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

Application for Disability Insurance Option Exercises Instructions / Checklist

THIS APPLICATION PACKAGE INCLUDES:

Application for Option Exercises – pages 1-3	Complete Sections 1-7 with the applicant.	☐
Use the Option Exercises application when applying for insurance coverage in connection with the Future Increase Option (FIO), Future Purchase Option (FPO), Benefit Purchase Rider (BPR) or Group Disability Replacement (GDR) rider.	This application should be used when applying for option exercises for individual disability, Retirement Protection Plus, Overhead Expense, Disability Buy-Out and adding additional benefits. Only pages 1-3 are needed for individual disability options where elimination period, benefit period and riders remain the same. Applying for Retirement Protection Plus options would also require only pages 1-3.	☐
	Do you have the correct state form (where the applicant currently lives or works. For exercise of FIO/FPO the client can also select where the original application was taken)?	☐
Supplements to the Option Exercise	Submit correct state form (to correspond with application submitted).	☐
A supplemental form must be included with every Overhead Expense, Disability Buy-Out or when requesting a change in or additional benefits (this includes requests for the Catastrophic Disability Benefit (CAT) or Student Loan Protection Rider (SLP)).	– Overhead Expense (OE) – Disability Buy-Out (DBO) – Request for Change in Benefits Supplement (CHG) -2 pages when requesting the removal or reduction of benefits – Request for Additional Benefits* (ADD) – 4 pages *Provide your client a copy of the Insurance Information Practices (C-NIIP-2003) and complete and submit the Authorization to Obtain and Release Information (C-AUTH-2013)	☐
Producer's Certification	Producer must be licensed and appointed in the contract state and where the application was signed.	☐
Authorization to Obtain/Release Information	Obtain all appropriate signatures and submit with the application.	☐
Form NON-MED-AUTH-2013 is used when no additional benefits are requested.	Submit this form on applications not requiring medical underwriting (i.e., FIOs with no additional benefits requested).	☐
Form C-AUTH-2013 authorizes the Company to obtain medical and other information about the proposed insured.	Submit this form on applications requiring medical underwriting (i.e., adding a benefit, CAT or SLP).	☐
Option Exercise Transmittal	Complete the New Business transmittal (AA1732) in full and submit with the application.	☐
Conditions of Coverage Forms	All prepayments must be submitted with a completed and signed Conditions of Coverage Form FIO-CC-2009.	
Supplement to Application for Insurance	Use when additional space is needed for application details.	☐
Financial Requirements	Include the most current financial documentation (i.e., 1040, Schedules, W-2, Paystubs, Employment Contract or YTD Profit and Loss).	☐

Submit the application by either faxing it to 1-800-683-1195 or email Application_Requirements@Berkshirelife.com.
Prepayment should be submitted using the Initial Premiums Reporting Requirements envelope #4129.

Guardian e-App is the preferred method to quickly prepare, sign and submit applications electronically.
Applications are always In Good Order with e-App!

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Application for Disability Insurance Option Exercises

Please complete all questions. If additional space is needed, please use the Remarks and Special Requests section.

I. Proposed Insured Information

a. Name (First, Middle Initial, Last) ______________________________

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

c. Social Security # _____ - _____ - _____

d. Residence Address (Street, City, State, ZIP) ______________________________ ______________________________

e. Telephone: Home (_____) _____ - _____
Business (_____) _____ - _____
Cell (_____) _____ - _____
Email Address ______________________________

f. Employer Name & Address (Street, City, State, ZIP) ______________________________ ______________________________

g. Exercised from Policy # ______________________________

h. Number of years with current employer: ______________

If less than 2 years, note prior employer______________

2. Options

a. Option Requested
- ☐ Future Increase Option (FIO/FPO)
- ☐ Benefit Purchase Rider (BPR)
- ☐ Group Disability Replacement Option (GDR) (please provide date and reason why coverage ended) ______________________________
- ☐ Other:______________________________

b. If FIO/FPO or GDR, total amount to be exercised:
Monthly Indemnity $______________________
Social Insurance Substitute (SIS) Amount $____________
Lump Sum (if DBO) $______________________

c. If requesting a special option, provide reason ______________________________

3. Benefit Change Requests

a. I am applying for a shorter elimination period or to add a disability benefit that is not available under the increase option applied for under 2a. (If yes, complete the Request for Additional Benefits Supplement.) .... ☐ Yes ☐ No

b. I am applying to change or remove a supplementary benefit available under the increase option applied for under 2a. (If yes, complete the Request for Change in Benefits Supplement.) .... ☐ Yes ☐ No

4. Occupational Information

a. Occupation(s) and Duties______________________________ ______________________________

b. How many hours per week are you at work in this occupation(s)? _____hours

c. Are you currently disabled and/or collecting disability benefits from any source? .... ☐ Yes ☐ No
If yes, provide details ______________________________

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, pensions 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 8 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. Employment Status
- ☐ Employee (no ownership)
- ☐ Sole Proprietor
- ☐ Partner _____% ownership
- ☐ S-Corporation Shareholder _____ % ownership
- ☐ C-Corporation Shareholder _____% ownership

b. Earned Income
1. Year-To-Date This Calendar Year $____________
2. Actual Filed Last Calendar Year $_________
3. Actual Filed Two Calendar Years Ago $____________

c. Is your Unearned Income more than 10% of total earned income? If yes, indicate the Unearned Income amounts and source……☐ Yes ☐ No
   1. Current Year $______________ 2. Prior Year $______________________
   Source____
d. Do you participate in a qualified retirement plan such as a 401(k), 403(b), SIMPLE, IRA or profit sharing? ☐ Yes ☐ No
e. 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 $______________________
f. Do you wish to have this retirement contribution considered as part of your earned income?……☐ Yes ☐ No
g. Total Net Worth if $10 million or more (assets minus liabilities, excluding primary residence) $______________________
h. Have you ever filed bankruptcy? ……☐ Yes ☐ No
   If yes, Type: ☐ Personal ☐ Business Date Filed:____________ Date Discharged:____________

6. Other Disability Coverage of the Proposed Insured

a. Excluding the policy identified by you in question 1g, do you have any disability insurance in force or applied for, or for which you are eligible within the next 12 months with any company, including Guardian or Berkshire? If yes, list all coverages below ……☐ Yes ☐ No

Type of Insurance: Individual (IDI), Group (G), Overhead Expense (OE), Disability Buy-Out (DBO), Retirement Protection (RP), Association (A), Other (O – Explain) **Status:** I = In Force, P = Pending, E = Eligible For

		Column A	Column B	Column C
1.	Company Name			
2.	Type			
3.	Status			
4.	Benefit Amount			
5.	Benefit Period			
6.	Social Insurance Benefit			
7.	Catastrophic Benefit			
8.	Retirement Protection			
9.	Employer Paid*	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
10.	Is this coverage being replaced? If yes, date to be replaced	☐ Yes ☐ No Date: ________	☐ Yes ☐ No Date: _______	☐ Yes ☐ No Date:________
11.	Amount to be replaced			

*Employer paid means your employer pays the premium and does not include it as taxable income to you.

7. Premium Information

a. Premium Structure: ☐ Level ☐ Graded
b. What percentage of the premium for the coverage you are applying for will be paid by your employer?
   ☐ None ☐ 100% ☐ Other ______%
c. If your employer will pay any part of the premium, will it be reportable by you as taxable income? ……☐ Yes ☐ No
d. If paid by the proposed insured, is it paid with: ☐ Pre-tax dollars ☐ After-tax dollars
e. Premium Mode: ☐ Annual ☐ Semiannual ☐ Quarterly ☐ Monthly – *available with Group Bill and Bank Draft only*
f. Billing Type: ☐ Paper Bill ☐ Group Bill ☐ Automatic Bank Draft:
   ☐ Add to my existing Guardian or Berkshire service
   ☐ New service (Complete Request for Guard-O-Matic arrangement Form R223)
g. Prepayment of Premium – *A prepayment must be accompanied by a signed Conditions of Coverage.*
   ☐ No money has been submitted with this application.
   ☐ $______________ has been submitted with this application for proposed insurance.

8. Remarks and Special Requests

9. Representations of the Proposed Insured and Owner

Those parties, who sign below, agree that:

1. This application and any other supplements or amendments to the application will form the basis for, and become part of and attached to, any policy or new coverage issued by Berkshire Life Insurance Company of America ("Company").
2. All of the statements that are part of the application and any other supplements to the 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, if found to be material to risk accepted by the Company, may adversely affect claims payment or may lead to rescission of any policy or new coverage that is issued based on this application. After two years from the Effective Date of this policy, no misstatement(s), except fraudulent misstatement(s), made by the applicant shall be used to void the Policy, or deny a claim for loss incurred or Disability commencing after the expiration of such two year period.
5. All coverage shown to be discontinued or replaced in answer to Question 6a 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 or new coverage issued. Further, benefits under any policy or new coverage issued based on this application may be reduced by the amount payable under such existing policies.
6. Insurance in the amount resulting from the exercise of the Future Increase Option, Future Purchase Option, Group Disability Replacement Option, Benefit Purchase Rider, or other increase option ("the Option") shall take effect in accordance with the agreement or provision providing the Option, so long as the new policy or additional coverage is delivered, the required premium is paid, and there has been no change in the income level, status of employment, or occupation of the Proposed Insured.
7. By paying premiums on a basis more frequently than annually, the total premium payable during one year's time may be greater than if the premium were paid annually. That is, the cost of paying annualized periodic premiums may be more than the cost of paying one annual premium.
8. I acknowledge receipt of the Insurance Information Practices.

The falsity of any statement in the application for this policy shall not bar the right to recovery under the policy unless such false statement was made with actual intent to deceive or unless it materially affected either the acceptance of the risk or the hazard assumed by the insurer.

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

Berkshire Life Insurance Company of America
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Insurance Information Practices

This notice is given to you at the time you apply for disability insurance to tell you about the information we may obtain with your application. Only qualified members of our Company's staff or its legal representatives will have access to your file to evaluate your eligibility for insurance. 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.

Authorization to Obtain and Release Non-Medical Information

Name of Proposed Insured ____________________________ Date of Birth ____________________

Address of Proposed Insured ____

____

I authorize any insurance or reinsurance company, employer, or consumer reporting agency that has any records or knowledge of me to release any and all non-medical information in its possession about me, to Berkshire Life Insurance Company of America ("Company") or its legal representatives. Non-medical information may include, as may be required, information pertaining to any of the following: employment and occupational duties; earned income, unearned income and net worth; any civil action or bankruptcy; any claim for disability income benefits; and any disability insurance in force, or applied for, or for which I am eligible within the next 12 months. I authorize the Company to obtain information on disability coverage in force or applied for from the Disability Income Reporting System through MIB, Inc.

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. The Company or its legal representatives will not release any information obtained to any person or organization except to reinsurance companies, MIB, Inc. , or other persons or organizations performing business or legal services in connection with an application, or as may be lawfully required, or as I may further authorize.

I know that I may revoke this authorization in writing, at any time, by sending a written request for revocation to 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 agree that 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. A copy of this authorization will be provided upon request. 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.

Signed at ______________________________ this __________ day of __________________, ________.
City and State / Day / Month / Year

______________________________ ______________________________
Signature of Proposed Insured / Witness Signature

Producer's Certification (Complete in all cases.)

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

Full Name (First, Middle Initial, Last) ______________________________

1. 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

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

   Program type: ☐ Resident/student ☐ Association ☐ QSPP ☐ VIP ☐ Professional Group ☐ Group Conversion ☐ Executive Bonus (Sec. 162)

   Program status: ☐ New ☐ Existing

   If existing, provide program name and code: ______________________________

3. Commissions

Producer's Name	Producer's Code	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.

The falsity of any statement in the application for this policy shall not bar the right to recovery under the policy unless such false statement was made with actual intent to deceive or unless it materially affected either the acceptance of the risk or the hazard assumed by the insurer.

Signed at ______________________ this __________ day of ______________, __________.
City and State Day Month Year

______________________________ ______________________________
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)

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Conditions of Coverage

I, ______________________________, the Proposed Insured, have applied for disability insurance coverage with Berkshire Life Insurance Company of America ("Company") and have submitted $______________ to the Company. The minimum amount of premium which may accompany an application is a monthly premium amount. It is understood and agreed that no liability is created or assumed by the Company, except for the refund of any premium amount submitted, unless and until a disability insurance policy or new coverage becomes effective. The insurance applied for will become effective and in force only if:

1. This application is approved by the Company, and
2. A modified policy or new coverage is delivered, and
3. Any amendment of the application or Special Exceptions Agreement to adjust the provisions of a policy is signed by the Proposed Insured and the Owner, where applicable, and
4. A policy or new coverage is issued during the lifetime of the Proposed Insured, and
5. The initial premium payment has been paid, and
6. The income level, status of employment, and occupation of the Proposed Insured remains insurable under the Company's underwriting standards.

Requests for a specific effective date are honored at the Company's discretion in accordance with its published guidelines on policy dating upon the conclusion of the underwriting review.

Should the Proposed Insured be determined uninsurable based on the Company's underwriting standards, or if the Company is unable to obtain required underwriting information within 60 days, the amount submitted will be returned to the Proposed Insured.

Should the amount submitted not be honored by the Proposed Insured's bank, the Company will discontinue consideration of the application.

No agent or broker has the authority to waive or alter any of the terms or conditions of the application for insurance or these Conditions of Coverage.

The premium check must be made payable to the Company (do not make check payable to the producer or leave payee blank).

I have read and understand the Conditions of Coverage.

Licensed Producer's Signature	Date	Applicant's Signature

THE GUARDIAN LIFE INSURANCE COMPANY OF AMERICA

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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.

BERKSHIRE LIFE INSURANCE COMPANY OF AMERICA
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New Business Transmittal

Fax new applications and Underwriting Requirements to 1-800-683-1195.
Note, originals are not required to be sent or email new applications to ApplicationRequirements@Berkshirelife.com

Complete This Section for All Applications Submitted

Date	**Agency Code**	**Proposed Insured (First, Middle, Last Name)**

Agency Contact Name, Phone and e-Mail	**DIS Name & Code**
Producer is: ☐ Inner Circle (IC) ☐ Chairman's ☐ President's ☐ Elite ☐ Platinum IC	**Producer Email and Phone (if specialty producer)**
Program is: ☐ Business Resource Center (BRC) ☐ Business Owner Advantage (BOA) ☐ Startup Savvy Underwriting (SUU) ☐ New Young Professional (NYP) ☐ Enhanced Quick Issue (EQI)* ☐ Qualified Sick Pay Program (QSPP)† ☐ Voluntary Income Protection (VIP)†	☐ Association† ☐ Resident/Student Program† ☐ Professional Group Program† ☐ Group Conversion† ☐ Option Exercise – Original Policy No. ___________ ☐ List Bill **Requires TeleMed through APPS or ExamOne*

† If existing program, please provide:
Plan Name:____ Plan No____

Check **(original required if faxing)** ☐ To Follow ☐ Enclosed Amount: $ ____________________

Conditional Receipt/Conditions of Coverage ☐ To Follow ☐ Enclosed

Financial Information* ☐ To Follow ☐ Enclosed Describe:____________________
**For a list of requirements, refer to the Financial Underwriting section 4 in the Field Underwriting Guide.*

Concurrent Life Application Submitted to Guardian? ☐ Yes ☐ No If yes, File No. ____________________

Recently Issued Life File (within 6 months)? ☐ Yes ☐ No If yes, File No. ____________________

Complete This Section When Using TeleMed

TeleMed Service: ☐ All Services ☐ Interview Only[1]	TeleMed Vendor: ☐ APPS ☐ ExamOne ☐ Portamedic[2]	Combo Case with another insurance carrier?[3] ☐ Yes ☐ No

[1] Vendor will not facilitate paramedical or APS services
[2] Combo case, Exception handling and TeleMed – Interview Only services not available with Portamedic
[3] Not available with TeleMed – Interview Only service

Complete This Section When Not Using TeleMed or using TeleMed – Interview Only

			***Provide requirement order details (e.g. doctor, vendor, case no. or ticket no.)..**
Part 2 – Medical	☐ To Follow	☐ Enclosed	
Part 2 – Non-Medical	☐ To Follow	☐ Enclosed	
APS Request*	☐ To Follow	☐ Enclosed	
Inspection Request*	☐ To Follow	☐ Enclosed	
Blood Profile*	☐ To Follow	☐ Enclosed	
H.O. Specimen*	☐ To Follow	☐ Enclosed	

THE GUARDIAN LIFE INSURANCE COMPANY OF AMERICA

BERKSHIRE LIFE INSURANCE COMPANY OF AMERICA
CALIFORNIA LOSS RATIO DISCLOSURE

The enterprise wide non-interest adjusted statutory loss ratio in 2014 was 89%.

The loss ratio shown here covers only a 12 month period. It does not necessarily represent the long term experience of the Company.

The Guardian Life Insurance Company of America
Berkshire Life Insurance Company of America
700 South Street
Pittsfield, Massachusetts 01201
Berkshire Life Insurance Company of America
is a subsidiary of and an administrator for
The Guardian Life Insurance Company of America, New York, NY

SUSPENSE TICKET

Agency No.	Insured Name	Date
Policy No.		Social Security No.
List Bill No.	List Bill Name	# Apps Submitted

All prepayments must be submitted with a Conditional Receipt

Dollar Amount	Special Instructions
$	

Billing Frequency:

☐ Annual

☐ Semiannual

☐ Quarterly

☐ Automatic Payment Plan (APP)

☐ List Bill (Monthly)

Prepared By

GUARDIAN®

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.")

Supplement To Application For Insurance

This application is to be attached to and made part of the policy.

Proposed Insured ______________________________ Date of Birth: ______________

Use this space to amplify and extend answers to questions in your application dated: ________________

Question No.	Additional Answers

I (We) represent that the answers as amplified and extended above are true and complete to the best of my (our) knowledge and belief and are part of my (our) application to the Company as described above.

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

______________________ Witness

______________________ Signature of Proposed Insured

______________________ Signature of Applicant/Owner