buy-Out Insurance

a. Funding: ☐ Monthly ☐ Lump Sum ☐ Down Payment Benefit Amount: Monthly: $_____ Lump Sum: $_____

b. Supplemental Benefits: ☐ Future Increase Option: Monthly: $_____ Lump Sum: $_____
☐ Other _____

c. Type of disability buy-sell agreement: ☐ Cross Purchase ☐ Entity Purchase ☐ Trusteed Cross Purchase
Status of disability buy-sell agreement: ☐ In force and dated _____ ☐ Date to be executed _____

d. Owner Information

Name of Owner (First, Middle Initial, Last) or name of trust or company: _____

Relationship to the Proposed Insured _____

Social Security #: _____

Tax ID #: _____

Address (Street, City, State, Zip):

_____

_____

Please complete the following if owner is a trust:

Date of Trust (mm/dd/yyyy): _____

Complete Names of Trustees:

_____

_____

e. Give names of all other stockholders or partners. If more than four partners or if there are any on whom Disability Buy-Out is not carried or proposed on the Supplement to Application for Insurance, list or explain in the Application for Disability Insurance, Section 10 Remarks and Special Requests.

Name and Title	Percentage Owned	Amount of DBO in Force	Amount of DBO Proposed
	%	$	$
	%	$	$
	%	$	$
	%	$	$

f. Does a familial relationship exist among any of the above stockholders or partners? ☐ Yes ☐ No
If yes, describe in the Application for Disability Insurance, Section 10 Remarks and Special Requests.

g. Indicate type of business organization: ☐ Professional Corporation/Personal Service Partnership
☐ Commercial Business

h. Business Financial Information

		Column A	Column B	Column C
1. Total Assets	$	Year-To-Date This Calendar Year	Actual Filed Last Calendar Year	Actual Filed Two Calendar Years Ago
2. Total Liabilities	$			
3. Business Net Worth *(line 1 minus line 2)*	$			
4. Gross Annual Sales		$	$	$
5. Net Profit After Taxes		$	$	$

☐ **BERKSHIRE LIFE INSURANCE COMPANY OF AMERICA**
Home Office: 700 South Street, Pittsfield, MA 01201
Berkshire Life Insurance Company of America is a wholly owned stock subsidiary of The Guardian Life Insurance Company of America, New York, NY

☐ **THE GUARDIAN LIFE INSURANCE COMPANY OF AMERICA**
Administrative Office: 700 South Street, Pittsfield, MA 01201

(Please check appropriate company(ies). Any insurer checked above is herein referred to as the "Company.")

Conditional Receipt for Disability Insurance

This receipt does not create any temporary or interim insurance. This receipt sets the date and conditions under which the insurance being applied for will go into effect. Unless all of the conditions in paragraph 2 below are met in full, no insurance will become effective. No agent of the Company and no broker is authorized to alter or waive any of the Company's requirements.

If Questions 7f through 7n on the accompanying Application for Disability Insurance are left blank or answered "Yes" no prepayment should be taken and no Conditional Receipt can be issued.

1. **Effective Date** – As used herein, "Effective Date" means the latest of (i) the date of the Application for Insurance, (ii) the date of the Representations to the Medical Examiner (or the date of the latest if more than one is required), (iii) the date of this receipt, (iv) the date of the latest completion of any medical examinations, tests, x-rays and electrocardiograms that the Company requires, or (v) the Policy Date, if any, requested in the Application.
2. **Conditions Under Which Insurance May Become Effective** – The insurance in the amount and for the policy applied for will, subject to the limitations in paragraph 4, become effective as of the Effective Date only if all of the following conditions are met:
   (a) an initial premium payment has been made as acknowledged below and honored on first presentation for payment. The check must be made payable to the Company (do not make check payable to the producer or leave payee blank);
   (b) on the Effective Date the proposed insured is, in the opinion of the Company authorized officers, insurable and an acceptable risk under the Company rules, limits and standards for the proposed insurance amount, policy, and benefits exactly as applied for without restriction or modification;
   (c) on the date of this receipt, all of my answers and statements in any part of the application(s) I have provided as of today's date are true, accurate, and complete to the best of my knowledge and belief. Solely with respect to this Condition 2(c), the Company will not void this receipt unless an untrue, inaccurate, or incomplete response materially affects the Company's decision to accept any risk or hazard;
   (d) information required by the Company to determine insurability must be received at the Company's Home Office within 60 days of the date of this receipt.

If any one of these conditions is not met, this receipt is void and there shall be no liability on the part of the Company. The Company will return the payment accompanying this receipt in the form of a Company check.

3. **Amendment of Application** – If the Company does not approve the application as applied for or if I request a modification as to the amount of insurance, policy, or benefits subsequent to the date of this receipt, then I understand that this receipt is void and there shall be no liability on the part of the Company. Should the Company offer insurance other than as applied for or in response to my request for a modification, such insurance shall not be effective unless and until:
   (a) the modified policy is delivered; and
   (b) an amendment of the application to adjust the provisions of the contract is signed by the proposed insured and the owner; and
   (c) the health and other conditions affecting the insurability of the proposed insured continues to remain the same as described in the Application for Insurance and the Representations to the Medical Examiner.

One Copy to Applicant **One Copy to Company**

Conditional Receipt for Disability Insurance | *Continued*

4. **Maximum Limits** – If the disability of the proposed insured occurs prior to the Company's approval, and the proposed insured satisfies the conditions set forth in paragraph 2 above, the Company's liability shall not be greater than the total amount of insurance (for the policy applied for) set forth in the schedule to the right. This amount shall be inclusive of all of the insurance on the proposed insured under conditional receipt pending and insurance in force with the Company.

Age*	Disability Income Limits	Total Disability Buy-Out Limits	Disability Overhead Expense Limits
under 56	$5,000/mo.	$500,000	$5,000/mo.
56-60	4,000/mo.	400,000	4,000/mo.
61-64	0	**	**

*Age means age of proposed insured at birthday nearest date of Conditional Receipt.
**Products not available.

5. **Acknowledgement of Payment** – We have received from _____(applicant):
   (a) the sum of $_____ to pay all or part of the first premium for the proposed disability income insurance policy;
   (b) the sum of $_____ to pay all or part of the first premium for the proposed disability buy-out insurance policy;
   (c) the sum of $_____ to pay all or part of the first premium for the proposed overhead expense insurance policy;

   on _____(proposed insured) in accordance with the Application(s) for insurance.

6. **Period of Coverage** – If less than the first full premium has been paid according to the mode of payment selected for the policy type and the amount of insurance applied for, any insurance effective under paragraphs 2 and 3 above shall be in force only for the pro rata portion of the policy year for which the premium has been paid. This portion of the policy year begins on the Effective Date and does not include any grace period.

I have read this receipt and have received a copy signed by the producer. I understand that insurance becomes effective only if all the conditions of paragraph 2 are met and then only from the Effective Date, and for not more than the limitations in paragraph 4. I understand that if a policy date is requested in the application that is later than the date of either the Application for Insurance or the Representations to the Medical Examiner, I am waiving some rights under this receipt. I further understand that this receipt is void if there is any incorrect, untrue, incomplete or omitted statement of material fact in the Application for Insurance, Representations to the Medical Examiner, or any supplemental form that becomes part of any policy issued.

Signed_____Applicant(s) Date_____(mm/dd/yyyy)

Signed_____Producer Date_____(mm/dd/yyyy)

One Copy to Applicant **One Copy to Company**

THE GUARDIAN LIFE INSURANCE COMPANY OF AMERICA

BERKSHIRE LIFE INSURANCE COMPANY OF AMERICA
Home Office: 700 South Street, Pittsfield, MA 01201
Berkshire Life Insurance Company of America is a wholly owned stock subsidiary of
The Guardian Life Insurance Company of America, New York, NY

Dating Information

(To be given to the applicant with the initial application for all policies applied for on a non-prepaid basis or where backdating or special dating is being requested.)

Backdating is the process of dating a policy earlier than the date the policy is issued. For example, a policy may be backdated to provide the policyowner with a lower insurance age and thus a lower premium. Special dating is the process of dating a policy on a specific date. Absent backdating or special dating, the policy will generally be dated the date it is physically issued. However, if the date of policy issue is the 29th, 30th or 31st of the month, the policy will be dated the 1st of the following month.

Premium is charged from the date the policy is dated. If you request backdating or special dating, or if the policy is delivered after its issue date, you may be required to pay premium for a period of time during which no insurance is in effect. The amount of such premium may depend on the time it takes to underwrite, issue, and deliver a policy to you. You may reduce our processing time and the amount of such premium by providing all information we request (including, for example, supplemental medical information) as quickly as possible and by accepting policy delivery promptly.

You are not required to pay premium under an insurance policy for a period of time during which that policy does not provide coverage. However, you may wish to waive this right in order to obtain the benefits of backdating or special dating.

Coverage will not take effect under the policy unless and until such time as you have taken delivery of the policy, paid the first premium and there has been no change in the proposed insured's health, income level, status of employment and/or occupation as stated in the application. If you would like the benefit of backdating or special dating but do not wish to waive your right not to pay premium for a period of time during which no insurance is in effect, you may opt to pay the first premium with the application in exchange for a Conditional Receipt. Doing so may reduce or eliminate the period of time for which you pay a premium without insurance being in effect. Certain restrictions apply to use of a Conditional Receipt. Ask your insurance representative to explain this option fully to you before you pay any money with your application.

Signed at _____ on _____
City/State month – day – year

_____
Applicant

_____
Witness

_____
Insurance Representative

One copy to: APPLICANT INSURER

GUARDIAN®

☐ **The Guardian Life Insurance Company of America ("Guardian")**
☐ **The Guardian Insurance & Annuity Company, Inc. ("GIAC")**
☐ **Berkshire Life Insurance Company of America ("Berkshire")**

Please check the appropriate company(ies). Any insurer selected above is herein referred to as the "Company**"**

AGENCY USE ONLY
New Application ☐
Bank Change ☐
Agency Code: _____

REQUEST FOR GUARD-O-MATIC ARRANGEMENT (page 1 of 2)

See next page for VUL instructions.

IMPORTANT: A voided blank check or photocopy is required for checking accounts or a deposit slip for a savings account. (starter checks are not acceptable)

The Company is requested and authorized to debit your financial institution or to initiate electronic funds transfer on or about the 1st (Only available for Disability policies and Traditional Life policies) or 15th of each month to pay premiums due and/or on the 1st business day of each month to pay the policy loan on the policy(ies) identified below (on or about the 15th of each month to pay the policy loan on Guardian policy(ies) administered by Berkshire). If neither, or both the 1st or 15th is selected, the 15th will be the default date for drafting.

I understand that:

1. Completion of this form shall not constitute a premium payment and/or loan payment. Authorization for premium payments is not effective until the initial premium(s) has been received and paid at the home office or you have requested initial premiums be paid under this Arrangement. Multiple months' premiums may be required to bring the policy to a current due date. If dividends are currently being used to purchase paid-up additional insurance, and dividends for term insurance policies and annuities will be left with us to accumulate at interest.
2. The Guard-O-Matic Premium Arrangement or Loan Payment Arrangement may be terminated by the Policyowner or by the Company upon written notice. If the Bank Depositor is other than the policyowner, the Company will terminate the arrangement upon written request of such Bank Depositor. The policyowner or depositor may cancel this authorization by giving our home office 30 days' written notice
3. If the Loan Payment Arrangement is cancelled, any outstanding loans will remain unpaid.
4. Any withdrawal returned due to insufficient funds may be deposited for collection a second time. We may terminate the Guard-O-Matic plan immediately by written notice in the event any withdrawal or electronic fund transfer is dishonored.

PLEASE PRINT

Type of account: ☐ Checking ☐ Savings ☐ Business Account

Begin deductions effective (Month) _____ (Year) _____

Financial Institution: _____

Address: _____ City: _____ State_____ Zip_____

Transit/ABA Number: ☐☐☐☐☐☐☐☐☐ (must be nine digits)

Account Number: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Name of Account Holder: _____

Address: _____ City: _____ State_____ Zip_____

Guard-O-Matic Premium Arrangement.

Policy Number	Draft Date Election (1st for DI &Traditional Life only)	Insured Name	Last 4 digits of SSN	For Home Office Use Only - Control No:
	☐ 1st ☐ 15th			
	☐ 1st ☐ 15th			
	☐ 1st ☐ 15th			
	☐ 1st ☐ 15th			

Guard-O-Matic Loan Payment Arrangement.

Life Policy Number	Amount to be Deducted	Life Policy Number	Amount to be Deducted

I authorize you to pay and charge to my account checks, electronic funds transfer debits or other account debits made upon my account by and payable to the order of the Company indicated above. I agree that your treatment of each check or debit, and your rights with respect to it, will be the same as if it were signed or initialed personally by me. I further agree that if any check or debit is dishonored for any reason you will not be under any liability even though dishonor results in the forfeiture of insurance. I further agree that this authorization is to remain in effect until you receive written notice from me of its revocation unless you end it earlier.

_____ _____

Date Signature of Bank Account Owner

_____

Signature of Policy Owner, if other than Bank Account Owner

R223 (Rev. 5/13)

IMNB000000110201

Complete if applying for Universal or Variable Universal Life Insurance:
Your policy is designed to have flexible premiums. When using the Guard-O-Matic check drafting feature, we require that a minimum premium be drawn from your account to keep the policy in force. You will be notified by a lapse notice if it is necessary to increase this amount to keep the policy from lapsing.

Please check the box below if you wish to request this option:

☐ Please deduct $_____ monthly from my account. I understand that this amount may need to be increased to keep the policy from lapsing.

If you have any questions about your policy or about the amounts to be drafted to pay premiums, please contact your agent.

"Please be advised that you will not automatically receive a confirmation statement for premium payments paid through the pre-authorized checking plan. Confirmation statements will be mailed only upon request. For details on the automatic monthly payments, please refer to your annual benefits statement, policy contract, or product prospectus. You will receive a confirmation if you have purchased a Park Avenue Variable Whole Life Insurance policy or a Park Avenue Variable Universal Life (97) Policy. Please contact our customer service department at 1-800-441-6455 for more information."

GUARD-O-MATIC General Information

You have elected to pay your insurance premiums and/or your policy loan by monthly deductions payable through your financial institution. To enjoy the benefits of this convenient method of payment, we suggest you review the following:

- Each month, deduct the amount(s) from your account balance. You may wish to attach a reminder to your account until this practice becomes automatic. The monthly deduction to your account for any policy premiums will be made on or about the 1st day of each month (Guardian life or Berkshire administered life or disability policies only) or 15th day of each month. The monthly deduction to your account for any policy loan payments will be made on the 1st business day of each month (on or about the 15th of each month to pay the policy loan on Guardian policy(ies) administered by Berkshire).
- A canceled check or other notification of a charge to the account will be provided by your financial institution with its periodic statement. Compare your records when the statement is received.
- Please provide us with 30 days' advance notification of any change in your banking arrangements. If advance notification cannot be provided, sufficient funds should be left in the old account to honor charges until our records are changed.
- Please inform us of any change in name or address.
- When this service is no longer in effect, premiums will be due according to the most frequent payment mode we offer.

INDEMNIFICATION AGREEMENT

TO: The Bank named on the previous page.

In consideration of your compliance with the request and authorization of the depositor named above,
THE GUARDIAN LIFE INSURANCE COMPANY OF AMERICA AND THE GUARDIAN INSURANCE & ANNUITY COMPANY, INC. AND BERKSHIRE LIFE INSURANCE COMPANY OF AMERICA (COLLECTIVELY, "GUARDIAN") AGREE THAT:

1. They will indemnify and hold you harmless from any liability, including costs, legal expenses and attorney fees, to any person having an account with you or to any beneficiary or other claimant under a policy covered by the Guard-O-Matic Arrangement arising out of the payment by you of any check or debit drawn by Guardian, its own order on the account of such depositor, or arising out of the dishonor by you, whether with or without cause, of any such check or debit drawn by Guardian, provided there are sufficient funds in such account to pay the same upon presentation, whether or not such claim or liability asserted against you be based upon the forfeiture, or alleged forfeiture, of a policy the premium on which is sought to be collected by Guardian by any such check or debit.
2. They will refund to you any amount erroneously paid by you to Guardian on any such check or debit if claim for the amount of such erroneous payment is made by you within fifteen months from the date of the check or debit on which such erroneous payment was made.

THE GUARDIAN LIFE INSURANCE COMPANY OF AMERICA
THE GUARDIAN INSURANCE & ANNUITY COMPANY, INC.
BERKSHIRE LIFE INSURANCE COMPANY OF AMERICA

Authorized in a resolution approved by the Board of Directors of The Guardian Life Insurance Company of America on April 27, 1960, and by the Board of Directors of The Guardian Insurance & Annuity Company, Inc. on November 17, 1988 and by the Board of Directors of the Berkshire Life Insurance Company of America on July 19, 2002.

R223 (Rev. 5/13)

☐ **The Guardian Life Insurance Company of America**

☐ **Berkshire Life Insurance Company of America**
700 South Street
Pittsfield, MA 01201

CONSENT FOR HIV TESTING

Please check the appropriate company(ies). Any insurer checked above is herein referred to as the "Company."

Berkshire Life Insurance Company of America is a wholly owned stock subsidiary of and an administrator for The Guardian Life Insurance Company of America, New York, NY

Special Instructions for the Soliciting Agent and the Medical Professional When Drawing Blood for Company's Proposed Insured

Soliciting Agent

1. If the state of residence of the Company's Proposed Insured is California, have the Proposed Insured read and complete this consent form when completing the Application for Insurance.

2. Deliver original to the Proposed Insured.

3. Forward 1 copy to the Company (Agency of Record) with the completed Application for Insurance.

4. Forward 2 copies to the Medical Professional drawing the blood.

Medical Professional

1. Retain 1 copy for your records.

2. Forward 1 copy to the lab along with the blood drawn.

☐ **The Guardian Life Insurance Company of America**

☐ **Berkshire Life Insurance Company of America**
700 South Street
Pittsfield, MA 01201

NOTICE OF AIDS VIRUS (HIV) ANTIBODY TESTING AND CONSENT FOR TESTING

Please check the appropriate company(ies). Any insurer checked above is herein referred to as the "Company."

Berkshire Life Insurance Company of America is a wholly owned stock subsidiary of and an administrator for The Guardian Life Insurance Company of America, New York, NY

The Tests
To evaluate your eligibility for insurance benefits, the insurer named above (the Insurer) has requested that you provide a sample of your blood or other bodily fluid for testing and analysis. One of the tests to be performed on this sample would be a test to determine the presence of antibodies to the Human Immunodeficiency Virus (HIV), also known as the AIDS Virus. The HIV antibody test is actually a series of tests done by a licensed laboratory using a medically accepted procedure, which is extremely reliable.

Pre-Testing Considerations
Many public health organizations have recommended that before taking an HIV-related test, a person should seek counseling to become informed of the implications of such a test. You may wish to consider counseling, at your own expense, prior to being tested.

Meaning of Test Results
This test is not a test for AIDS. It is a test for antibodies to the HIV Virus, the causative agent for AIDS, and shows whether you have been exposed to the virus. A positive HIV antibody test result does not mean that you have AIDS, but that you are at significantly increased risk of developing AIDS or AIDS-related conditions. Federal authorities say that persons who are HIV antibody positive should be considered infected with the AIDS virus and capable of infecting others. Positive HIV antibody test results will adversely affect your application for insurance. This means that your application may be declined, that an increased premium may be charged, or that other policy changes may be necessary.

An HIV test will be considered positive only after a confirmation by a laboratory procedure which is extremely reliable. Nonetheless, the HIV antibody test is not 100% accurate. Possible errors include:

False Positives: the test gives a positive result, even though you are not infected. This happens only rarely and is more common in persons who have not engaged in high-risk behavior. Retesting should be done to help confirm the validity of a positive test.

False Negatives: the test gives a negative result, even though you are infected with HIV. This happens most commonly in recently infected persons; it takes at least 4 to 12 weeks for a positive test result to develop after a person is infected.

Your private physician, a public health clinic or an AIDS information organization in your city may be able to provide you with further information concerning the medical implications of a positive test result. We are providing you with a list of AIDS Counseling Services where you can obtain assistance in understanding the meaning of the test and its results.

HIV and AIDS
Acquired Immunodeficiency Syndrome (AIDS) is a life-threatening disorder of the immune system, caused by a virus, HIV. Many people do not have any symptoms when they first become infected by HIV, though some people do experience a flu-like illness that may include fever, headache, tiredness and enlarged lymph nodes. The virus is transmitted by sexual contact with an infected person, from an infected mother to her newborn infant, or by exposure to infected blood (as in needle sharing during IV drug use). Persons at high risk of contracting AIDS include males who have sexual contact with another man, intravenous drug users, hemophiliacs, and persons having sexual contact with any of these persons. Individuals who have a history of high-risk behavior should change those behaviors to prevent getting or giving AIDS or the HIV virus, regardless of whether they are tested. Specific important changes in behavior include safe sex practices including condom use for sexual contact with anyone other than a long-term monogamous partner and not sharing needles.

Note to Producer: Original to Proposed Insured
1 Copy to the Insurer 1 Copy to the Examiner 1 Copy to the Lab

Confidentiality of Test Results
All test results will be treated confidentially. The results of the test will be reported by the laboratory to the Insurer. The results also may be reported to that insurance company's affiliates, and to employees of the Insurer who have the responsibility to make underwriting decisions on behalf of the Insurer or to legal counsel who needs such information to effectively represent the Insurer in regard to your application. The test results may be disclosed to a reinsurer, if the reinsurer is involved in the underwriting process. In addition, if your HIV antibody test is abnormal (positive), a generic code signifying a non-specific test abnormality may be made known to the Medical Information Bureau (MIB, Inc.) as described in the notice given you at the time of application. The fact that the test has been done and the results of the test will not be otherwise disclosed except as may be required by law or as authorized by you.

Notification of Test Results
If your HIV antibody test is negative, no routine notification will be sent to you. If your test results are reported by the laboratory to the Insurer as being positive, you are entitled to that information. Because a trained person should deliver that information so that you can understand clearly what the test result means, you are asked to name a private physician so that the Insurer can have him or her tell you the test result and explain its meaning.

Name and address of physician for reporting a possible positive test result:

_____

Address:_____

If you do not designate a physician to receive this information and the Insurer reports any positive test result directly to you, we urge you to contact a private physician, the county department of health, the State Department of Health Services, a local medical society, or an alternative testing site for appropriate counseling after you receive your result.

Consent
I have read and I understand this Notice of AIDS Virus (HIV) Antibody Testing and Consent for Testing. For my information, I have been given written material about AIDS. I voluntarily consent to the withdrawal of blood from me by needle or to the providing of another bodily fluid sample, the testing of that blood or other bodily fluid for HIV antibodies, and the disclosure of the test results as described above. I understand that my consent may be withdrawn at any time before blood or other bodily fluid is actually obtained. I have read the information on this form about what a test result means and understand that I should contact one of the individuals or agencies mentioned above for further information and counseling if the test result is positive. I understand that I have a right to request and receive a copy of this authorization. A photocopy of this form will be as valid as the original.

_____ _____
Name of Proposed Insured (Please Print) Signature of Proposed Insured or Parent/Guardian

_____ _____
Address Date Signed

Note to Producer: Original to Proposed Insured
1 Copy to the Insurer 1 Copy to the Examiner 1 Copy to the Lab

☐ The Guardian Life Insurance Company of America

☐ Berkshire Life Insurance Company of America
700 South Street
Pittsfield, MA 01201

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Please check the appropriate company(ies). Any insurer checked above is herein referred to as the "Company."

Berkshire Life Insurance Company of America is a wholly owned stock subsidiary of and an administrator for The Guardian Life Insurance Company of America, New York, NY

"I," "me," "my" means the Applicant signing this Authorization.

This authorization is at the request of the individual whose name appears below.

In order to allow my insurance agent or broker to communicate with the Company and me about any medical, psychological or psychiatric or other health care information concerning my application for coverage, reinstatement, or other transaction, I authorize the Company to disclose the specific reasons for the underwriting decision to my agent or broker and/or to his or her marketing organization. I understand that the Company will not condition eligibility for coverage, underwriting or risk rating determination, or payment of benefits on any provision of this authorization. **I understand that this disclosure may involve specific, protected health information regarding me. I also understand that authorizing this disclosure is optional and I am not required to sign this authorization.**

REDISCLOSURE OF INFORMATION
I understand that if the person(s) or organization(s) that receives information provided pursuant to this authorization is not subject to federal privacy regulations, the information may be redisclosed and will no longer be protected by the federal privacy regulations.

REVOCATION OF AUTHORIZATION
As described in the Company's Notice of Privacy Practices, I understand that I may revoke this authorization in writing at any time by sending a written revocation to the Company, ATTN: PRIVACY ADMINISTRATOR, Underwriting Department, 700 South Street, Pittsfield, Massachusetts 01201. I also understand that any such revocation will not be effective to the extent that action has been taken by the Company in reliance on this authorization or the extent that the Company has legal right to contest a claim under the policy which I have applied for or to contest the policy itself.

EXPIRATION OF AUTHORIZATION
This authorization will be valid for 24 months from the date of my signature below.

A copy of this authorization is as valid as the original.

_____
Applicant's Name (Please Print)

_____ _____
Applicant's Signature **Date**

RETURN ONE COPY TO HOME OFFICE, LEAVE ONE COPY WITH APPLICANT

Berkshire Life Insurance Company of America
700 South Street • Pittsfield, Massachusetts 01201
1-800-819-2468

DISABILITY INCOME PROTECTION COVERAGE
REQUIRED OUTLINE OF COVERAGE

Policy Form 1400

1. READ YOUR POLICY CAREFULLY – This outline provides a very brief description of Your Policy. This is not the insurance contract and only the actual provisions will control. The Policy itself sets forth in detail the rights and obligations of both You and Your insurance company. It is, therefore, important that YOU READ YOUR POLICY CAREFULLY.

2. DISABILITY INCOME PROTECTION – Policies of this category are designed to provide, to persons insured, Coverage for Disabilities resulting from a covered Injury or Sickness, subject to any limitations set forth in the Policy. Coverage is not provided for basic hospital, basic medical-surgical, or major medical expenses.

3. BENEFITS OF THE POLICY – The Policy provides benefits for Total Disability.

   $_____ Monthly Indemnity will be paid each month while You are Totally Disabled.

   Benefits will start at the end of an Elimination Period of _____.

   Your Benefit Period is _____.

   Total Disability Definition – The definition of Total Disability that applies to the Policy is checked below:

   ☐ Total Disability or Totally Disabled means that, as a result of Sickness or Injury, You are unable to perform with reasonable continuity the substantial and material acts necessary to pursue Your Usual Occupation in the usual and customary way.

   Your Usual Occupation means the occupation (or occupations, if more than one) in which You are actively engaged and regularly performing when Your Disability begins.

   ☐ Total Disability or Totally Disabled means that as a result of Sickness or Injury, You are unable to perform with reasonable continuity the substantial and material acts necessary to pursue Your Usual Occupation in the usual and customary way.

   Your Usual Occupation means the occupation (or occupations, if more than one) in which You are actively engaged and regularly performing when Your Disability begins.

   If You have limited Your Usual Occupation to the performance of the substantial and material duties of a single medical specialty or to a single dental specialty, We will deem that specialty to be Your Usual Occupation.

   ☐ Total Disability or Totally Disabled means that as a result of Sickness or Injury, You are unable to perform with reasonable continuity, the substantial and material acts necessary to pursue Your Usual Occupation in the usual and customary way and You are not working in any occupation.

   Your Usual Occupation means the occupation (or occupations, if more than one) in which You are actively engaged and regularly performing when Your Disability begins.

OPTIONAL BENEFITS – You have applied for those optional benefits checked below. There is a separate premium charge for each added benefit.

☐ Social Insurance Substitute Rider 1401 (All classes) – This rider provides a benefit for Disability when the benefits that You may be receiving from any social insurance plan do not equal or exceed the SIS Maximum Monthly Indemnity.

Your SIS Maximum Monthly Indemnity is $_____ per month.

The SIS benefit each month is equal to the SIS Maximum Monthly Indemnity less any benefits You are receiving from a social insurance plan. Social insurance benefits include benefits for disability from workers' compensation or occupational disease law or for disability or retirement from Social Security.

This benefit will be added to the Monthly Indemnity of the Policy in each month when such indemnity is payable for Disability.

This rider terminates on the earlier of the Expiration Date or the date You retire under the Social Security Act.

☐ Two-Year Partial Disability Benefit Rider 1403 (see Partial Disability Benefit Rider 1402 below)

Benefits for Partial Disability may be payable for up to 24 months in any one claim.

☐ Partial Disability Benefit Rider 1402 (Classes 6, 6M, 5, 5M, 4, 4M, 3, 3D and 3M) – This rider provides reduced Monthly Indemnity when You are Partially Disabled.

Partial Disability means that You are at work and are not Totally Disabled under the terms of the Policy but, because of Sickness or Injury, Your Loss of Income is at least 15% of Your Prior Income.

The rider has the same Elimination Period as Your Policy.

For each month of the first 12 months that You are eligible for a Partial Disability benefit in the same claim, We will pay a Loss of Income Indemnity. The Loss of Income Indemnity is equal to Your Loss of Income less any individual disability insurance benefits You are receiving, from Us and all other insurance companies, on policies that are in force on or before the Effective Date of this rider. In no event will the Loss of Income Indemnity exceed Your Monthly Indemnity. If you continue to be Partially Disabled in the same claim after the Loss of Income Indemnity has been paid for 12 months, We will pay a Partial Indemnity.

Your Partial Indemnity is based on the following formula:

$$\text{Partial Indemnity} = \frac{\text{Loss of Income}}{\text{Prior Income}} \times \text{Monthly Indemnity}$$

If You have a Social Insurance Substitute Rider, an Automatic Benefit Enhancement Rider, or an Additional Monthly Benefit Rider, any Monthly Benefits provided by these riders will be added to the Monthly Indemnity of this formula.

You may be Totally or Partially Disabled to satisfy the Elimination Period of the Policy or rider and to meet the conditions for waiver of premium.

You may not renew this rider after the Expiration Date.

☐ 3% Compound Cost Of Living Adjustment Rider 1404 (Classes 6, 6M, 5, 5M, 4, 4M, 3, 3D and 3M) – This rider provides on the anniversary of a claim, while benefits are payable, a 3% adjustment in Monthly Indemnity that will be applicable to benefits paid for the next 12 months.

If You have a Social Insurance Substitute Rider, an Automatic Benefit Enhancement Rider, or an Additional Monthly Benefit Rider, any Monthly Benefits provided by these riders will be adjusted in the same manner.

You may not renew this rider after the Expiration Date.

☐ Future Increase Option Rider 1405 (Classes 6, 6M, 5, 5M, 4, 4M, 3, 3D and 3M) – This rider gives You the right to apply for additional disability income insurance in future years despite any change in Your health or occupation. Your Option Date each year is the Policy Anniversary until You are Age 55.

This rider includes a Special Option Date that may be used once while this rider is in effect if You lose Your Group Long-Term Disability Coverage and it is not subsequently replaced.

Your total Future Increase Option is $_____.

Until You are Age 45, You may apply for all or part of the remaining Total Increase Option on any one Option Date. On or after Age 45, You may apply for up to one-third of the remaining Total Increase Option, or the remaining Total Increase Option if it is less than $1,000, on any Option Date.

Each Increase Policy applied for during an Option Period or a Special Option Period will be underwritten to determine the maximum amount of Monthly Indemnity, if any, available to You. You must provide evidence of Your Income, employment and all other disability insurance with any insurer that is in force, which You have applied for, or for which You are eligible by reason of Your employment. We may require additional evidence of financial insurability, as necessary. You do not have to provide evidence of Your medical insurability or occupation.

This rider expires after You are Age 55 or, if earlier, when You use Your last Increase Option.

☐ Automatic Benefit Enhancement Rider 1406 (Classes 6, 6M, 5, 5M, 4, 4M, 3, 3D and 3M) – This rider provides for an Automatic Increase of 4% in the Monthly Indemnity of the Policy on each of six consecutive Policy Anniversaries.

After a Rider Review Date and before the next Policy Anniversary, You may submit an application to renew this rider for the smallest of:

- another six Automatic Increases; or
- the number of Automatic Increases between Your attained Age and Age 60; or
- the number of Automatic Increases which will not cause the Monthly Indemnity to exceed the maximum amount of allowable Monthly Indemnity available to You based on Our underwriting rules in effect at the time You apply for rider renewal.

If You apply to renew this rider, You must provide evidence of Your medical insurability, Income, occupation, employment and other insurance in force, applied for, or for which You are eligible by reason of Your employment. We may require additional evidence of financial insurability to renew this rider.

Your application to renew this rider will be underwritten in accordance with Our underwriting guidelines in effect at the time You apply for renewal to determine if You are eligible to renew this rider.

If benefits have been paid by Us under the Policy, You are not eligible to renew this rider.

This rider is renewable at six-year intervals but not past Age 60.

☐ Residual Disability Benefit Rider 1407 (Classes 2, 2M, 1 and 1M) – This rider provides one-half of the Monthly Indemnity when You are Residually Disabled after a period of Total Disability.

The Residual Indemnity of this rider is payable for six months or, if earlier, the end of the Benefit Period.

You must be Totally Disabled for the length of the Elimination Period before You become Residually Disabled.

Residual Disability means that You are at work and are performing with reasonable continuity, one or more of the substantial and material acts necessary to pursue Your Usual Occupation in the usual and customary way, but due to Injury or Sickness:

– You are unable to perform all of the substantial and material acts necessary; or
– You are unable to perform them for more than one-half of the time normally required.

You may not renew this rider after the Expiration Date.

☐ Unemployment Waiver of Premium Rider 1409 (All classes) – Under this rider, We will waive the premiums of the Policy if You become unemployed and receive unemployment compensation for at least 60 consecutive days.

We will waive the premiums for a 12-month period beginning on the date You become unemployed even if You return to work.

Premiums may not be waived for a subsequent Unemployment Period until 48 months have elapsed from the end of the previous Unemployment Period.

You may not renew this rider after You are Age 60.

☐ 6% Maximum Cost Of Living Adjustment Rider 1412 (Classes 6, 6M, 5, 5M, 4, 4M, 3, 3D and 3M) – This rider adjusts the Monthly Indemnity of Your Policy at the end of each 12 months in a continuous claim to reflect any changes in the cost of living.

We will adjust Your Monthly Indemnity based on changes in the Consumer Price Index for All Urban Consumers (CPI-U) from the start of claim. If You have a Social Insurance Substitute Rider, an Automatic Benefit Enhancement Rider, or an Additional Monthly Benefit Rider, any Monthly Benefits provided by these riders will be adjusted in the same manner.

Your Monthly Indemnity may vary from year to year as the CPI-U rises or falls in relation to the Original Index Month. The adjustment to the Monthly Indemnity will never be less than what a 3% compound rate would provide or more than a 6% compound rate would provide.

You may not renew this rider after the Expiration Date.

☐ Four-Year Delayed Cost Of Living Adjustment Rider 1413 (Classes 6, 6M, 5, 5M, 4, 4M, 3, 3D and 3M) – This rider provides, starting on the fourth anniversary of a claim while benefits are payable, a 3% adjustment in Monthly Indemnity that will be applicable to benefits paid for the next 12 months.

If You have a Social Insurance Substitute Rider, an Automatic Benefit Enhancement Rider, or an Additional Monthly Benefit Rider, any Monthly Benefits provided by these riders will be adjusted in the same manner.

You may not renew this rider after the Expiration Date.

☐ Graded Lifetime Indemnity for Total Disability Rider 1414 (Classes 6, 6M, 5, 5M, 4, 4M, 3, 3D and 3M) –

This rider provides lifetime benefits if You become Totally Disabled before Age 65 and remain continuously Totally Disabled in the same claim after the Expiration Date. The Lifetime Indemnity percentage is based on Your Age when the continuous Total Disability begins. For each year after Age 45, the percentage decreases by 5%.

You may not renew this rider after You attain Age 65 and are not Totally Disabled.

☐ Retirement Protection Plus Disability Benefit Rider 1415 (Classes 6, 6M, 5, 5M, 4, 4M, 3, 3D and 3M) – This rider provides an RPP Monthly Indemnity benefit payable to an irrevocable trust if You are Totally Disabled and not at work in any occupation.

$_____ RPP Monthly Indemnity will be paid at the end of each month while You are Totally Disabled and not at work in any occupation.

Benefits will start at the end of an Elimination Period of _____

You may not renew this rider after Age 65.

☐ Lump Sum Disability Benefit Rider 1416 (Classes 6, 6M, 5, 5M, 4, 4M, 3, 3D and 3M) – This rider provides a lump sum benefit at the later of the Expiration Date of the Policy or the end of the Benefit Period if Disabled. The Lump Sum Benefit Amount will only be paid if the Policy and this rider are in force on the Expiration Date of the Policy, and if the sum of Contributing Payments is equal to or greater than the Qualifying Amount. The Lump Sum Benefit Amount is equal to the sum of Contributing Payments multiplied by 35%.

Contributing Payments are any Total Disability benefits and/or Residual Disability benefits paid under the Policy until the later of the Expiration Date or the end of the Benefit Period if Disabled.

Your Qualifying Amount is $_____.

You may not renew this rider after the Expiration Date.

☐ Basic Partial Disability Benefit Rider 1417 (Classes 6, 6M, 5, 5M, 4, 4M, 3, 3D and 3M) – This rider provides reduced Monthly Indemnity when You are Partially Disabled.

Partial Disability or Partially Disabled means that You are at work and You are not Totally Disabled under the terms of the Policy, but due to Injury or Sickness:

- You experience a Loss of Income that is at least 20% of Your Prior Income; and either
- You are unable to perform one or more of the substantial and material acts necessary to pursue Your Usual Occupation; or

- You are able to perform all of the substantial and material acts necessary to pursue Your Usual Occupation but not for the length of time they normally require.

The rider has the same Elimination Period as Your Policy.

Your Partial Indemnity is based on the following formula:

$$\text{Partial Indemnity} = \frac{\text{Loss of Income}}{\text{Prior Income}} \times \text{Monthly Indemnity}$$

During the first six months in which Partial Indemnity is payable, We will deem Your Loss of Income to be 50% of Your Prior Income or the actual percentage of loss, if greater.

If You have a Social Insurance Substitute Rider or an Automatic Benefit Enhancement Rider, any Monthly Benefits provided by these riders will be added to the Monthly Indemnity of this formula.

You may be Totally or Partially Disabled to satisfy the Elimination Period of the Policy and to meet the conditions for waiver of premium.

You may not renew this rider after the Expiration Date.

☐ 3% Maximum Cost Of Living Adjustment Rider 1418 (Classes 6, 6M, 5, 5M, 4, 4M, 3, 3D and 3M) – This rider adjusts the Monthly Indemnity of Your Policy at the end of each 12 months in a continuous claim to reflect any changes in the cost of living.

On the first Review Date, We will adjust the Monthly Indemnity by multiplying the Monthly Indemnity by the Cost of Living Adjustment Factor. On each subsequent Review Date while benefits are payable, We will adjust the Monthly Indemnity by multiplying the prior year's adjusted Monthly Indemnity by the Cost of Living Adjustment Factor.

The Cost of Living Adjustment Factor will never be less than 1.00 or greater than 1.03.

You may not renew this rider after the Expiration Date.

☐ Benefit Purchase Rider 1419 (Classes 6, 6M, 5, 5M, 4, 4M, 3, 3D and 3M) – This rider gives You the opportunity to apply for additional disability income insurance in future years despite any change in Your health. We will review Your eligibility for an Increase Policy on every third Policy Anniversary while this rider is in effect. To keep this rider in effect, You must submit an application and other evidence of insurability during the Benefit Purchase Period.

You may apply for one Increase Policy between each Review Date while this rider is in effect if You have at least a 50% increase in Your Income during the first three years after the Effective Date of the Policy or since the last Review Date, or You lose Your Group Long-Term Disability Coverage and it is not subsequently replaced.

Each Increase Policy applied for during a Benefit Purchase Period or as part of a Special Benefit Purchase Option Offer will be underwritten to determine the maximum amount of Monthly Indemnity, if any, available to You. You must provide evidence of Your Income, occupation, employment and all other disability insurance with any insurer that is in force, which You have applied for, or for which You are eligible. We may require additional evidence of financial insurability, as necessary. You do not have to provide evidence of Your medical insurability.

This rider terminates when the first of the following events occurs:

- An application for an Increase Policy and required evidence of insurability is not received during the Benefit Purchase Period; or
- Less than 50% of Our offer to increase the Monthly Indemnity is accepted; or
- The initial premium for any Increase Policy is not paid; or
- The date of Your request to decrease the Monthly Indemnity of the Policy to which this rider is attached; or
- The date of Your written request to terminate this rider; or
- You attain Age 55; or
- The Policy terminates.

☐ Student Loan Protection Rider 1427 (Classes 6, 6M, 5, 5M, 4, 4M, 3, 3D and 3M) –This rider provides a Student Loan Protection Monthly Benefit when You are Totally Disabled.

If You are Totally Disabled according to the terms of the Policy, and the Student Loan Protection Elimination Period of _____days has been satisfied, benefits of up to $_____ (Student Loan Protection Maximum Monthly Benefit) will be paid at the end of each month.

Reimbursable Student Loan Expense means the monthly amount You incur and pay for a claimed month as a result of a Student Loan Obligation.

Student Loan Protection Maximum Monthly Benefit is shown in the Schedule Page. It is the maximum amount of monthly benefit We will pay under this rider.

Student Loan Protection Monthly Benefit is equal to the Reimbursable Student Loan Expense, not to exceed the Student Loan Protection Maximum Monthly Benefit.

Student Loan Protection Termination Date is shown in the Schedule Page. It is the date on which coverage under this rider terminates, if it has not already terminated.

This rider terminates on the Student Loan Protection Termination Date, or if earlier, when You no longer have a Student Loan Obligation.

4. EXCLUSIONS AND LIMITATIONS OF THE POLICY – We will not pay benefits for any Disability:

- caused by, substantially contributed to by, or which results from military training, military action, military conflict, or war, whether declared or undeclared, while You are serving in the military or units auxiliary thereto, or working for contracted military services;
- during any period of time in which You are incarcerated or detained as the result of a conviction;
- caused by, substantially contributed to by, or which results from Your commission of, or attempt to commit, a felony as defined under local, state, or federal law;
- caused by, substantially contributed to by, or which results from Your being engaged in an illegal occupation;
- caused by, substantially contributed to by, or which results from an intentionally self-inflicted Injury;
- during the first three months of Disability or the Elimination Period, if longer, that is caused by, substantially contributed to by, or which results from normal pregnancy or childbirth; or
- due to any loss We have excluded by name or specific description.

LIMITATION WHILE OUTSIDE THE UNITED STATES, CANADA OR MEXICO -You must be living full time in the 50 states which comprise the United States of America, the District of Columbia, Canada or Mexico in order to receive benefits under the Policy, except for incidental travel or vacation; otherwise, benefits will cease. Incidental travel or vacation means being outside of the 50 states which comprise the United States of America, the District of Columbia, Canada or Mexico for less than 60 days in a 12-month period. You may not recover benefits that have ceased pursuant to this limitation.

If benefits under the Policy have ceased pursuant to this limitation and You return to the 50 states that comprise the United States of America, the District of Columbia, Canada or Mexico, You may become eligible to resume receiving benefits under the Policy. You must satisfy all terms and conditions of the Policy in order to be eligible to resume receiving benefits under the Policy.

If You remain outside of the 50 states which comprise the United States of America, the District of Columbia, Canada or Mexico, premiums will become due beginning six months after benefits cease.

PRE-EXISTING CONDITION LIMITATION – We will not cover any loss that begins in the first two years after the Effective Date from a Pre-existing Condition.

Pre-existing Condition means You suffered from a physical or mental condition whether diagnosed or undiagnosed that was misrepresented or not disclosed in Your application for the Policy; and for which You received a Physician's advice or treatment within two years before the Effective Date of the Policy; or which caused symptoms within one year before the Effective Date of the Policy for which a prudent person would usually seek professional medical advice, diagnosis or treatment. We will not cover any loss that begins in the first two years after the Effective Date from a Pre-existing Condition.

MENTAL AND/OR SUBSTANCE-RELATED DISORDERS LIMITATION – Benefits for any Disability due to a Mental and/or Substance-Related Disorder will be paid for a period not longer than the Maximum Benefit Period for Mental and/or Substance-Related Disorders as shown in the Schedule Page of the Policy.

After the Maximum Benefit Period for Mental and/or Substance-Related Disorders and subject to the Policy provisions, We will only pay benefits while You are continuously confined in a Hospital for treatment of a Disability due to a Mental and/or Substance-Related Disorder, and You are under the regular medical care of a Physician.

Under no circumstance will We pay benefits for any Disability due to a Mental and/or Substance-Related Disorder that We have excluded by name or specific description.

5. RENEWABILITY OF THE POLICY – You may renew the Policy at the end of each Premium Term until the Expiration Date. During that time, We cannot change the premium or cancel the Policy.

   After the Expiration Date, You may renew the Policy at the end of each Premium Term as long as You are not Disabled and You are actively and regularly employed Full Time for at least 10 months each year and the premium is paid on time. If You renew the Policy after the Expiration Date, We will issue a new Schedule Page at that time.

   Your premium will be at Our rates then in effect for persons of Your Age, Class of Risk, Occupation Class, and any special class rating that applies to the Policy. We have the right to change such premiums on a class basis on any Policy Anniversary.

6. PREMIUMS OF YOUR POLICY – Your Policy has a grace period of 31 days for payment of premium, during all of which time the Policy remains in force. The premium for your Policy is payable every _____ months.

☐ Your premium is on a level basis.

		Level Premium
Policy	1400	$_____
Social Insurance Substitute Rider	1401	$_____
Partial Disability Benefit Rider	1402	$_____
Two-Year Partial Disability Benefit Rider	1403	$_____
3% Compound Cost of Living Adjustment Rider	1404	$_____
Future Increase Option Rider	1405	$_____
Residual Disability Benefit Rider	1407	$_____
Unemployment Waiver of Premium Rider	1409	$_____
6% Maximum Cost of Living Adjustment Rider	1412	$_____
Four-Year Delayed Cost of Living Adjustment Rider	1413	$_____
Graded Lifetime Indemnity for Total Disability Rider	1414	$_____
Retirement Protection Plus (RPP) Disability Benefit Rider	1415	$_____
Lump Sum Disability Benefit Rider	1416	$_____
Basic Partial Disability Benefit Rider	1417	$_____
3% Maximum Cost of Living Adjustment Rider	1418	$_____
Student Loan Protection Rider	1427	$_____
Policy Fee		$_____
Total		$_____

☐ Your premium is on a graded basis. Premiums are guaranteed but increase annually on the Policy Anniversary to age 60 and then are level until the Policy Expiration Date.

		Premium on Policy Date _____ Year	Premium on Policy Anniversary at Age 60 _____ Year
Policy	1400		
Social Insurance Substitute Rider	1401		
Partial Disability Benefit Rider	1402		
Two-Year Partial Disability Benefit Rider	1403		
3% Compound Cost of Living Adjustment Rider	1404		
Future Increase Option Rider	1405		
Residual Disability Benefit Rider	1407		
Unemployment Waiver of Premium Rider	1409		
6% Maximum Cost of Living Adjustment Rider	1412		
Four-Year Delayed Cost of Living Adjustment Rider	1413		
Graded Lifetime Indemnity for Total Disability Rider	1414		
Retirement Protection Plus (RPP) Disability Benefit Rider	1415		
Lump Sum Disability Benefit Rider	1416		
Basic Partial Disability Benefit Rider	1417		
3% Maximum Cost of Living Adjustment Rider	1418		
Student Loan Protection Rider	1427		
Policy Fee			
Total		$_____	$_____

Your issued Policy will contain a schedule of all premiums for each year after the date of issue.

THE GUARDIAN LIFE INSURANCE COMPANY OF AMERICA

BERKSHIRE LIFE INSURANCE COMPANY OF AMERICA
Home Office: 700 South Street, Pittsfield, MA 01201
Berkshire Life Insurance Company of America is a wholly owned stock subsidiary of
The Guardian Life Insurance Company of America, New York, NY

Business Reducing Term Disclosure

Important Information About The Guardian Business Reducing Term Disability Income Policy For Which You Have Applied

Thank you for applying for a Business Reducing Term Disability Income Insurance policy ("the Policy") offered by The Guardian Life Insurance Company of America, New York, New York ("Guardian"). The Policy provides disability coverage with respect to a loan or other financial obligation for which you are obligated to repay, according to the terms and conditions stated in the Policy. Because the Policy contains some unique features, we have provided this form to ensure that you have an understanding of some of its benefits, features and limitations. Specifically, please be advised:

- The monthly indemnity and length of time for which benefits are payable under Policy are underwritten and issued based on the specific loan, and corresponding repayment schedule, identified in the application for the Policy. Any renegotiation of this loan, or change in the loan's repayment schedule, including any increase in the periodic payment amount or lengthening of the loan term, may impact the extent to which Policy benefits are payable.
- Should the insurable interest or economic need for the Policy no longer exist or be reduced, Guardian may, with proper notification in advance of any Policy anniversary, refuse to renew the Policy, or require a reduction in the benefit limits as a condition of renewal.
- The Loss Payee for the Policy is the bank or other lender identified in the application for the Policy.

If you any questions or concerns regarding the coverage provided by the Policy, please contact your agent or broker. This Business Reducing Term Disclosure form does not alter the terms, conditions, limitations, or exclusion(s) (if any), of any policy that may be issued.

By signing this form, I acknowledge my receipt of this form.

Signed this _____ day of _____, _____ (month, year).

_____
(Applicant Signature)