☐ **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

Disability Insurance Application Instructions / Checklist

THIS APPLICATION PACKAGE INCLUDES:

Application for Disability Insurance – pages 1-7	Complete sections 1-12 in all cases (see instruction below for section 7). Do you have the correct state forms (must be where the applicant lives or works)?	☐
Product Supplements to the Application	When applying for Overhead Expense and Disability Buy Out, also complete the appropriate supplement to the application for insurance.	☐
	No supplement needed when applying for IDI, RPP* and reducing term.	☐
**Be sure to complete the proper RPP Assignment form and submit with the application.*		
Financial Information (section 5)	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.	☐
Health Information (section 7)	Completion of the Health Information of the Proposed Insured section 7 is recommended, but optional when a Berkshire or Guardian paramedical exam is completed. Section 7 must be completed to submit a prepayment.	☐
	If any part of questions 7f through 7i or 7u through 7x is answered "Yes", do not take a prepayment or issue a Conditional Receipt.	☐
Remarks & Special Requests (section 10)	Use this section to provide answer details when space is not sufficient. Identify each detail by question number. If additional space is needed, use the Supplement to the Application for Insurance (C-APP-SUPP).	☐
Representations of Proposed Insured and Owner (section 12)	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.	☐
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.	☐
Authorization for Disclosure of Protected Health Information (AA1542)	Discuss with your client completing this form. This form provides underwriting the authority to discuss details of the case with the agent.	☐
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.	☐
Producer's Certification	All commissioned agents must be licensed and appointed where application was signed and at the time it is signed.	☐
	Include the endorsing agent when submitting under an exclusive endorsed group (e.g. association, resident-student program).	☐
Medical Requirements	All medical requirements must be ordered through and received directly from our approved medical vendors (e.g. labs, paramedical exams, Attending Physician Statements (APS).)	☐
TeleMed	Complete and submit the TeleMed Request form to the vendor.	☐
	Indicate TeleMed on the New Business Transmittal	☐
	If not using TeleMed or if using TeleMed - Interview Only, you must order the necessary medical requirements.	☐
New Business Transmittal (AA1732)	Submit a transmittal to specify instructions for application processing.	☐
	If you are submitting or recently have submitted a life insurance application with Guardian, please notify us of this Combo Case status on the 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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(Please check appropriate company(ies). Any insurer checked above is herein referred to as the "Company.")

Application for Disability Insurance

I. Proposed Insured Information

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

b. Gender: ☐ Male ☐ Female

c. Social Security #: _____

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

_____

_____

How long at this address? _____

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

f. Place of Birth: _____

g. Telephone: Home _____

Cell _____

E-mail Address: _____

h. Are you a U.S. citizen ☐ Yes ☐ No

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

How long have you lived in the U.S. on a full-time basis? _____
(If residence has not been continuous, give dates, and explain in Remarks and Special Requests section 10)

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? _____

2. Business Information

a. Current Employer: _____

Number of years with current employer _____

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

_____

_____

c. Business Telephone: _____

Business Website: _____

d. Nature of Business: _____

e. Occupation: _____

Number of years in this occupation _____

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

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

3. Occupational Information

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

Description of Specific Duties	% of Time Devoted to Each Duty

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

_____

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

_____

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

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

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

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

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

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

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

4. Other Insurance Coverage of the Proposed Insured

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

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

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

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

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

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

5. Personal Financial Information of the Proposed Insured

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

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

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

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

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

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

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

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

6. Additional Information of the Proposed Insured

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

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

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

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

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

e. Indicate "yes" if any apply: 1) your professional license has ever been suspended or revoked; 2) there is a pending investigation or complaint concerning you with a regulatory, governmental, or other entity that oversees your profession; 3) you have ever been disbarred; or 4) you have ever been fined or sanctioned by an entity that oversees your profession. ☐ Yes ☐ No

f. Within the last three years, have you participated, or do you plan to participate in any of the following activities: piloting any type of aircraft; mountain or rock climbing; scuba diving; hang gliding; parachuting or skydiving; motor vehicle racing; 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 any application for insurance declined, postponed, modified, rated, cancelled, rescinded, or have you withdrawn a pending application, or had a renewal or reinstatement request refused? ☐ Yes ☐ No

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

i. Are you currently a member of, or do you 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

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

k. Have you been alerted to, 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

7. Health Information of the Proposed Insured

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

a. Name of your primary care physician: If none, check here ☐

Address of primary care physician (Street, City, State, Zip): _____

b. Date and reason last consulted? _____

c. What treatment or medication was given or recommended?

Primary care physician telephone: _____

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

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

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

f. 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 or Chronic Fatigue Syndrome? ☐ Yes ☐ No

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

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

i. Are you now pregnant? If yes, expected delivery date: _____ ☐ Yes ☐ No

j. Are you currently taking prescription medication, or have you been prescribed any medication within the last six months? ☐ Yes ☐ No

k. Have you ever had or been treated for cancer or tumor? ☐ Yes ☐ No

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

1. high blood pressure, chest pain or disorder of the heart or circulatory system? ☐ Yes ☐ No
2. diabetes or disorder of the glands, bone, blood or skin? ☐ Yes ☐ No
3. arthritis, rheumatism, or disorder of the joints, limbs or muscles? ☐ Yes ☐ No
4. disorder or condition of the back, neck or spine? ☐ Yes ☐ No
5. disorder of the eyes, ears, nose or throat? ☐ Yes ☐ No
6. hernia, hepatitis, or disorder of the liver, gall bladder, esophagus, stomach, pancreas, spleen, intestines, colon or rectum? ☐ Yes ☐ No
7. epilepsy, stroke, dizziness, headache, muscle weakness, or disorder of the brain or spinal cord? ☐ Yes ☐ No
8. allergy, asthma, sinusitis, emphysema, disorder of the lungs or respiratory system, or sleep apnea? ☐ Yes ☐ No
9. complications of pregnancy, infertility, or any disorder of the breasts, reproductive or genital organs, prostate, kidneys, or urinary systems? ☐ Yes ☐ No
10. anxiety, depression, nervousness, stress, mental or nervous disorder, or other emotional disorder? ☐ Yes ☐ No
11. Chronic Fatigue Syndrome, Fibromyalgia, Epstein Barr Virus or Lyme Disease? ☐ Yes ☐ No

m. Do you have any loss of hearing or sight, an amputation of any kind, or any physical deformity, impairment or handicap? ☐ Yes ☐ No

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

o. 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

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

q. 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

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

s. Within the past 12 months, have you had symptoms of any condition listed in this Section 7, except those conditions listed in question 7h, for which you have not sought medical attention or advice? ☐ Yes ☐ No

t. Do either of your parents have a history of: diabetes; cancer; high blood pressure; heart disease; Huntington's Disease or mental illness? ☐ Yes ☐ No

	Age if Living	Age at Death	Cause of Death
FATHER			
MOTHER			

8. Premium Information

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

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

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

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

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

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

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

9. Coverage Applied For

Indicate all insurance applied for with this application and specify coverage desired. Complete the appropriate product supplement for Overhead Expense, Disability Buy-Out and Income ProVider. Complete column A and question h when applying for ProVider Plus, and column B and questions i through m for Reducing Term.

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

Complete the Following When Applying for Disability Income

h. Supplemental Benefits – ProVider Plus

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

Complete the Following When Applying for Reducing Term Insurance

i. Loss Payee Name: _____

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

Loss Payee Tax ID #: _____

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

_____

_____

Owner Name: _____

Owner Tax ID #: _____

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

- ☐ Business Loan
- ☐ Purchase Agreement
- ☐ Employment Contract
- ☐ Student Loan – Have you deferred payments of this loan or do you intend to do so?
  - ☐ Yes ☐ No If yes, describe how long below.
  - *Details:* _____
- ☐ Other _____

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

l. Names of all debtors or guarantors:

_____

_____

_____

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

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

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

I am responsible for payments for a total of _____ months

10. Remarks and Special Requests

Provide 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. For additional space use the Supplement to the Application for Insurance (C-APP-SUPP).

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

12. Representations of the Proposed Insured and Owner

Those parties who sign below, agree that:

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

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

GUARDIAN®

Life Customer Service Office
3900 Burgess Place
Bethlehem, PA 18017

Disability Customer Service Office
700 South Street
Pittsfield, MA 01201

☐ **THE GUARDIAN LIFE INSURANCE COMPANY OF AMERICA**
☐ **THE GUARDIAN INSURANCE & ANNUITY COMPANY, INC.**
☐ **BERKSHIRE LIFE INSURANCE COMPANY OF AMERICA**
(Please check appropriate company(ies). Any insurer checked above is herein referred to as the "Company.")

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.

GUARDIAN℠

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

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

☐ **THE GUARDIAN LIFE INSURANCE COMPANY OF AMERICA**
☐ **THE GUARDIAN INSURANCE & ANNUITY COMPANY, INC.**
☐ **BERKSHIRE LIFE INSURANCE COMPANY OF AMERICA**
(Please check appropriate company(ies). Any insurer checked above is herein referred to as the "Company.")

Authorization to Obtain and Release Information

Name of Proposed Insured _____ Date of Birth _____

Address of Proposed Insured _____

This Authorization Is Designed To Comply With The HIPAA Privacy Rule

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

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

Medical Records and other information. I authorize any physician, medical or mental health professional, practitioner, hospital, clinic, other health facility, pharmacy, pharmacy benefit manager, consumer reporting agency, the Social Security Administration, MIB, Inc., insurance or reinsurance company, or employer or other organization, institution or person that has any records or knowledge of the Proposed Insured or his/her health to release any and all medical and non-medical information in its possession about the Proposed Insured, 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 the Proposed Insured. I understand that the information released could contain reference to may relate to the symptoms, evaluation, diagnosis, examination, treatment or prognosis of any mental or physical condition (except HIV), including psychiatric, and psychological conditions, 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 agree that if I sign this authorization electronically, that it will be equally as effective and valid as if I signed the form through traditional means. I understand, however, that I am under no obligation to sign this document electronically.

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

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

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

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

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

_____ _____
Signature of Proposed Insured or Parent/Legal Guardian — Witness Signature

*IMNB000000004

Producer's Certification (Complete in all cases.)

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

First Middle Initial Last Name

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

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

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

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

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

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

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

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

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

Remarks (and additional instructions)

7. Commissions

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

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

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

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

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

_____
State(s) Where Licensed

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

_____ Signed _____
Date Submitted (Agency Personnel)

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

Application for Disability Insurance –
Income ProVider Disability Insurance Supplement

I. Proposed Insured Information

a. Name (First, Middle Initial, Last)

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

2. Personal Disability Insurance

a. Case # _____

b. Supplemental Benefits

- ☐ Basic Residual Disability
- ☐ Enhanced Residual Disability
- ☐ Extended Own Occupation
- ☐ True Own Occupation
- ☐ Cost of Living Adjustment
  - ☐ 3% ☐ 6%
- ☐ 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

GUARDIAN®

Application for Disability Insurance –
Disability Buy-Out Insurance Supplement

1. Proposed Insured Information

a. Name (First, Middle Initial, Last)

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

2. Disability Buy-Out Insurance

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

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

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

d. Owner Information

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

Relationship to the Proposed Insured _____

Social Security #: _____

Tax ID #: _____

Address (Street, City, State, Zip):

_____

_____

Please complete the following if owner is a trust:

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

Complete Names of Trustees:

_____

_____

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

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

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

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

h. Business Financial Information

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

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

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

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

Conditional Receipt for Disability Insurance

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

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

If Question 7u, 7v, 7w or 7x is answered "Yes," no prepayment should be taken and no Conditional Receipt can be issued.

1. **Effective Date** – As used herein, "Effective Date" means the latest of (i) the date of the Application for Insurance, (ii) the date of the Representations to the Medical Examiner (or the date of the latest if more than one is required), (iii) the date of this receipt, (iv) the date of the latest completion of any medical examinations, tests, x-rays and electrocardiograms that the Company requires, or (v) the Policy Date, if any, requested in the Application.
2. **Conditions Under Which Insurance May Become Effective** – The insurance in the amount and for the policy applied for will, subject to the limitations in paragraph 4, become effective as of the Effective Date only if all of the following conditions are met:
   (a) an initial premium payment has been made as acknowledged below and honored on first presentation for payment. The check must be made payable to the Company (do not make check payable to the producer or leave payee blank);
   (b) on the Effective Date the proposed insured is, in the opinion of the Company authorized officers, insurable and an acceptable risk under the Company rules, limits and standards for the proposed insurance amount, policy, and benefits exactly as applied for without restriction or modification;
   (c) on the date of this receipt, all 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**

GUARDIAN®

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

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

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

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

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 1st (Guardian life policies only) or 15th of each month to pay premiums due and/or on the 1st business day of each month to pay the policy loan on the policy(ies) identified below (on or about the 15th of each month to pay the policy loan on Guardian policy(ies) administered by Berkshire).

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: _____

Account Number: | | | | | | | | | | | | | | | | | | | | | | | | |

Transit/ABA Number: | | | | | | | | | Name of Account Holder: _____

Guard-O-Matic Premium Arrangement.

List Policy Numbers	Draft Date Election Guardian life policies only	Insured Name	Last 4 digits of SS#	For Home Office Use Only – Control No:

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

IMNB000000110201

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

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

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

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

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

GUARD-O-MATIC General Information

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

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

INDEMNIFICATION AGREEMENT

TO: The Bank named on the previous page.

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

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

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

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

R223 (Rev. 7/12)

☐ **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."

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

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.**

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

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

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

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

_____
Applicant's Name (Please Print)

_____ _____
Applicant's Signature **Date**

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