



GUARDIAN®

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.