



- 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.")*

Disability Insurance Application Instructions / Checklist

THIS APPLICATION PACKAGE INCLUDES:

Notice of Insurance Information Practices

Give this form to the applicant.

Application for Insurance Part 1 – pages 1-9

Complete Sections 1-9 in all cases. Do you have the correct state forms (must be where the applicant lives or works)?

Supplements to the Application for Insurance

At least one supplemental form must be included with every case submitted.

Submit correct state form (to correspond with application submitted).

Do you have the correct supplement(s) fully completed for the appropriate type(s) of insurance applied for?

- Individual Disability Insurance (TDI) – 1 page (including Additional Monthly Benefit Rider*)
- Retirement Protection Plus (RPP) – 1 page
- Overhead Expense (OE) – 2 pages
- Disability Buy-Out (DBO) – 2 pages
- PayGuard or Business Reducing Term (RT) – 1 page

*Complete only Sections 1 and 3c of the Individual Disability Insurance (TDI) supplement. The new policy to mirror base policy and if looking to make changes to base policy, submit an Application for Change or Reinstatement - Disability Insurance (17CC-H).

Representations of Proposed Insured and Owner

Signature of the proposed insured on this form confirms their agreement that the application is complete, correctly recorded and true to the best of his or her knowledge.

Obtain all appropriate signatures and submit with the application.

Must be included with every case submitted.

Authorization to Obtain/Release Information

This form authorizes the Company to obtain medical and other information about the proposed insured.

Obtain all appropriate signatures and submit with the application.

Must be included with every case submitted.

Producer's Certification

Complete page 1 and 2 in all cases and submit with the application.

Agent must be licensed and appointed where application was signed.

If part of an association, include the endorsing agent.

Application for Insurance Part 2 Non-Medical

Obtain all appropriate signatures and submit with the application (not required if submitting through the TeleMed program).

TeleMed

TeleMed is an underwriting service employed to capture the disability application's Medical Exam, labs and inspection report. TeleMed streamlines the underwriting process by delegating the gathering of medical information to a specialist.

Complete and submit the TeleMed Request form to the vendor.

Complete the TeleMed Transmittal and submit with the application.

If this is not a TeleMed case or TeleMed - Interview Only is selected, you must complete the Part 2 Non-Medical and order the necessary medical requirements (i.e., paramed, labs, inspection, etc.).

Financial Information

Financial verification is required in all cases, except residents applying within the resident limits and cases submitted through the Enhanced Quick Issue Program.

Section 7 of Part 1 must be completed in all cases.

Obtain W-2, recent paystub, tax return or employment agreement.

Conditional Receipt

A Conditional Receipt must be submitted with every prepayment. Refer to the Conditional Receipt Guidelines for information on our policy dating and prepayment refunding procedures.

Obtain appropriate signatures, submit one copy with the application.

Do not accept a prepayment if questions 4m or 4n are "Yes" (see instruction on page 4 of Part 1).

Do not accept a prepayment if any questions 4o through 4r are "Yes."

Automatic Payment Plan

If a new service, complete and submit the Request for Guard-O-Matic Arrangement form.

Submit a copy of a canceled check or a savings deposit slip.

Additional forms may be required, but are not part of this package. If relevant to this case, complete additional forms and submit with the application package.

2. Business Information

a. Name of Current Employer _____

b. Business Address _____
(If mailing address is PO Box, include street address as well.)_____
City State ZIP*Business Phone* _____*Business Website* _____

c. Occupation _____

d. Job Title _____

e. Nature of Business _____

f. How many years employed with
your current employer?

(If less than 2 years, please furnish previous employer below.)

g. Former Employer _____

Address_____
City State ZIP

h. Occupation _____

i. Job Title _____

j. Nature of Business _____

3. Occupational Information

a. Describe, in order of importance, all duties of your occupation. Include all activities that are performed in connection with the duties of your occupation, including but not limited to travel, sales and supervisory.

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.

Application for Insurance | Part I Continued

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

- d. If you are a medical doctor or dentist, what percent of your gross income is derived from surgical procedures, such as catheterization, angioplasty, stent placement, pacemaker implant, endoscopy, or other surgical procedure? _____ %

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

- f. Number of years in this occupation _____
- g. How many hours per week are you at work in this occupation? _____ hours

- h. 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:

- i. Do you have any other part- or full-time jobs, occupations or employment? Yes No If yes, describe:

- j. Do you supervise any employees? Yes No If yes, how many? _____
- k. Are you a business owner? Yes No _____
- l. What percentage of the business do you own? _____ %

- m. What type of business do you own?
 Sole Proprietorship Partnership "S" Corporation
 Limited Liability Company (LLC) "C" Corporation
 Limited Liability Partnership (LLP)
 Other: _____
- n. Do you intend to change any occupation or employment within the next six months? Yes No If yes, provide details:

4. The Following Questions Apply to the Proposed Insured

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

- a. Do you intend to reside or travel outside of the U.S.? Yes No
(If yes, indicate location, frequency, for work or pleasure, date of departure, length of stay.)

5. Remarks and Special Requests

Provide all 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.

6. Other Disability 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

Type of Insurance

DI = Disability Income Insurance
OE = Overhead Expense
RP = Retirement Protection

DBO = Buy-Out
KEY = Key Person
RT = Reducing Term

Category

IND = Individual
G = Group
A = Association

Status

I = In Force
AP = Applied For,
or Date of Eligibility

Company Name:			
Type of Insurance:			
Category:			
Status:			
Date insurance applied for, issued, or eligible for (if known):			
Policy Number (if known):			
Benefit Amount:	\$	\$	\$
Benefit Period:			
Social Insurance Benefit:	\$	\$	\$
Automatic Increase Option:		%	%
Future Increase Option (amount remaining):	\$	\$	\$
Catastrophic Benefit:	\$	\$	\$
Retirement Benefit:	\$	\$	\$
Does employer pay premium and not include it as taxable income to you?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
If group coverage, is it convertible?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

- b. Replacement

Is the insurance being applied for replacing this coverage?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, amount to be replaced?	\$	\$	\$
Anticipated Date:			

When issuing any insurance as a result of this application, the Company will rely on the fact that you can and will permanently terminate the coverage as specified above following the delivery of the policy and will not at any time reinstate this coverage. If the coverage is not terminated, the Company reserves all rights outlined in any policy issued. Further, if the coverage is not terminated, benefits under any policy issued based upon this application may be reduced by the amount payable under such existing policies.

- c. Is additional group disability coverage available through your employer? Yes No
- If yes, do you have the option to participate in the future?
(If yes, give details in Remarks and Special Requests.) Yes No

7. Personal Financial Information of the Proposed Insured

- a. **Earned Income.** Fill in the amounts requested for last year and two years ago using your individual and/or business income tax returns and supporting schedules. **Note:** Do not list income that is not reported to the IRS. Explain in Remarks and Special Requests, any significant fluctuations between years. Describe any changes since the end of the most recent calendar year. Put loss amounts in parentheses.

	Year-To-Date	Actual Filed Last Calendar Year	Actual Filed Two Calendar Years Ago
1. Non-owner employee salary, wages and bonus from Form W-2	\$	\$	\$
2. Business owner salary, wages, and bonus from Form W-2	\$	\$	\$
3. Sole Proprietor net income (after business expenses) from Form 1040, Schedule C	\$	\$	\$
4. Share of Partnership or Sub-Chapter "S" corporation income (after business expenses) shown on Form 1040 or 1120 "S", Schedule K-1	\$	\$	\$
5. Other earned income (explain source)	\$	\$	\$
6. Total Earned Income (add lines 1-5)	\$	\$	\$

- b. **Unearned Income.** Unearned income or passive income includes, but is not limited to, income from dividends, capital gains, interest (including tax exempt interest), rentals, royalties, retirement plans, alimony, investments, and business interests as an inactive owner.

Is your unearned income more than 10% of total earned income (line 6 above)?

Yes

No

If yes, indicate the unearned income amounts.	\$	\$	\$
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Sources: _____

c. Retirement Contributions

1. Do you participate in a qualified retirement plan? Yes No

2. If yes, what type? 401(k)/403(b) SIMPLE Defined Benefit IRA Profit Sharing

Other: _____

3. i. Your Annual Contribution	\$	\$	\$
ii. Your Employer's Match, if any	\$	\$	\$
iii. Additional Employer Contributions	\$	\$	\$
iv. Total Contributions (add lines i - iii)	\$	\$	\$

4. Do you wish to have this retirement contribution considered as part of your earned income?

Yes

No

Application for Insurance | Part I Continued

d. **Net Worth** Does your net worth exceed \$6 million?

Yes No

If yes, describe the net worth in detail below. Net worth is asset value less any outstanding debt or mortgage on the asset.

Cash, Savings, Stocks, Bonds

\$ _____

Fair Market Value of your business (excluding goodwill)

\$ _____

Personal Property

\$ _____

Real Estate

\$ _____

Other

\$ _____

Explain: _____

e. **Bankruptcy**

Have you ever filed bankruptcy?

Yes No Personal Business

If yes, answer the following questions:

(a) Date bankruptcy filed?

(b) Date bankruptcy discharged?

8. Premiums

a. Mode

- Annual Semiannual Quarterly
 Automatic payment plan
 (Complete the Request for Guard-O-Matic Arrangement form.)
 New Service Add to My Existing Service
 Monthly (list bill only – not available for all products)
 Other: _____

b. Premium to Be Paid By:

Proposed Insured Employer/Corporation

If both, list percentage of split:

%	%
_____	_____
Proposed Insured	Employer/Corporation

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 by

Pre-tax or After-tax dollars

e. Send premium notices to:

Residence Owner's Address Business

Other: _____

List Bill

New - Billing Name _____

Common Billing Date _____

Existing Account # _____

- f. Prepayment of Premium
- No money has been submitted with this application for proposed insurance.
- \$ _____ has been submitted with this application for proposed insurance. *If money is submitted when this application is signed, the terms of the Conditional Receipt shall apply if conditions are met.*
-
- g. Is the policy being applied for through an association of which you are a member?
- Yes No
- Association Name _____

9. Remarks and Special Requests

Provide all 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, 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.

10. Amendments or Corrections (For Home Office or Customer Service Office Use Only)



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Representations of the Proposed Insured and Owner

Those parties who sign below, agree that:

1. This Application for Insurance (Part 1), Application for Insurance (Part 2 Non-Medical), 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 discontinued in answer to Question 6b 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. 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. Any changes or corrections made by the Company and noted in the "Amendments or Corrections" section 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 includes any false or misleading information on an application for an insurance policy is subject to criminal and 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

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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 complies with the HIPAA Privacy Rule

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, other health facility, pharmacy, pharmacy benefit manager, consumer reporting agency, the Social Security Administration, the Medical Information Bureau, insurance or reinsurance company, or employer or other organization, institution or person that has any records or knowledge of me or my health to release any and all medical and non-medical information in its possession about me or my minor children, to the Company or its legal representatives. 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 me or my minor children. I understand that the information released could contain reference to or results of HIV Antibody (AIDS) testing, and may relate to the symptoms, evaluation, diagnosis, examination, treatment or prognosis of any mental or physical condition, including psychiatric conditions (but excluding psychotherapy notes), and drug or alcohol abuse.

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.

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, the Medical Information Bureau, 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 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 Personal Representative

Personal Representative's Authority or Relationship to 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:

First	Middle Initial	Last Name
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1. How well do you know the proposed insured?

Known well for _____ years Known slightly for _____ years
 Met very recently Relative? _____

2. Indicate the purpose of this insurance. Check any that apply.

For the Proposed Insured:

Personal Income Protection Personal Loan Protection
 Retirement Contribution Protection
 Other: _____

For the Proposed Insured's Business:

Overhead Expense Protection Disability Buy-Out Protection
 Financial Obligation Protection
 Other: _____

3. **Complete if applying for an Employer-Sponsored Plan (QSPP, VIP):** If this application is submitted through an Employer-Sponsored Plan, please complete the following:

New Existing Plan # _____

4. **Complete if applying through an Association Program:** If this application is submitted through an active Association Program, please complete the following:

New Existing Plan # _____

5. **Complete if applying through a Group Conversion Program:** If applying through a Group Conversion Program, indicate the Group Conversion Program name and code:

Program Name	Code
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6. Is this coverage being applied for through the New Young Professionals Program? Yes No

7. 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

8. 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

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

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

11. Remarks (and additional instructions)



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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 4m or 4n on the accompanying Application for Insurance are left blank or are answered "Yes," no prepayment should be taken and no Conditional Receipt should be issued. However, with respect to question 4n, if the proposed insured's only medical advice, counseling, or treatment was for a routine physical examination resulting in no diagnosis being made or treatment rendered, or for the common cold with a complete recovery, then a prepayment can be taken, and a 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 answers and statements in any part of the application(s) having an earlier date are complete and true as though given on the date of this receipt;
 - (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



- 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 4m or 4n on the accompanying Application for Insurance are left blank or are answered "Yes," no prepayment should be taken and no Conditional Receipt should be issued. However, with respect to question 4n, if the proposed insured's only medical advice, counseling, or treatment was for a routine physical examination resulting in no diagnosis being made or treatment rendered, or for the common cold with a complete recovery, then a prepayment can be taken, and a 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 answers and statements in any part of the application(s) having an earlier date are complete and true as though given on the date of this receipt;
 - (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

**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

Individual Disability Insurance Supplement to the Application for Insurance | Policy Forms I400 and I500

I. Proposed Insured Information

a. Proposed Insured

	First	Middle Initial	Last Name
--	-------	----------------	-----------

b. Social Security Number

--	--	--	--

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

--	--	--	--

2. Premium Structure

 Level Graded Step Rate

3. Personal Disability Insurance

a. Policy Form No.

--	--	--	--

Monthly Indemnity

\$

Elimination Period

--	--	--	--

Benefit Period

--	--	--	--

Occupational Class

--	--	--	--

b. Supplemental Benefits

 3% Compound Cost of Living Adjustment Residual Disability Benefit 6% Maximum Cost of Living Adjustment Partial Disability Benefit Four-Year Delayed Cost of Living Adjustment Graded Lifetime Indemnity for Total Disability Unemployment Waiver of Premium Catastrophic Disability Benefit

\$

 Future Increase Option

\$

 Social Insurance Substitute

\$

 Other

--	--	--	--

--	--	--	--

--	--	--	--

c. Additional Coverage

 Additional Monthly Benefit

\$

--	--	--	--

**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

Overhead Expense Insurance Supplement to the Application for Insurance

I. Proposed Insured Information

a. Proposed Insured

First	Middle Initial	Last Name
_____	_____	_____

b. Social Security Number

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

2. Overhead Expense Insurancea. *Monthly Indemnity/Benefit Amount*

\$

Monthly Indemnity/Benefit Period

_____ months

Elimination/Waiting Period

_____ days

Occupational Class

b. **Supplemental Benefits** *Residual Disability* *Future Purchase Option*

\$

c. Your share of covered expenses?

\$

and

% of total.

d. Are there other employees in the firm who generate revenue?

 Yes No*If yes, what is the compensation for these employees and the percentage of gross revenue they generate?*

e. **Owner Information****(if other than the proposed insured)***Name of Owner*

Address

(If mailing address is PO Box, include street address as well.)

City

State

ZIP

Social Security #/Tax ID #

Relationship to Proposed Insured

Overhead Expense Insurance Supplement to the Application for Insurance | Continued

Monthly Expenses of the Business Entity

f. What are the current average monthly overhead expenses incurred for the items shown?
(If responsibility for expenses shared jointly with others, include only the portion for which the proposed insured is responsible.)

<i>Advertising</i>	\$	_____
<i>Car and Truck Expenses</i>		_____
<i>Commissions and Fees</i>		_____
<i>Contract Labor</i>		_____
<i>Depreciation and Section 179 Expense Deduction</i>		_____
<i>Employee Benefit Programs</i>		_____
<i>Insurance</i>		_____
<i>Interest:</i>		
<i>Mortgage (Paid to Banks, etc.)</i>		_____
<i>Other</i>		_____
<i>Legal and Professional Services</i>		_____
<i>Office Expenses</i>		_____
<i>Pension and Profit Sharing Plans</i>		_____
<i>Rent or Lease (Other Business Property)</i>		_____
<i>Repairs and Maintenance</i>		_____
<i>Taxes and Licenses</i>		_____
<i>Utilities</i>		_____
<i>Wages*</i>		_____
<i>Other Expenses (itemized):</i>		
_____		_____
_____		_____
_____		_____
_____		_____
TOTAL (Should agree with 2c.)	\$	_____

*Exclude compensation for members of insured's profession.

**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

Disability Buy-Out Insurance Supplement to the Application for Insurance

I. Proposed Insured Information

a. Proposed Insured

First	Middle Initial	Last Name

b. Social Security Number

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

2. Premium Structure
 Level Step Rate
3. Disability Buy-Out Insurance

a. Funding:

 Lump Sum Monthly Down Payment
Indemnity/Benefit Amount

Monthly: \$	Lump Sum: \$
-------------	--------------

Indemnity/Benefit Period

months*Elimination/Waiting Period*

months*Occupational Class*

b. **Supplemental Benefits**
 Presumptive Permanent Disability Benefit
(include with all monthly and down payment plans)
 Future Purchase Option

Monthly: \$	Lump Sum: \$
-------------	--------------

c. Type of buy-sell agreement
(in force or to be drafted):
 Cross Purchase Entity Purchase
 Trusteed Cross Purchase
Status of buy-sell agreement:
 In force and dated

 Date to be drafted by

d. **Owner Information***Name of owner (first name, middle initial and last name) or name of trust, company or other owner:*

Address

(If mailing address is PO Box, include street address as well.)

City

State

ZIP

Social Security #/Tax ID #

Disability Buy-Out Insurance Supplement to the Application for Insurance | *Continued*

Owner's Relationship to Proposed Insured

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 there are any on whom Disability Buy-Out (DBO) is not carried or proposed, explain in the *Application for Insurance, Part 1, Remarks and Special Requests, Section 9.*)

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:

g. What is the current Fair Market Value of the business organization?

\$

h. Indicate type of business organization:

Professional Corporation/Personal Service Partnership
 Commercial Business

i. Describe business valuation method in detail (separately provide all supporting schedules and information)

j. Business Financial

1. Total Assets	\$	Actual Year-To-Date	Actual Filed Last Calendar Year	Actual Filed Two Calendar Years Ago
2. Total Liabilities	\$			
3. Business Net Worth (1-2)	\$			
4. Gross Annual Sales	\$	\$	\$	\$
5. Net Profit After Taxes	\$	\$	\$	\$



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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 Insurance | Part 2 Non-Medical

I. Proposed Insured Information

a. Proposed Insured

First	Middle Initial	Last Name

b. Social Security Number

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

d. Name of your personal physician

If none, check here

Address of personal physician

(If mailing address is PO Box, include street address as well.)

Personal physician's
telephone number

City	State	ZIP

e. Date and reason last consulted?

f. What treatment or medication was given or recommended?

g. Height:

	feet	inches
--	------	--------

Weight:

	lbs.
--	------

h. Weight change past year:

Gain Loss _____ lbs. None

Reason for change:

(Please provide details in Remarks and Special Requests for any "Yes" answers.)

i. Have you ever had or been treated for cancer or tumor?

Yes No

j. In the last 10 years, have you had, been treated for or received a consultation or counseling for:

i. high blood pressure, chest pain or disorder of the heart or circulatory system?

Yes No

ii. diabetes or disorder of the glands, bone, blood or skin?

Yes No

iii. complications of pregnancy, infertility, or any disorder of the breasts, reproductive or genital organs, prostate, kidneys, or urinary systems?

Yes No

Application for Insurance | Part 2 Non-Medical *Continued*

- iv. hernia, hepatitis, or disorder of the liver, gall bladder, esophagus, stomach, pancreas, spleen, intestines, colon or rectum? Yes No
-
- v. arthritis, rheumatism, or disorder of the joints, limbs or muscles? Yes No
-
- vi. disorder or condition of the back, neck or spine? Yes No
-
- vii. allergy, asthma, sinusitis, emphysema, disorder of the lungs or respiratory system, or sleep apnea? Yes No
-
- viii. epilepsy, stroke, dizziness, headache, or disorder of the brain, or spinal cord? Yes No
-
- ix. disorder of the eyes, ears, nose or throat? Yes No
-
- x. anxiety, depression, nervousness, stress, mental or nervous disorder, or other emotional disorder? Yes No
-
- xi. Chronic Fatigue Syndrome, Fibromyalgia, Epstein Barr Virus or Lyme Disease? Yes No
-
- k. Do you have any loss of hearing or sight, an amputation of any kind, or any physical deformity, impairment or handicap? Yes No
-
- l. 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), or any deficiency of the immune system such as Human Immunodeficiency Virus? Yes No
-
- m. i. Are you currently taking prescribed medication? Yes No
-
- ii. Are you currently taking non-prescription medication? Yes No
-
- n. i. Have you ever used stimulants, hallucinogens, narcotics or any other controlled substance? (If yes, complete the Alcohol and Drug Usage Supplement.) Yes No
-
- ii. Have you ever had or been advised to have counseling or treatment for alcohol or drug use? (If yes, complete the Alcohol and Drug Usage Supplement.) Yes No
-
- o. Are you now pregnant? If yes, expected delivery date: Yes No
-
- p. Within the past five years, have you had a sickness or injury for which you have made a benefits claim or for which you will make a benefits claim? Yes No
-
- q. Within the past five years, have you had a physical exam or check-up of any kind? Yes No
-
- r. 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
-
- s. Within the past 12 months, have you had symptoms of any condition listed in this Section 1, except those conditions listed in question 1.I., for which you have not sought medical attention or advice? Yes No
-
- t. Other than as previously stated on this application, in the last five years have you received medical advice or counseling from physicians, medical or mental health professionals, counselors, psychotherapists, chiropractors, or other practitioners, or have you been a patient in a hospital, clinic, sanatorium, or other medical facility? Yes No
-
- u. Do you have a family history of: diabetes, cancer, high blood pressure, heart disease, mental illness or suicide? Yes No
-

	Age if Living	Cause of Death	Age at Death
FATHER			
MOTHER			
BROTHERS and SISTERS			
No. Living _____			
No. Dead _____			

2. Remarks and Special Requests

DETAILS OF "YES" ANSWERS. IDENTIFY QUESTION & NUMBER.

Give 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, practitioners or hospitals. Additional paper may be attached if necessary to explain details.

I understand and agree that the statements and answers in this Application for Insurance (Part 2 Non-Medical) are written as made by me; to the best of my knowledge and belief are full, complete and true; and that they shall be a part of the contract of insurance, if issued.

Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

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

Witness

Signature of Proposed Insured



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

AGENCY USE ONLY	
New Application	<input type="checkbox"/>
Bank Change	<input type="checkbox"/>
Agency Code:	_____

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

In this Request for G-O-M Arrangement form, the "Company" is the insurer checked above

See next page for VUL instructions.

IMPORTANT: A voided blank check or photocopy (starter checks are not acceptable) is required for checking accounts or a deposit slip for a savings account. See next page for general Guard-O-Matic information.

Guardian and/or GIAC and/or Berkshire is requested and authorized to debit your financial institution or to initiate electronic funds transfer on or about the 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).

I understand that:

- 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. If dividends are currently being used to reduce premiums, then once this authorization is approved, dividends for life insurance policies will be used to purchase paid-up additional insurance, and dividends for term insurance policies and annuities will be left with us to accumulate at interest.
- 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.
- If the Loan Payment Arrangement is cancelled, any outstanding loans will remain unpaid.
- 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.

_____ and (1) _____ (2) _____	
Signature of Policyowner	Signature of Bank Depositor (if other than policyowner)
Type of account: Checking <input type="checkbox"/> Savings <input type="checkbox"/>	Begin deductions effective _____ (Month) _____ (Year)
Financial Institution: _____	Street Address: _____
City: _____ State: _____ Zip: _____	Transit/ABA Number: _____
Account Number: _____	Name of Bank Depositor: _____
Guard-O-Matic Premium Arrangement (Deductions to occur on or about the 15 th of each month.)	Guard-O-Matic Loan Payment Arrangement (Deductions to occur on the 1 st business day or 15 th of each month as described above.) (available for Individual Life Products only)
List Policy Number(s)	List Policy Number(s) Amount to be Deducted
_____	_____
_____	_____
_____	_____

For Home Office Use Only, Control No.:

Authorization to Honor Checks or Account Debits Drawn by:	
<i>The Guardian Life Insurance Company of America (Guardian) and/or The Guardian Insurance & Annuity Company, Inc. (GIAC) and/or Berkshire Life Insurance Company of America (Berkshire)</i>	
Name of Bank Depositor _____	Account Number _____
Financial Institution _____	Bank Address _____
<p><i>As a convenience to me, 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 Guardian/GIAC/Berkshire 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></p> <p>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.</p>	
_____ Date	_____ Signature of Depositor
_____ Additional Signature (if Joint Account)	



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 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.

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 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.

- 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

**Special Instructions for Medical Professional
When Drawing Blood for Company 's Proposed Insured**

1. If the state of residence of the Company's Proposed Insured is New Jersey, have the Proposed Insured read and complete the consent form before drawing the blood.
2. Retain 1 copy for your records.
3. Forward 1 copy to the lab along with the blood drawn.
4. Forward 2 copies to the Company's agency along with the exam performed.
5. Deliver original to the Proposed Insured.

- The Guardian Life Insurance Company of America**
- Berkshire Life Insurance Company of America**
700 South Street
Pittsfield, MA 01201

HIV ANTIBODY TESTING CONSENT

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

Type of Policy Applied For: _____

Insurer (Company) Address:
700 South Street
Pittsfield Massachusetts 01201

Examiner: _____

The Tests

To evaluate your eligibility for insurance or insurance benefits, it is requested that you provide a sample of your blood for testing and analysis. One of the tests to be performed on this sample may 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 medically accepted procedure which is extremely reliable. The testing will be performed by a licensed laboratory.

Disclosure of Test Results

All test results will be treated confidentially. The results of the test will be reported to the insurer named above (Company). The results also may be reported to its affiliates, reinsurers, or contractors in connection with insurance you have or have applied for. Along with the insurer these organizations may also have access to your insurance file. In addition, if your HIV antibody test is abnormal (positive), a generic code signifying a non-specific blood 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.

In addition, New Jersey law requires that laboratories must report in writing to the New Jersey Department of Health any results of infection with HIV. The laboratory must report any identifying information it may have with regard to you if your HIV antibody test is abnormal.

Meaning of Test Results

While positive HIV antibody test results do not mean that you have AIDS, they do mean that you are at seriously 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. If your blood is tested for HIV antibodies and if your test results are positive, the Insurer will contact you for the name of a physician or other health care provider to whom you may authorize disclosure and with whom you may want to discuss the results. Positive HIV antibody test results will adversely affect your insurance application.

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, the testing of my blood for HIV antibodies, and the disclosure of the test results as described above.

Name of Proposed Insured (Please Print)

Date of Birth

Signature of Proposed Insured

Date

State of Residence

- 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 the event my application for insurance is not approved or if my policy is issued at a rate or with benefits other than as applied for, 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.**

REDISCLASURE 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.

REVOCAION 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**
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.")

Catastrophic Disability Benefit Rider Supplement to Application

This Supplement is attached to and made part of the policy.

Name of Proposed Insured: _____ Date of Birth: _____

- | | Yes | No |
|---|--------------------------|--------------------------|
| 1. Have you ever had an injury or sickness which caused a loss of: sight in both eyes, hearing in both ears, speech, or the use of two arms or two legs? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Do you need human assistance of any kind to perform every day activities such as bathing, continence, dressing, eating, using the toilet or transferring (for example, from the chair to your bed)?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Do you use any special medical equipment or appliances such as a wheelchair, pacemaker, oxygen tank, cane, catheter, or artificial limb? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Have you ever received treatment, attention or advice for memory loss or confusion, Alzheimer's disease, stroke, senility, dementia, loss of speech or comprehension of spoken language? | <input type="checkbox"/> | <input type="checkbox"/> |

Please provide details below for any "Yes" answers to Questions 1 – 4:

Remarks: _____

Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

I declare that my statements and answers are correctly recorded, complete and true to the best of my knowledge and belief. I am aware that these statements and answers will become part of my application to the Company.

Date Signed

Signature of Proposed Insured

Witness