



- 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:

Application for Insurance Part 1 – pages 1-8

Complete Sections 1-8 in all cases. Do you have the correct state forms (must be where the applicant lives or works)?

Supplements to the Application for Insurance

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

- Individual Disability Insurance (TDI) – 1 page
- 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

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

*Be sure to complete the proper RPP Assignment form and submit with the application.

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.

Notice of Insurance Information Practices

Please provide this form to the applicant.

Authorization to Obtain/Release Information

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

Producer's Certification

Agent must be licensed and appointed where application was signed.

If part of an association, include the endorsing agent.

Authorization for Disclosure of Protected Health Information (AA1542)

Recommend your client complete this form as it provides underwriting the authority to discuss details of the case with the 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 except in California).

TeleMed

Complete and submit the TeleMed Request form to the vendor.

Indicate TeleMed on the New Business 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

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

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

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

Conditional Receipt

Obtain appropriate signatures, submit one copy with the application.

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.

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 (R223).

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

New Business Transmittal (AA1732)

Submit a transmittal to specify instructions for processing the application.

If you are or recently have submitted a life insurance application with Guardian, please be sure to notify us of this Combo Case status on the New Business Transmittal.

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.



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Application for Insurance | Part I

Please indicate all insurance applied for with this Part 1 Application and include the appropriate application supplement for each product selected to right.

- Individual Disability Insurance
- Individual Disability Insurance – Retirement Protection Plus Program
- Overhead Expense Disability Buy-Out
- Business Reducing Term/PayGuard

I. Proposed Insured Information

a. Proposed Insured

First Middle Initial Last Name

Suffix Previous Last Name

b. Gender

Male Female

c. Social Security Number

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

e. Place of Birth

f. Are you a U.S. citizen?

Yes No (If no, answer the following questions)

Visa Type Visa Duration

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

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

Do you expect to remain in the U.S. permanently?

Yes No If no, include details:

When do you expect to obtain U.S. citizenship or permanent residency?

g. Home Address

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

City State ZIP

h. How long at this address?

i. Telephone Number

Home Phone Number Cell Phone Number

j. E-mail Address

k. If less than 2 years at current address, please furnish previous address:

Address

City State ZIP

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. _____

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 supervise any employees? Yes No If yes, how many? _____
- j. Are you a business owner? Yes No
- k. What percentage of the business do you own? _____ %
- l. What type of business do you own? Sole Proprietorship Partnership "S" Corporation
 Limited Liability Company (LLC) "C" Corporation
 Limited Liability Partnership (LLP)
 Other: _____
- m. Do you plan to change any occupation or employment within the next six months? Yes No If yes, provide details: _____

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

4. The Following Questions Apply to the Proposed Insured

(Please provide details in Section 8 Remarks and Special Requests to all "Yes" answers.)

- a. Do you plan 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.) _____
- b. Do you drive a motor vehicle? _____ Driver's License State _____ Driver's License # _____ Yes No
- c. Within the past five years, have you been convicted of any motor vehicle moving violations or had your driver's license suspended or revoked? (If yes, details must include date of violation, description of violation and penalty.) Yes No
- d. Within the last 10 years, have you been convicted of a felony? Yes No
- e. Have you ever had a professional license suspended or revoked, or is such license under review, or have you ever been disbarred? Yes No

Application for Insurance | Part I | Continued

- f. Within the last three years, have you participated in any of the following, or do you plan in the future to participate in any of the following: piloting any type of aircraft; mountain climbing or rock climbing; scuba diving; hang gliding; parachuting or skydiving; motor vehicle racing; or other hazardous activity? (If yes to any, complete Aviation and/or Avocation Supplement.) Yes No
-
- g. Within the past five years, have you had disability, accident, medical, life or health insurance declined, postponed, modified, rated, cancelled, rescinded, or have you withdrawn a pending application, or had a renewal or reinstatement refused? Yes No
-
- h. Have you used tobacco, nicotine, or any nicotine delivery system in any form in the last 12 months? (If you have quit, date last used: _____) Yes No
-
- i. Do you plan to apply for or are you currently applying for any other life, long-term care, disability or accident insurance? (In Section 8 Remarks and Special Requests, include amount applying for and company applying with, and whether this other insurance will be in addition to or in lieu of insurance with Berkshire or Guardian.) Yes No
-
- j. Are you currently a member of, or do you plan on joining, any branch of the United States Military, including the Army, Navy, Air Force, Marine Corps, Coast Guard, National Guard, or any reserve military unit? Yes No
-
- k. Are you currently employed by, or seeking employment with, any company or entity which provides military, paramilitary, or security services outside of the United States? Yes No
-
- l. Have you been alerted to, received orders for, or had any indication of an overseas assignment or active service with any branch of the United States Military, including the Army, Navy, Air Force, Marine Corps, Coast Guard, National Guard, or any reserve military unit? Yes No
-
- m. Have you ever had or been treated for cancer, heart attack, stroke, diabetes, or any disease of the liver, lungs, kidneys, or heart, or any disorder of the back or spine? Yes No
-
- n. Are you currently receiving any medical advice, counseling or treatment for any medical, surgical or psychiatric condition? Yes No
-

If questions 4m or 4n are left blank or answered "Yes," no prepayment should be taken and no Conditional Receipt issued.

5. 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

IDI = Individual
STD = Group STD
LTD = Group LTD
A = Association

Status

I = In Force
P = Pending
E = Eligible For

i. Company Name:			
ii. Type of Insurance:			
iii. Category:			
iv. Status:			
v. Date insurance applied for, issued, or eligible for (if known):			
vi. Policy Number (if known):			
vii. Benefit Amount:	\$	\$	\$
viii. Benefit Period:			
ix. Social Insurance Benefit:	\$	\$	\$
x. Automatic Increase Option:		%	%
xi. Future Increase Option (amount remaining):	\$	\$	\$
xii. Catastrophic Benefit:	\$	\$	\$
xiii. Retirement Benefit:	\$	\$	\$
xiv. 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
xv. 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?*	\$	\$	\$
Date for coverage to be replaced			

**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 the coverage. 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. Further, if the coverage is not terminated, the Company reserves all rights outlined in any policy issued.*

6. 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 Section 8 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.

	Column A Year-To-Date This Calendar Year	Column B Actual Filed Last Calendar Year	Column C 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, pension plans, 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

	Column A	Column B	Column C
If yes, indicate the unearned income amounts.	\$	\$	\$

Sources: _____

c. Retirement Contributions

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

	Column A	Column B	Column C
2. Total Annual Contribution (including your contribution and employer contributions)	\$	\$	\$

3. 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, itemize net worth below.
- Cash, Savings, Stocks, Bonds \$ _____
- Fair Market Value of your business (excluding good will) \$ _____
- Personal Property \$ _____
- Real Estate (excluding primary residence) \$ _____
- 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?* _____

7. 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. What percentage of premium 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 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? *Proof of membership may be required.* Yes No
 Association Name _____

8. 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.

9. Amendments or Corrections (For Home 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 5b 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. Changes or corrections made by the Company and noted in the "Amendments or Corrections" section are ratified by the owner upon acceptance of a policy containing this Application with the noted changes or corrections. In those states where written consent is required by statute or State Insurance Department regulation for amendments as to plan, amount, classification, age at issue, or benefits, such changes will be made only with the owner's written consent.
8. By paying premiums on a basis more frequently than annually, the total premium payable during one year's time will be greater than if the premium were paid annually. That is, the cost of paying annualized periodic premiums will be more than the cost of paying one annual premium.
9. If applying for Disability Buy-Out insurance, if no written buy-sell agreement is in place, one must be executed before a disability occurs that would qualify for benefits under the policy. Otherwise, the Company will have no liability other than to refund premiums. We will require a written assurance within one year of the policy date that an agreement is in place. If no assurance is received, the policy will be voided and the premiums refunded.

Any person who knowingly, and with intent to defraud any insurance company or other person, files an application of insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and may also be subject to civil or criminal prosecution in a court of competent jurisdiction for insurance fraud.

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.")

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 and may relate to the symptoms, evaluation, diagnosis, examination, treatment or prognosis of any mental or physical condition (except HIV), 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

Signature of Proposed Insured or Personal Representative

Personal Representative's Authority or Relationship to Proposed Insured

Witness Signature



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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.

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)

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Conditional Receipt for Disability Insurance

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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

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 Insurancea. **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 Future Increase Option

\$

 Social Insurance Substitute

\$

 Retirement Protection Plus*Monthly Indemnity*

\$

Elimination Period 180 days 360 days*Benefit Period*

To Age 65

 Other



- 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.")

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 primary care physician

If none, check here

Address of primary care physician

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

Primary care 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

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

Application for Insurance | Part 2 Non-Medical | Continued

- 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, muscle weakness, 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, Huntington's 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 _____			



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

<u>AGENCY USE ONLY</u>	
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:

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 Begin deductions effective _____ (Month) _____ (Year)

Financial Institution: _____

Street Address: _____ City: _____

State: _____ Zip: _____ Transit/ABA Number: _____

Account Number: _____ Name of Account Holder: _____

Guard-O-Matic Premium Arrangement.

List Policy Numbers	Insured's Name	Last 4 Digits of Policyowners's SS#
_____	_____	_____
_____	_____	_____
_____	_____	_____

Guard-O-Matic Loan Payment Arrangement.

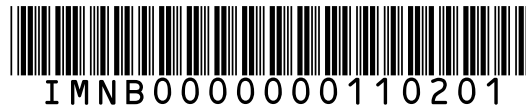
Life Policy Numbers	Amount to be Deducted	Life Policy Number	Amount to be Deducted
_____	_____	_____	_____
_____	_____	_____	_____

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 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 For Home Office Use Only, Control No.:



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 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 AND CONSENT FORM FOR AIDS VIRUS (HIV) ANTIBODY/ANTIGEN 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 or Other Bodily Fluid for Company's Proposed Insured

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

The Guardian Life Insurance Company of America

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

NOTICE AND CONSENT FORM FOR AIDS VIRUS (HIV) ANTIBODY/ANTIGEN TESTING

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

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Insurer: the "Company"

Examiner Name and Address: _____

Acquired Immunodeficiency Syndrome (AIDS) is a life-threatening disorder of the immune system. It is caused by a virus called Human Immunodeficiency Virus (HIV). The virus is spread by sexual contact with an infected person, by exposure to infected blood (as in needle sharing during intravenous drug use or, rarely, as a result of a blood transfusion), or from an infected mother to her newborn infant.

To determine your insurability, the insurer named above (the insurer) has requested that you provide a sample of your blood for testing and analysis. All tests will be performed by a licensed laboratory.

Unless precluded by law, tests will be performed to determine the presence of HIV antibodies or antigens. The HIV antibody test that we perform is actually a series of tests done by a medically accepted procedure. The HIV antigen test directly identifies AIDS viral particles. These tests are extremely reliable. Should you desire more information about the test of HIV infection before providing a blood sample, you may wish to consult with your physician or your local health department. If you are at high risk of HIV infection, you may want to be counseled and tested by your physician or at a free/low cost local test site. Your local health department can provide you with information as to the location of these sites.

All tests results will be treated confidentially. They will be reported by the laboratory to the insurer. When necessary for business reasons in connection with insurance you have or have applied for with the Insurer, the Insurer may disclose test results to others such as its affiliates, reinsurers, employees or contractors, but not to agents and brokers.

If the Insurer is a member of the Medical Information Bureau (MIB, Inc.), and if the test results for HIV antibodies/antigens are other than normal, the Insurer will report to the MIB, Inc. a generic code which signifies only a nonspecific blood test abnormality. If your HIV test is normal, no report will be made about it to the MIB, Inc.

The organizations described in the last two paragraphs may maintain the test results in a file or data bank. There will be no other disclosure of test results or even that the tests have been done except as may be required or permitted by law or as authorized by you.

If your HIV test results are normal, no routine notification will be sent to you. If the HIV test results are other than normal, the Insurer will contact you. The Insurer may ask you for the name of a physician or other health care provider to whom you may authorize disclosure and with whom you may wish to discuss the results.

Positive HIV antibody/antigen test results do not mean that you have AIDS, but that you are at significantly increased risk of developing AIDS or AIDS-related conditions. Federal authorities say that persons who are HIV antibody/antigen positive should be considered infected with the AIDS virus and capable of infecting others.

Positive HIV antibody or antigen test results or other significant blood abnormalities will adversely affect your application for insurance. This means that your application may be declined, that an increased premium may be charged, or that other policy changes may be necessary.

You are urged, at this time, to designate the physician or other health care provider to whom the HIV test results may be disclosed by the Insurer in the event the results are other than normal.

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

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

NOTICE AND CONSENT FORM FOR AIDS VIRUS (HIV) ANTIBODY/ANTIGEN 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

I authorize the disclosure of any HIV test results which are other than normal to the following physician or health care provider:

Name _____ Address _____

Zip Code _____

I have read and understand this Notice of Consent for AIDS Virus (HIV) Antibody/Antigen Testing. I voluntarily consent to the withdrawal of blood from me by needle, the testing of that blood, and the disclosure of the test results as described above.

I understand that I have the right to request and receive a copy of this authorization. A photocopy of this form will be as valid as the original.

Proposed Insured

Date of Birth

Signature of Proposed Insured or Parent/Guardian

State of Residence

Date

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

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

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

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

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

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

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

In 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 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.

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