Guardian®

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

APPLICATION FOR DISABILITY INSURANCE: PART I

SECTION 1: PROPOSED INSURED INFORMATION

A. First Name | Middle Initial | Last Name | Suffix

Previous Last Name (if applicable)

B. Gender: ☐ Male ☐ Female

C. Social Security Number:

D. 1. Residence Address:

Street

City | State | Zip Code

2. If less than two years, state prior address:

Street

City | State | Zip Code

E. Date of Birth (mm/dd/yyyy):

F. State, Country of Birth:

G. Phone:

H. Email Address:

SECTION 1: PROPOSED INSURED INFORMATION (CONTINUED)

I. **1.** Are you a U.S. citizen or green card holder? ☐ Yes ☐ No

If No, please answer the following:

2. Visa Type:

3. Visa Duration:

SECTION 2: BUSINESS INFORMATION

A. **1.** Current Employer:

2. Number of years with current employer:

3. If less than two years, state prior employer:

B. Business Address:

Street

City | State | Zip Code

C. Business Website:

D. Nature of Business or Industry:

E. How many people are employed by your business/organization?

F. **1.** Is this a home-based business? ☐ Yes ☐ No

2. If yes, what percentage of time do you spend working outside the home? %

SECTION 3: OCCUPATIONAL INFORMATION

A. Occupation:

B. Number of years working in this occupation:

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

D. 1. Job Title:

For Medical Occupations Only: Physicians, Fellows, Residents, and Students - Please list certification(s) or intended certification(s):

2. Medical Board Specialty Certification:

3. Medical Board Subspecialty Certification:

E. Academic degrees, professional licenses, and/or designations held (if none, so state):

F. 1. Are you any of the following?

☐ Student ☐ Resident ☐ Fellow ☐ None

2. If yes, what is your expected graduation date?

G. Describe the specific duties of your occupation, including but not limited to surgery, travel, sales, and supervisory duties. If the space provided is not adequate, provide additional details in Remarks & Special Requests Section 9.

Description of Specific Duties	% of Time Devoted to Each Duty

H. 1. Do you ever perform any manual duties such as operating machinery, carrying or lifting objects in excess of 30 lbs., climbing ladders, or driving a delivery vehicle? ..... ☐ Yes ☐ No

If yes, please provide details:

2. Do you ever wear any protective gear or attire? ..... ☐ Yes ☐ No

If yes, please provide details:

SECTION 3: OCCUPATIONAL INFORMATION (CONTINUED)

I. Have you been continuously at work full-time (at least 30 hours per week) performing the usual duties of your occupation for the past six months? ☐ Yes ☐ No

If no, explain in Remarks & Special Requests Section 9.

J. Do you supervise any employees? ☐ Yes ☐ No

If yes, how many? ☐

K. Employment Status?

☐ Employee (no ownership)

☐ Sole Proprietor or 1099 Employee

☐ Partner ☐ % of ownership

☐ S-Corp Shareholder ☐ % of ownership

☐ C-Corp Shareholder ☐ % of ownership

L. Do you currently plan to change your occupation, job, or employment within the next six months? ☐ Yes ☐ No

If yes, provide details:

M. Do you have any other part-time or full-time occupations, jobs, or employment? ☐ Yes ☐ No

If yes, provide details:

SECTION 4: OTHER INSURANCE COVERAGE

A. 1. Within the past six months, have you applied for life insurance through The Guardian Life Insurance Company of America ("Guardian") or any other company?..... ☐ Yes ☐ No

2. If yes, what company? _____

B. Do you have any disability insurance in force or applied for, or for which you are eligible within the next 12 months with any company, including Guardian or Berkshire Life Insurance Company of America ("Berkshire")?.... ☐ Yes ☐ No

If yes, list all coverages in the chart below.

Type: Individual (IDI); Long-Term Disability (LTD); Short-Term Disability (STD); Overhead Expense (OE); Disability Buy-Out (DBO); Retirement Protection (RP); if other, please specify.

Include all sources of insurance including Association, Employer, Group, Self-Purchased, etc.

		Column A	Column B	Column C	Column D
1.	Company Name				
2.	Type				
3.	Status (In-Force, Applied For, Eligible For)				
4.	Benefit Amount	$	$	$	$
5.	Benefit Period				
6.	Catastrophic Benefit	$	$	$	$
7.	Retirement Protection	$	$	$	$
8.	Employer-Paid*	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
9.	Is this coverage being replaced? If yes, date to be replaced	☐ Yes ☐ No Date: _____	☐ Yes ☐ No Date: _____	☐ Yes ☐ No Date: _____	☐ Yes ☐ No Date: _____
10.	Amount to be replaced	$	$	$	$

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

SECTION 5: PERSONAL FINANCIAL INFORMATION

For purposes of this section only, Earned Income means the income you are required to report to the Internal Revenue Service ("IRS") for income tax purposes. This includes W-2 wages, salary, bonuses, your share of net business income, and all other compensation you received for work or services. Explain in Remarks & Special Requests Section 9, any significant fluctuations between years.

A. Earned Income

1. Year-to-Date This Calendar Year: $

2. Actually Filed with the IRS Last Calendar Year: $

3. Actually Filed with the IRS Two Calendar Years Ago: $

B. What percentage of your Earned Income is commission-based? % (if none, enter 0)

C. Would you like to have contributions such as your 401(k) or 403(b) considered as part of your Earned Income?

☐ Yes ☐ No ☐ Not Applicable

If yes, complete question (D).

D. Total Annual Retirement Contributions:

Personal Contributions		**Employer Contributions**	
1. Year-To-Date This Calendar Year:	$	**4.** Year-To-Date This Calendar Year:	$
2. Last Calendar Year:	$	**5.** Last Calendar Year:	$
3. Two Calendar Years Ago:	$	**6.** Two Calendar Years Ago:	$

SECTION 6: ADDITIONAL INFORMATION

(Please provide details in Remarks & Special Requests Section 9 to all "Yes" answers)

A. Have you or a business you've owned ever filed, or plan to file, for bankruptcy? ☐ Yes ☐ No

If yes, Type: ☐ Personal ☐ Business Filing Date: Discharge Date:

B. Do you presently intend to reside or travel outside of the U.S. for any period(s) longer than 6 months? ☐ Yes ☐ No

C. Within the last five years, have you been convicted of any motor vehicle violation(s) or had your driver's license suspended or revoked? ☐ Yes ☐ No

D. Within the last 10 years, have you been convicted of a felony, or is such a charge pending against you? ☐ Yes ☐ No

E. Do any of the following apply? 1) Your professional or occupational license or certification has ever been suspended, revoked, restricted, inactivated, surrendered, or the like; 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. Have you participated within the last three years, or do you plan to participate in any activities such as: rock climbing; mountaineering; motor sports; parachuting; or underwater diving? ☐ Yes ☐ No
(If yes, complete the Avocation Supplement.)

SECTION 6: ADDITIONAL INFORMATION (CONTINUED)

(Please provide details in Remarks & Special Requests Section 9 to all "Yes" answers)

G. To the best of your knowledge and belief, have you used any tobacco or nicotine products and/or nicotine delivery systems in the last 12 months? ☐ Yes ☐ No

(If you no longer use any of the above, date last used: ☐)

H. Are you now, or do you within the next 5 years intend to become, a member of the U.S. Armed Forces; or have you received military orders or been placed on alert? ☐ Yes ☐ No

SECTION 7: 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 any part of the premium is paid by you, is it paid with: ☐ Pre-Tax dollars ☐ After-Tax dollars

D. Premium Mode: ☐ Annual ☐ Semi-annual ☐ Quarterly ☐ Monthly (available with Group Bill and Automatic Bank Draft only)

E. Billing Type: ☐ Paper Bill

☐ Automatic Bank Draft: ☐ New Service (Complete Request for Guard-O-Matic (GOM) Arrangement Form R223)

☐ Add to my existing Guardian or Berkshire services – GOM #: ☐

☐ Group Bill: ☐ Existing Group # ☐

☐ 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.*

☐ No money has been submitted with this application.

☐ $ ☐ has been submitted with this application.

SECTION 8: COVERAGE APPLIED FOR

Indicate all insurance applied for with this application and specify coverage desired. Complete the appropriate application supplement as noted below:

- ☐ Individual Disability (Including Retirement Protection) – Complete Individual Disability Insurance Supplement
- ☐ Overhead Expense (Including Business Loan Protection) – Complete Overhead Expense Insurance Supplement
- ☐ Disability Buy-Out – Complete Disability Buy-Out Insurance Supplement
- ☐ Reducing Term – Complete Reducing Term Insurance Supplement

SECTION 9: REMARKS & SPECIAL REQUESTS

Identify each detail by question number. For additional space use the Supplement to the Application for Insurance.

SECTION 10: AMENDMENTS OR CORRECTIONS (FOR HOME OFFICE USE ONLY)

SECTION 11: REPRESENTATIONS OF THE PROPOSED INSURED AND OWNER

Those parties who sign below, agree that:

1. This Application for Disability Insurance: Part I, Application for Insurance: Part II – Health and Medical History, any required Representations to the Medical Examiner, and any other supplements or amendments to this Application for Disability Insurance: Part 1 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 you have identified to be replaced in answer to Question 4B 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 provided 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 any monthly indemnity or benefit 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 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 written assurance within one year of the policy date that a written buy-sell agreement is in place. If no written 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 for 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Signed at City, State

Today's Date (mm/dd/yyyy)

Signature of Proposed Insured

Signature of Applicant/Owner if Other than Proposed Insured

Witness Signature

PRODUCER'S CERTIFICATION (COMPLETE IN ALL CASES)

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

First Name	Middle Initial	Last Name	Suffix

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

Program type:

☐ Student/Resident ☐ Association ☐ Qualified Sick Pay Program ☐ Voluntary Insurance Program

☐ Professional Group ☐ Group Conversion ☐ Executive Bonus (Sec. 162)

Program status: ☐ New ☐ Existing

If existing, provide program name and code: ____

4. Commissions:

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

Answer questions 5 through 7 for new policies and option exercises with additional benefits, enhancements to existing benefits, or shortening of the elimination period:

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

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

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

Remarks (and additional instructions):

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 for 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Signed at City, State

Today's Date (mm/dd/yyyy)

Type or Print Producer's Name

Signature of Soliciting Producer

State(s) Where Licensed

☐ **The Guardian Life Insurance Company of America**

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

NOTICE AND CONSENT FOR BLOOD TESTING
Which May Include 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 the Soliciting Agent and the Medical Professional When Drawing Blood for Company's Proposed Insured

Soliciting Agent

1. If the state residence of the Company's Proposed Insured is New York, have the Proposed Insured read and complete this consent form when completing the Application for Insurance.
2. Deliver original to the Proposed Insured.
3. Forward 1 copy to the Company (Agency of Record) with the completed Application for Insurance.
4. Forward 2 copies to the Medical Professional drawing the blood.

Medical Professional

1. Retain 1 copy for your records.
2. Forward 1 copy to the lab along with the blood drawn.

☐ **The Guardian Life Insurance Company of America**

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

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

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.

The consent you give by signing this form authorizes the Insurer to contract with a qualified medical professional to withdraw blood and order laboratory tests only in regard to your present application for insurance.

Unless precluded by law, tests may be performed to determine the presence of antibodies or antigens to the Human Immunodeficiency Virus (HIV), also known as the AIDS virus. 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. Other tests which may be performed include determinations of blood cholesterol and related lipids (fats) and screening for liver or kidney disorders, diabetes, and immune disorders.

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 involved solely in the underwriting process such as its affiliates, reinsurers, employees, or contractors. 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. Other test results may be reported to the MIB, Inc. in a more specific manner. The organizations described in this paragraph 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 also contact you if there are other abnormal test results which, in the Insurer's opinion are significant. The Insurer will 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. If your test is positive, you might consider further independent testing at your own expense.

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 may designate below the person(s) to whom test results can be disclosed in the event of an adverse underwriting decision.

The toll-free number for the New York Department of Health which may be called for further information about AIDS, the meaning of HIV-related test results, and the availability and location of HIV-related counseling services is: 1-800-541-2437.

I have read and I understand this Notice of Consent For Blood Testing Which May Include 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

Name and Address of Proposed Insured, Physician, or other individual authorized to receive test results:

_____

_____

_____

_____ _____ _____
Signature of Proposed Insured or Parent/Guardian Date State of Residence

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

Guardian®

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

APPLICATION FOR INDIVIDUAL DISABILITY INSURANCE – INDIVIDUAL DISABILITY INSURANCE SUPPLEMENT

If applying for an individual disability insurance policy, complete sections 1 and 2 only. If applying for a separate Retirement Protection Plus policy, complete sections 1 and 3 only.

SECTION 1: PROPOSED INSURED INFORMATION

A. First Name | Middle Initial | Last Name | Suffix

B. Date of Birth (mm/dd/yyyy): **C.** Occupation Class (if unsure, leave blank):

D. Is this part of an Approved Employee Multi-Life Program (Unisex Rates)? ☐ Yes ☐ No

E. GSI Case # (Fully Underwritten Buy-Ups Only):

SECTION 2: INDIVIDUAL DISABILITY INSURANCE

A. Monthly Benefit Amount: $

B. Elimination Period:

☐ 30 Days ☐ 60 Days ☐ 90 Days ☐ 180 Days ☐ 360 Days ☐ 720 Days

C. Benefits Selection:

Select options from a single column only.

	Essential Package	**Select Package**	**Premier Package**
1. Definition of Disability	Two-Year Modified Own Occupation (Any Occupation Thereafter)	Two-Year True Own Occupation (Modified Thereafter)	True Own Occupation
2. Premium Structure	Level	☐ Level ☐ Graded	☐ Level ☐ Graded
3. Benefit Period	☐ 2 Year ☐ 10 Year ☐ 5 Year ☐ To Age 65	☐ 2 Year ☐ To Age 65 ☐ 5 Year ☐ To Age 67 ☐ 10 Year ☐ To Age 70	☐ 2 Year ☐ To Age 65 ☐ 5 Year ☐ To Age 67 ☐ 10 Year ☐ To Age 70

SECTION 2: INDIVIDUAL DISABILITY INSURANCE (CONTINUED)

	Essential Package	Select Package	Premier Package
4. Increase Option	N/A	☐ Future Increase Option $ _____ ☐ Benefit Purchase Rider	☐ Future Increase Option $ _____ ☐ Benefit Purchase Rider
5. Automatic Benefit Enhancement (ABE)	N/A	☐ Automatic Benefit Enhancement (ABE)	☐ Automatic Benefit Enhancement (ABE)
6. Mental and/or Substance-Related Disorders Limitation	24 Month	☐ 24 Month ☐ Unlimited	☐ 24 Month ☐ Unlimited
7. Partial/Residual Disability	☐ Short-Term Residual	☐ Enhanced Partial ☐ Basic Partial	☐ Enhanced Partial ☐ Basic Partial
8. Cost of Living Adjustment (COLA)	N/A	☐ Four-Year Delayed ☐ 3% Compound ☐ 6% Maximum	☐ Four-Year Delayed ☐ 3% Compound ☐ 6% Maximum
9. Catastrophic Disability (CAT)	N/A	☐ Basic CAT Benefit Amount $ _____ ☐ Enhanced CAT Benefit Amount $ _____	☐ Basic CAT Benefit Amount $ _____ ☐ Enhanced CAT Benefit Amount $ _____
10. Extended Benefits	N/A	☐ Graded Lifetime Benefit for Total Disability ☐ Lump Sum Disability	☐ Graded Lifetime Benefit for Total Disability ☐ Lump Sum Disability
11. Retirement Protection	N/A	☐ Retirement Protection Plus Monthly Benefit $ _____ Elimination Period: ☐ 180 Days ☐ 360 Days	☐ Retirement Protection Plus Monthly Benefit $ _____ Elimination Period: ☐ 180 Days ☐ 360 Days

SECTION 2: INDIVIDUAL DISABILITY INSURANCE (CONTINUED)

	Essential Package	Select Package	Premier Package
12. Additional Benefits	☐ Social Insurance Substitute Benefit Amount $	☐ Social Insurance Substitute Benefit Amount $ ☐ Supplemental Benefit Term Rider Benefit Amount $ Elimination Period: ☐ 90 Days ☐ 180 Days Benefit Term: ☐ 10 Year ☐ 15 Year	☐ Social Insurance Substitute Benefit Amount $ ☐ Supplemental Benefit Term Rider Benefit Amount $ Elimination Period: ☐ 90 Days ☐ 180 Days Benefit Term: ☐ 10 Year ☐ 15 Year

SECTION 3: RETIREMENT PROTECTION PLUS – SEPARATE POLICY

A. Benefit Amount: $

B. Premium Structure: ☐ Level ☐ Graded

C. Elimination Period: ☐ 180 Days ☐ 360 Days

D. Supplemental Benefits:
You may only select one in each row.

1. Increase Option	☐ FIO: $
2. Cost of Living Adjustment (COLA)	☐ Four-Year Delayed ☐ 3% Compound ☐ 6% Maximum

Guardian®

Authorization to Obtain and Release Information

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

Customer Service Office
Mailing Address
P.O. Box 981590
El Paso, TX 79998-1590

Name of Proposed Insured _____

Date of Birth (mm/dd/yyyy) _____

This Authorization Is Designed to Comply with The Health Insurance Portability Act of 1996 as amended (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.

I hereby authorize the disclosure and/or release of all the information below to the Company (Company referred to herein includes The Guardian Life Insurance Company of America and/or The Guardian Insurance & Annuity Company, Inc., and/or Berkshire Life Insurance Company of America, and/or other subsidiaries and affiliates), its service providers, employees, or to its legal representatives.

Medical Records and other information. I authorize any physician, medical or mental health professional, practitioner, provider, hospital, clinic, other health or medical facility, laboratory, pharmacy, pharmacy benefit manager, therapist, health plan, benefit plan administrator, electronic health record provider, consumer reporting agency or other reporting agency, Governmental Agency, including the Veteran's Administration, the Social Security Administration, MIB, Inc., the Department of Motor Vehicles, state agency, insurance or reinsurance company (including the Company), or employer or other company, organization, institution or person that has any records or knowledge of the Proposed Insured and/or his/her health to disclose and/or release any and all medical and non-medical information, whether in paper or in electronic format, in its possession about the Proposed Insured. 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, diagnosis, or treatment of the Proposed Insured. Non-medical information includes information such as credit reports, consumer reports, employment, occupation, payment records, financial information or records, and/or publicly accessible sources. The information outlined above may be provided by those listed above and/or compiled and interpreted by third parties.

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

I acknowledge that any agreements I have made to restrict my health information do not apply to this Authorization and I instruct any physician, health care professional, provider, hospital, clinic, health or medical facility, other health care provider or health plan, insurer, or other entity to disclose my entire medical record without restriction. I understand that the information released could contain reference to or results of Human Immunodeficiency Virus (HIV) or Antibody (Acquired Immune Deficiency Syndrome (AIDS)), genetic testing, or genetic information and may relate to the symptoms, evaluation, diagnosis, examination, treatment or prognosis of any mental or physical condition, including psychiatric, and psychological conditions.

I agree that this Authorization shall be valid for twenty-four (24) months from the date shown below and that a copy of this Authorization shall be as valid as the original. I agree that if I sign this Authorization electronically, including via voice authorization, 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 Chief Underwriter at the address above. 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.

IMNB351800004010 2

I understand that the Company or its legal representatives will use the information obtained by this Authorization in connection with underwriting my application for insurance, to determine eligibility for insurance, to determine the premium for the insurance, to obtain reinsurance, to service any insurance issued, to administer coverage, to evaluate any claim for insurance benefits, to determine eligibility for benefits under an existing policy, and to conduct any other legally permissible activities that relate to any existing coverage, coverage that I have applied for, or may in the future apply for with the Company. In addition to the above, the Company or its legal representative may use the information to perform actuarial or research studies, analytics, review internal processes or experience. 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 issued. 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. Providers of health care services may not refuse to provide treatment or payment for health care services if I refuse to sign this Authorization. The Company or its legal representatives will not release any information obtained using this Authorization 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, agencies, companies or organizations performing business or legal services in connection with an application, claim, to perform actuarial or research studies perform analytics, or in evaluating our internal processes or experience 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). If I am applying for insurance and/or have existing coverage with the Company, information collected to determine eligibility for insurance and/or for benefits under an existing policy will be shared by the Company. I further understand that any policy issued will be delivered to the policy owner, which may be a party other than the Proposed Insured, and that this Authorization may become part of any policy issued.

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 MIB Pre-Notice, and Medical Records. I also acknowledge that I or an individual authorized to act on my behalf is entitled to receive an additional copy of this authorization. Any alteration of this Authorization will not be accepted.

Signed at _____ _____

City and State | Month/Day/Year

_____ _____

Signature of Proposed Insured (*or parent or guardian if Insured is under 18*) | Signature of Witness

Insurance Information Practices

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

Customer Service Office
Mailing Address
P.O. Box 26100
Lehigh Valley, PA 18002-6100

Thank you for your interest in insurance with our Company (Company referred to herein includes The Guardian Life Insurance Company of America and/or The Guardian Insurance & Annuity Company, Inc., and/or Berkshire Life Insurance Company of America). This brief description of our underwriting process is designed to help you understand how an application for insurance is handled, the types and sources of information we may collect, the circumstances under which we may disclose that information to others, and your right to learn the nature of that information upon written request. In order to underwrite your application for insurance, the Company or its affiliates to whom you are applying for insurance, will collect certain information it deems necessary to evaluate your application. Evaluating your eligibility for insurance is dependent on a number of factors such as your age, medical history, financial information, amount of coverage you are applying for, your occupation, your avocations and other personal information. In connection with this application, the Company may also review your credit report, or obtain or use a credit-based insurance score or other information that may be obtained using a third party.

This notice is given to you at the time you apply for 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 determine your eligibility for insurance or to service your claim for benefits under a policy. Your authorization will govern our requests for information and any later disclosure of that information. However, the information collected by the Company may in certain circumstances be disclosed to third parties without your specific authorization as permitted or required by law. 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 10 Hudson Yards, New York, NY 10001.

Fair Credit Reporting Act Pre-Notice

As part of underwriting your application, the Company may request investigative consumer report(s) from consumer reporting agency(ies). Such report(s) may include information about your character, general reputation, credit standing, credit worthiness, credit capacity, personal characteristics or mode of living, except as may be related directly or indirectly to your sexual orientation. It can be obtained through personal interviews with people who know you and/or through publicly available information. You may ask to be interviewed in connection with any report. Upon your written request, we will inform you if we have asked for an investigative consumer report. 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 and the nature and scope of the report. You can obtain a copy of a report by contacting the consumer reporting agency.

MIB Pre-Notice

MIB, Inc. is a not-for-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB Member company for life or disability insurance, or if a claim for benefits is submitted to such company, MIB, Inc., 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 MIB, Inc.

If you make a request of MIB, Inc., it will arrange to disclose the information it may have in your file. If you question the accuracy of the information in the its file, you may contact MIB, Inc. and seek to correct the information according to procedures set forth in the Federal Fair Credit Reporting Act. MIB, Inc.'s address is 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734 and its telephone number is 866-692-6901. Information for consumers about MIB, Inc. may be obtained on its website at www.mib.com.

Personal Information Telephone Interview

We may phone you to verify, acquire or supplement information you have given us on your application. The call will be made from our underwriting office, from a consumer reporting agency acting for us, or from a third party collecting the information on our behalf. You may be asked to provide a voice authorized signature during such interviews.

This notification must be given to the Proposed Insured.

Authorization for Disclosure of Protected Health Information

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

Customer Service Office
Mailing Address
P.O. Box 26100
Lehigh Valley, PA 18002-6100

"I," "me," "my" means the Proposed Insured signing this Authorization.

This Authorization is at the request of the Proposed Insured whose name appears below.

In order to allow my insurance representative to communicate with the Company (Company referred to herein includes The Guardian Life Insurance Company of America and/or The Guardian Insurance & Annuity Company, Inc., and/or Berkshire Life Insurance Company of America) and me about any medical, psychological or psychiatric or other health care information concerning my application for insurance coverage, reinstatement, or other insurance transaction, I authorize the Company to disclose the specific reasons for the underwriting decision to my insurance representative and/or to their delegate . 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.**

REVOCATION OF AUTHORIZATION

I know that I may revoke this Authorization in writing, at any time, by sending a written request for revocation to the Chief Underwriter at the address above. 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.

EXPIRATION OF AUTHORIZATION

This Authorization will be valid for twenty-four (24) months from the date of my signature below. However, this time limit may be shorter if the time period permitted by applicable law in the state where the policy is delivered or issued for delivery is less.

I agree that a copy of this Authorization shall be as valid as the original. I agree that if I sign this Authorization electronically, including via voice authorization, 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.

_____
Proposed Insured's Name (Please Print)

_____ _____
Proposed Insured's Signature Date
(or parent or guardian if insured is under 18)

Guardian®

Notice of Producer Compensation

This notice is required by the New York State Department of Financial Services

Guardian Financial Representatives, Sales Managers, Disability Income Specialists, Long Term Care Specialists, Investment Specialists, Sales Representatives, Special Agents, Wholesalers, Brokers, Full Time Agents, Financial Professionals, and General Agents, sometimes referred to as "Producers", are committed to working with clients to help them achieve personal, family and business goals. Your Producer has also been appointed by The Guardian Life Insurance Company of America, and some or all of its subsidiaries (collectively, Guardian), to offer its products to you.

As you consider this important purchase, there are a few things you should know:

- Insurance producers are authorized by their license to confer with insurance purchasers about the benefits, terms and conditions of insurance contracts; to offer advice concerning the substantive benefits of particular insurance contracts; to sell insurance; and to obtain insurance for purchasers. The role of the producer in any particular transaction typically involves one or more of these activities.
- Should you choose to purchase this policy/contract, your Producer, will receive compensation from Guardian. Compensation for individual life insurance and annuity sales are strictly limited by New York State law.
- Further, compensation for group contracts is subject to the amounts on file with the New York State Department of Financial Services.
- Pursuant to New York State law, your Producer is prohibited from rebating any of his/her compensation to you.
- The compensation your Producer will receive on this policy/contract may depend on several factors, including:
    - the premium or deposit amount of the policy/contract
    - the policy or contract type you purchase
    - persistency (i.e. the percentage of all life insurance policies sold by your Producer that are in force year after year)
    - the tenure of your Producer with Guardian
    - the volume of sales (limited to sales of individual disability insurance)

After reading this, if you wish, you may request more detailed information about your Producer's compensation. You may also request and will receive information regarding your Producer's compensation for any other product that your Producer presented.

Thank you for considering this purchase. Kindly indicate your receipt and acknowledgment of this notice by signing below:

Signature of Policy or Contract Owner	Signature of additional Policy or Contract Owner
Printed Name	Printed Name
Date	Date

☐ NMI ☐ RMI

A Resource for Clients

Guardian®

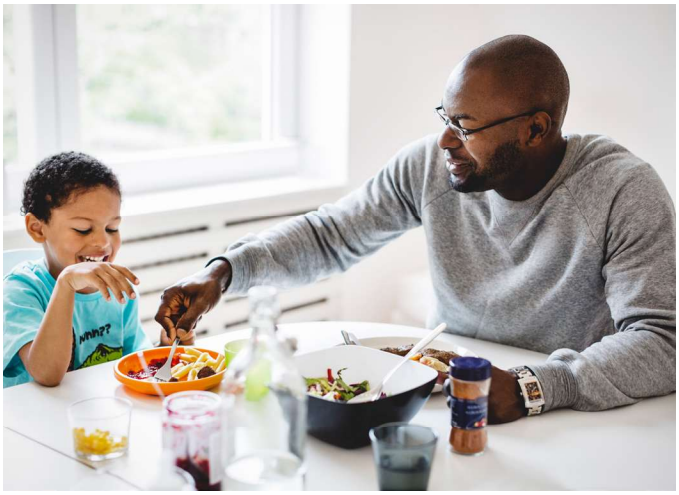
How It Works

The Automatic Benefit Enhancement (ABE) Rider

What is the Automatic Benefit Enhancement rider?

The Automatic Benefit Enhancement Rider ("ABE") is a unique feature that provides automatic 4% compound increases to your policy's monthly benefit. Increases occur each year for up to six years despite any changes in health, income or occupation.

You do not apply for the ABE rider; rather, your eligibility will be determined by us at the time of underwriting. There is no additional premium for this rider. Each annual benefit increase will include a corresponding attained age premium increase, if you accept. Should you decline two consecutive increases, no future offers will be made and the rider will terminate. Additional terms and conditions apply.



The Guardian Life Insurance Company of America

guardianlife.com

New York, NY

Pub8776BL (11/20)
2020-112023 (Exp. 11/22)ABE-APPL

Guardian

Conditional Receipt for Individual Disability Insurance

The insurer identified below will be herein referred to as the "Company."

Mailing Address
700 South Street
Pittsfield, MA 01201

BERKSHIRE LIFE INSURANCE COMPANY OF AMERICA

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

This Conditional Receipt for Individual Disability Insurance ("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 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.

1. **Effective Date** – As used herein, "Effective Date" means the latest of (i) the date of the Application for Individual Disability Insurance: Part I, (ii) Application for Insurance: Part II – Health and Medical History, (iii) the date of the Medical Supplement for Individual Life and Disability Insurance – Part II (or the date of the latest if more than one is required), (iv) the date of this Receipt, (v) the date of the latest completion of any medical examinations, tests, x-rays and electrocardiograms that the Company requires, or (vi) 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 line blank);
   - **B.** on the Effective Date the Proposed Insured is, in the opinion of the Company, 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 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 continue to remain the same as described in the Application for Individual Disability Insurance: Part I, Application for Insurance: Part II - Health and Medical History and the Medical Supplement for Individual Life and Disability Insurance – Part II.

One Copy to Applicant – One Copy to Company

DI-CR-2020 NY

4. **Maximum Limits** – If the disability of the Proposed Insured occurs prior to the Company's approval of the Application, and the Proposed Insured satisfies the conditions set forth in paragraph 2, the Company's liability shall not be greater than the total amount of insurance (for the policy applied for) set forth in the schedule below. This amount shall be inclusive of all of the disability insurance on the Proposed Insured under this Receipt pending and disability insurance in force with the Company.

Age*	Disability Income Limits	Disability Buy-Out Limits	Disability Overhead Expense Limits	Disability Income Term Limits
Under 56	$5,000/mo.	$500,000	$5,000/mo.	$5,000/mo.
56 – 60	$4,000/mo.	$400,000	$4,000/mo.	$4,000/mo.
61 – 64	$0	**	$0	$0

*Age means age of Proposed Insured at birthday nearest date of Receipt.

** Product not available.

5. **Acknowledgment of Payment** – We have received from _____ (Applicant) on behalf of _____ (Proposed Insured) in accordance with the Application(s) for insurance:

   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;

   D. the sum of $ _____ to pay all or part of the first premium for the proposed disability income term policy.

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 or 3 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.

Signatures

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 the Application for Individual Disability Insurance: Part I, the Application for Insurance: Part II – Health and Medical History, or the Medical Supplement for Individual Life and Disability Insurance – Part II, then I am waiving some of my 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 Individual Disability Insurance: Part I, the Application for Insurance: Part II – Health and Medical History, or the Medical Supplement for Individual Life and Disability Insurance – Part II, or any supplemental form that becomes part of any policy issued.

_____ _____

Signature of Applicant(s) Today's Date (mm/dd/yyyy)

_____ _____

Signature of Producer Today's Date (mm/dd/yyyy)

One Copy to Applicant – One Copy to Company

Agreement to Conduct Business Electronically

The Guardian Life Insurance Company of America and its affiliated entities, including, The Guardian Insurance & Annuity Company, Inc., Berkshire Life Insurance Company of America and Park Avenue Securities LLC (together referenced as "Guardian") are required to provide you with disclosures and other information when you (i) access and/or log in to a Guardian website; (ii) proceed with an electronic process in connection with an application for life insurance or disability insurance; (iii) accept delivery of an approved life insurance or disability insurance policy; and/or (iv) receive information and/or request specific transactions electronically regarding your policy, contract or account (as applicable). We can only provide these disclosures and other information electronically with your consent. You are not required to conduct business electronically.

1. **Definitions**

The “Agreement” refers to this Agreement to Conduct Business Electronically. “You” and “your” refers to the individual, business or legal entity (i) accessing a Guardian website; (ii) proceeding with an electronic process in connection with an application for life or disability insurance; (iii) accepting delivery of an approved life or disability insurance policy; and/or (iv) receiving information and/or requesting specific transactions electronically regarding your policy, contract or account (as applicable).

2. **Consumer Consent**

With your consent, Guardian can deliver disclosures and information to you by: displaying or delivering the information electronically and requesting that you print or download the information and retain it for your records. Your consent also permits Guardian to use an electronic signature and electronic records in connection with the requested transaction.

By clicking "I Agree" or “I Accept”, you affirmatively consent and agree that:

- Guardian can provide all disclosures required by law and other information about your legal rights and duties electronically.
- Guardian may send the disclosures and other information to you electronically via email or via a Guardian portal.
- The use of a key pad, mouse or other device to click "I Agree" or “I Accept” constitutes your signature, acceptance and agreement as if actually signed by you in writing and has the same force and effect as a signature affixed by hand. You agree that the lack of a certification, authority or other third-party verification will not in any way effect the validity or enforceability of your signature.
- By logging in, entering a Guardian website and making a request, or otherwise following a procedure to verify your identity and intent to make a request, you are applying your electronic signature to your request. In addition to making disclosures and information available to you electronically, your electronic signature applies to all requests and transactions you make electronically on the website.

3. **Withdrawal of Consent to Use Electronic Records**

If you decide that you no longer wish to use electronic records or proceed with an electronic process for the purposes described herein, you must notify Guardian that you are withdrawing your consent to use electronic records or proceed with an electronic process. You may withdraw that consent at any time. If you withdraw your consent, Guardian will not be able to continue processing any transactions you have requested electronically but may continue processing any requested transactions through non-electronic means. The provisions of the Agreement will remain in full force and effect until terminated in accordance with the provisions hereof.

4. **Procedure to Update Information Required to Contact You Electronically**

If you consent to use electronic records or proceed with an electronic process and your e-mail address changes or there is some other change in the method by which Guardian can contact you electronically, you must update your Guardian records with your updated contact information.

5. How You Can Obtain a Paper Copy of Your Records

You have the right to receive disclosures and other information in paper form. You may request paper copies of any disclosure or other information by contacting Guardian at 1-888-Guardian (482-7342).

6. Hardware and Software Requirements

To access and retain information and electronic records from Guardian, you must:

1. Be able to view the disclosures and other information on your monitor and save files to your computer or send screen prints to your printer, which can be done with your browser.
2. Be able to receive email that contains hyperlinks to Websites in order for Guardian to provide information to you.
3. Have access to an Internet service using one of the following Web browsers as may be applicable to your circumstances:

Desktop Browsers, Minimum Version

- Internet Explorer, V.10
- Chrome, latest version
- Firefox, V.40
- Safari, V.8

Mobile and Tablet Browsers/Operating Systems, Minimum Version

- Chrome, V.67
- Firefox, V.56
- Safari, V.11.1
- iOS

If you are registering as a user and you do not have the required software and/or hardware, or if you do not wish to use electronic records and signatures for any other reason, DO NOT select "I Agree" or “I Accept” where shown on the screen and the registration process will be terminated.

7. Legal Effect

By consenting, you agree that electronic disclosures and information have the same meaning and effect as if Guardian provided paper disclosures to you. Disclosures and information are considered to be received by you within 24 hours of the time emailed or posted in a Guardian portal, unless you notify Guardian that the disclosure or information was not received.

8. General

Your consent does not mean that Guardian must provide the disclosures and information electronically. Guardian is still permitted, at its option and discretion, to deliver any and all disclosures and information on paper. Guardian may also require that certain communications from you be delivered to Guardian on paper at a specified address.

Guardian reserves the right to cancel its provision of disclosures and information electronically as described in this Agreement, change the terms of use of any service or send disclosures and information in paper form at any time. Guardian is responsible for sending the information and disclosures electronically but is not responsible for any delay or failure of your receipt.

Guardian may record certain data and metadata concerning any transaction performed on the site in order to process any transactions or requests, to maintain a history of the transactions performed using the site, to resolve disputes, and for other business, legal, or regulatory reasons and may retain such information for the period of time required by such business, legal or regulatory requirements. This data and metadata may include and is not limited to: IP

addresses; mouse clicks; scrolling; keystrokes; and other information indicating your experience in submitting or receiving information to Guardian, or requesting that Guardian take action in response to a request made by you.

PLEASE READ THIS AGREEMENT CAREFULLY BEFORE PROCEEDING. IF YOU DO NOT AGREE TO THE TERMS OF THIS AGREEMENT, PLEASE DO NOT PROCEED AND YOU SHOULD LEAVE THE SITE IMMEDIATELY.

9. Acceptance

By agreeing, you agree and affirm:

- That you have read this Agreement to Conduct Business Electronically and consent to the terms thereof.
- That you are authorized to give this consent, have access to the internet and are at least 18 years of age.
- That you understand that there are certain risks associated with the transmission of confidential information, electronic delivery notifications, and other communications through electronic delivery over the internet including but not limited to unauthorized access, system outages, delays and disruptions in telecommunications services and the internet.
- You understand and acknowledge that you are not required to consent to electronic delivery of disclosures and other information and that you can withdraw your consent at any time.
- You understand that you may request paper copies of any disclosure or other information by contacting Guardian at 1-888-Guardian (482-7342).

With my signature below, I confirm that I have read the Agreement to Conduct Business Electronically and consent to the terms thereof. I understand that I am not required to conduct business electronically and can opt out.

_____ _____

Signature Date

Guardian®

Medical Supplement for Individual Life And Disability Insurance - Part II

The insurer identified below will be herein referred to as the "Company."

THE GUARDIAN LIFE INSURANCE COMPANY OF AMERICA

Unless subsidiary checked below:

☐ THE GUARDIAN INSURANCE & ANNUITY COMPANY, INC.

☐ BERKSHIRE LIFE INSURANCE COMPANY OF AMERICA

Customer Service Office
Mailing Address
P.O. Box 26100
Lehigh Valley, PA 18002-6100

Health and Personal History of Proposed Insured

SECTION A: Proposed Insured Information

1. First Name _____ MI _____ Last Name _____

2. Date of Birth (mm/dd/yyyy) _____

SECTION B: Primary Doctor Information

Please provide information about the primary care doctor you last consulted within the past 5 years. If you have consulted more than one primary care doctor within the past 5 years, please provide complete details in the Additional Details section.

1. Primary Care Doctor _____

2. Street Address _____

City _____ State _____ Zip _____

3. Phone _____ **4.** Date Last Seen (mm/dd/yyyy) _____

5. Reason ☐ Routine Physical ☐ Check-up ☐ Other *If reason for visit is "Other," please explain.* _____

_____

6. What treatment or medication was given or recommended? _____

7. Was your primary care doctor the last physician seen? ☐ Yes ☐ No *If "No," please complete the following:*

a. Doctor Last Seen _____

b. Street Address _____

City _____ State _____ Zip _____

c. Phone _____ **d.** Date Last Seen (mm/dd/yyyy) _____

e. Reason _____

f. What treatment or medication was given or recommended? _____

SECTION C: Proposed Insured's Health/Medical History

If you answer "Yes" to any of the questions below, please provide details in the Additional Details section.

1. Height _____ ft _____ in **2.** Weight _____ lbs

3. Have you lost more than 10 lbs in the past year? ☐ Yes ☐ No *If "Yes," please provide the following information:*

a. Reason for change in weight: ☐ Diet ☐ Exercise ☐ Illness ☐ Pregnancy (women only)

☐ Other _____

b. How much weight have you lost in the past year? _____ lbs

4. In the past 10 years, to the best of your knowledge and belief have you been diagnosed with, treated for, tested positive for, been given medical advice by a member of the medical profession or received a consultation or counseling for:

a. any cancer or tumor? ☐ Yes ☐ No

b. high blood pressure, heart murmur, irregular heartbeat, palpitations, heart attack, coronary artery disease, chest pain, or any other disease or disorder of the heart, blood vessels or circulatory system? ☐ Yes ☐ No

c. high blood sugar, high cholesterol, diabetes, thyroid disorder or any disease or disorder of the blood (except HIV), skin, glands or endocrine system? ☐ Yes ☐ No

d. disease or disorder of the kidney, bladder or urinary systems (including blood or protein in the urine)? ☐ Yes ☐ No

e. any disease or disorder of the prostate, breasts, reproductive system (including infertility) or genital organs or complications of pregnancy? ☐ Yes ☐ No

f. Crohn's disease or colitis, blood in stool, hepatitis or any disease or disorder of the liver, colon, pancreas, spleen, stomach, intestines, esophagus, rectum, gall bladder or hernia, or surgery for weight loss? ☐ Yes ☐ No

g. arthritis, chronic pain, auto-immune or connective tissue disorder, multiple sclerosis, Parkinson's disease, tremor? ☐ Yes ☐ No

h. any disease, disorder or condition of the back, neck, spine/spinal cord, joints, limbs, or bones? ☐ Yes ☐ No

i. asthma, emphysema, chronic obstructive pulmonary disease, shortness of breath, disease or disorder of the lungs or respiratory system, allergies, or any sleep disorder including sleep apnea? ☐ Yes ☐ No

j. seizure disorder, stroke, transient ischemic attack (TIA), memory loss, Alzheimer's disease, dizziness, headache, or disease or disorder of the brain? ☐ Yes ☐ No

k. any disease or disorder of the eyes, vision, ears, hearing, nose or throat? ☐ Yes ☐ No

l. anxiety, depression, stress, attention deficit disorder (ADD), post-traumatic stress disorder (PTSD), or any other mental, nervous, eating or emotional disorder? ☐ Yes ☐ No

m. chronic fatigue syndrome, fibromyalgia, neuritis, neuralgia, narcolepsy, insomnia, restless leg syndrome, Epstein Barr virus, Lyme Disease, muscle weakness or any disease or disorder of the muscles, nerves or nervous system? ☐ Yes ☐ No

5. Have you had an amputation of any kind or any physical deformity, handicap or impairment that has been diagnosed by a member of the medical profession? ☐ Yes ☐ No

6. Within the past 10 years, have you received any speech, physical or occupational therapy? ☐ Yes ☐ No

SECTION C: Proposed Insured's Health/Medical History (continued)

7. Within the past 10 years, have you been diagnosed by or received treatment from a licensed member of the medical profession for:

(answer when applying for Life insurance) Acquired Immune Deficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV)? ☐ Yes ☐ No

(answer when applying for Disability insurance) Acquired Immune Deficiency Syndrome (AIDS) or any other immune disorder (other than HIV)? ☐ Yes ☐ No

8. Are you currently taking prescription medication or have been prescribed any medication within the past 6 months that was not already disclosed? ☐ Yes ☐ No

9. Are you currently taking non-prescription medication or supplements? ☐ Yes ☐ No

10. Describe your complete use of tobacco or tobacco products below. This includes, but is not limited to: cigarettes, cigars, pipes, chewing tobacco, snuff, hookah, nicotine gum, nicotine patch, and electronic delivery devices. *If additional space is needed, please provide in the Additional Details section.*

Type of Product	Quantity	Frequency	Date Last Used (mm/dd/yyyy)
Cigarettes		☐ Daily ☐ Weekly ☐ Monthly ☐ Yearly	
Cigars		☐ Daily ☐ Weekly ☐ Monthly ☐ Yearly	
Pipes		☐ Daily ☐ Weekly ☐ Monthly ☐ Yearly	
Chewing Tobacco		☐ Daily ☐ Weekly ☐ Monthly ☐ Yearly	
Other _____		☐ Daily ☐ Weekly ☐ Monthly ☐ Yearly	
☐ I have never used tobacco products.			

11. Describe your complete use of alcohol below. This includes, but is not limited to: beer, wine and liquor. *If additional space is needed, please provide in the Additional Details section.*

Note: Alcohol types and equivalent amounts: 1 Beer = 12 oz. 1 Wine = 4 oz. 1 Liquor = 1 oz.

Type of Product	Quantity	Frequency	Date Last Used (mm/dd/yyyy)
Beer		☐ Daily ☐ Weekly ☐ Monthly ☐ Yearly	
Wine		☐ Daily ☐ Weekly ☐ Monthly ☐ Yearly	
Liquor		☐ Daily ☐ Weekly ☐ Monthly ☐ Yearly	
Other_____		☐ Daily ☐ Weekly ☐ Monthly ☐ Yearly	
☐ I have never used alcohol.			

12. Describe your use of marijuana, in any form, in the last 5 years below. If you have not used marijuana in the last 5 years, check here ☐.

a. Purpose: ☐ Recreational/Social ☐ Medicinal *If purpose is medicinal, please provide the below information:*

i. Reason for Use: _____

ii. Prescribing Doctor's Name: _____

b. Date Last Used (mm/dd/yyyy): _____

c. Frequency: _____ times per: ☐ day ☐ week ☐ month ☐ year

13. **Age 15 and over:** In the past 10 years, have you used stimulants, cocaine, heroin, morphine, hallucinogens, methamphetamines, narcotics, opioids or any other controlled substance except as prescribed by a member of the medical profession? *If "Yes," complete the Alcohol and Drug Usage Supplement.* ☐ Yes ☐ No

SECTION C: Proposed Insured's Health/Medical History (continued)

14. **Age 15 and over:** In the past 10 years, have you had or been advised to have counseling or treatment for alcohol or drug use or been advised by a member of the medical profession to limit your use of alcohol or drugs? This includes both prescription and non-prescription drugs. *If "Yes," complete the Alcohol and Drug Usage Supplement.* ☐ Yes ☐ No

15. **Age 15 and over:** Are you now pregnant? *If "Yes," expected delivery date*: _____ ☐ Yes ☐ No

16. Are you currently receiving or within the last 5 years, have you had a sickness, injury or any other condition for which you received or applied for any disability benefits including worker's compensation, social security disability insurance or any other form of disability insurance? ☐ Yes ☐ No

17. Within the past 5 years, have you had a physical exam, check-up of any kind, or diagnostic tests performed that were not previously disclosed, except for HIV or AIDS tests? ☐ Yes ☐ No

18. Within the past 5 years, have you been advised by a member of the medical profession to have surgery or any diagnostic tests that were <u>not</u> performed, except for HIV or AIDS tests? ☐ Yes ☐ No

19. Do you have an appointment scheduled within the next 6 months to seek medical attention, excluding routine physicals? ☐ Yes ☐ No

20. Other than as previously stated on this application, are you currently or in the past 5 years have you received medical advice, counseling, or treatment for any medical, surgical, psychological, or psychiatric condition from a medical professional, or have you been a patient in a hospital, clinic, rehabilitation center, or other medical facility? ☐ Yes ☐ No

21. Age 6 and below and Life coverage only:

a. Was the Proposed Insured born prematurely (gestational age less than 37 weeks)? ☐ Yes ☐ No
If "Yes," provide gestational age: _____

b. Was the Proposed Insured's birth weight less than 5 pounds? ☐ Yes ☐ No

c. Has the Proposed Insured ever been evaluated, tested, treated for, or diagnosed with any growth or developmental delays or failure to thrive? ☐ Yes ☐ No

SECTION D: Family History

1. To the best of your knowledge, have any immediate family members (father, mother or sibling) died before age 60 from cardiovascular disease or cancer? ☐ Yes ☐ No

2. To the best of your knowledge, have any immediate family members (father, mother or sibling) been diagnosed before age 60 with cardiovascular disease or cancer? ☐ Yes ☐ No

3. Have any immediate family members been diagnosed or treated by a member of the medical profession for diabetes, mental illness, or a hereditary condition of the brain, muscles, nervous system, eyes or kidneys? ☐ Yes ☐ No

4. Complete the chart below for all immediate family members (father, mother or sibling). The Gender column only needs to be completed for siblings. *If additional space is needed, please provide in the Additional Details section.*

Family Member	Gender Male (M) or Female (F)	Age of Onset	Age if Living	Age at Death	Condition and/or Cause of Death (if applicable)
Father	NA				
Mother	NA				
Sibling	☐ M ☐ F				
Sibling	☐ M ☐ F				
Sibling	☐ M ☐ F				
Sibling	☐ M ☐ F				
Sibling	☐ M ☐ F				

SECTION E: Additional Details

Provide all details to any "Yes" answers, identifying each detail by question number. Include, if applicable, all dates, diagnoses, stage or severity of diagnoses, known symptoms, tests performed (except HIV), treatment (recommended or received), medications (types and amounts), surgeries, length of disability, days of work missed, job restrictions or modifications due to injury or sickness, physical limitations, and the names and addresses of all treatment providers including, but not limited to, physicians, medical or mental health professionals, counselors, psychotherapists, chiropractors, acupuncturists, practitioners, or hospitals, clinics or other medical or mental health facilities. For additional space use the Supplement to the Application for Insurance.

SECTION F: Signatures

I understand and agree that the statements and answers in this application: (1) are written as made by me; (2) to the best of my knowledge and belief are full, complete and true; and (3) shall be a part of the contract of insurance, if issued.

The following does not apply to life insurance: Any person who knowingly and with intent to defraud any insurance company or other person files an application for 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Signed at _____ _____

City and State | Month/Day/Year

_____ _____

Signature of Witness | Signature of Proposed Insured

Guardian®

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

☐ **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?	☐	☐
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)?	☐	☐
3.	Do you use any special medical equipment or appliances such as a wheelchair, pacemaker, oxygen tank, cane, catheter, or artificial limb?	☐	☐
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?	☐	☐

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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

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

Berkshire Life Insurance Company of America
700 South Street • Pittsfield, Massachusetts 01201
1-800-819-2468

DISABILITY INCOME PROTECTION COVERAGE
REQUIRED OUTLINE OF COVERAGE

Policy Form 18ID

1. READ THE POLICY CAREFULLY – This outline provides a very brief description of the Policy. This is not the insurance contract, and only the actual provisions will control. The Policy itself sets forth in detail the rights and obligations of both the Policyowner and the insurance company. It is, therefore, important that THE POLICY BE READ VERY CAREFULLY.

2. DISABILITY INCOME PROTECTION – Policies of this category are designed to provide, to persons insured, Coverage for Disabilities resulting from a covered Injury or Sickness, subject to any limitations set forth in the Policy. Coverage is not provided for basic hospital, basic medical-surgical, or major medical expenses.

3. BENEFITS OF THE POLICY – The Policy provides benefits for Total Disability.

   $_____ Monthly Benefit will be paid each month while You are Totally Disabled.

   Benefits start to accrue at the end of an Elimination Period of _____.

   The Benefit Period is _____.

   Total Disability Definition – The definition of Total Disability that applies to the Policy is checked below:

   ☐ Total Disability or Totally Disabled means that, solely due to Injury or Sickness, You are not able to perform the material and substantial duties of Your Occupation. You will be Totally Disabled even if You are Gainfully Employed in another occupation so long as, solely due to Injury or Sickness, You are not able to work in Your Occupation.

   If Your Occupation is limited to a Medical Doctor or Doctor of Osteopathy and more than 50% of Income is earned from Hands-on Patient Care, We will consider You to be Totally Disabled even if You are Gainfully Employed in Your practice or another occupation so long as, solely due to Injury or Sickness, You are not able to provide Hands-on Patient Care.

   Hands-on Patient Care means meeting with a patient in a clinical setting for the purposes of providing medical advice, evaluation, diagnosis, or treatment, that You regularly and personally provide, during the 12 months prior to Your Disability.

   If Your Occupation is limited to a Medical Doctor or Doctor of Osteopathy and more than 50% of Income is earned from performing Surgical Procedures, We will consider You to be Totally Disabled even if You are Gainfully Employed in Your practice or another occupation so long as, solely due to Injury or Sickness, You are not able to perform Surgical Procedures.

   Surgical Procedures means the medical interventions involving an incision with instruments performed by You in a clinical or hospital setting normally involving anesthesia and/or respiratory assistance, that You regularly perform, during the 12 months prior to Your Disability. These procedures can be performed on either an inpatient or outpatient basis. Providing hypodermic injections, in itself, is not a Surgical Procedure.

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

Working an average of more than 40 hours in a week, in itself, is not a material and substantial duty.

Your Occupation means the occupation (or occupations, if more than one) in which You are Gainfully Employed during the 12 months prior to the time You become Disabled. Your Occupation does not mean a specific job title, designation, industry, or job with a certain employer.

☐ Total Disability or Totally Disabled means that, solely due to Injury or Sickness, You are not able to perform the material and substantial duties of Your Occupation.

You will be Totally Disabled even if You are Gainfully Employed in another occupation so long as, solely due to Injury or Sickness, You are not able to work in Your Occupation.

Working an average of more than 40 hours in a week, in itself, is not a material and substantial duty.

Your Occupation means the occupation (or occupations, if more than one) in which You are Gainfully Employed during the 12 months prior to the time You become Disabled. Your Occupation does not mean a specific job title, designation, industry, or job with a certain employer.

If You have limited Your Occupation to the performance of the material and substantial duties of a single medical specialty or to a single dental specialty, We will deem that specialty to be Your Occupation.

☐ Total Disability or Totally Disabled means that, solely due to Injury or Sickness, You are not able to perform the material and substantial duties of Your Occupation.

You will be Totally Disabled even if You are Gainfully Employed in another occupation so long as, solely due to Injury or Sickness, You are not able to work in Your Occupation.

Working an average of more than 40 hours in a week, in itself, is not a material and substantial duty.

Your Occupation means the occupation (or occupations, if more than one) in which You are Gainfully Employed during the 12 months prior to the time You become Disabled. Your Occupation does not mean a specific job title, designation, industry, or job with a certain employer.

☐ Until We have paid benefits for two years in the same claim, Total Disability or Totally Disabled means that, solely due to Injury or Sickness, You are not able to perform the material and substantial duties of Your Occupation. You will be Totally Disabled even if You are Gainfully Employed in another occupation so long as, solely due to Injury or Sickness, You are not able to work in Your Occupation.

Thereafter, Total Disability or Totally Disabled means that, solely due to Injury or Sickness, You are not able to perform the material and substantial duties of Your Occupation and You are not Gainfully Employed.

Working an average of more than 40 hours in a week, in itself, is not a material and substantial duty.

Your Occupation means the occupation (or occupations, if more than one) in which You are Gainfully Employed during the 12 months prior to the time You become Disabled. Your Occupation does not mean a specific job title, designation, industry, or job with a certain employer.

☐ Until We have paid benefits for two years in the same claim, Total Disability or Totally Disabled means that, solely due to Injury or Sickness, You are not able to perform the material and substantial duties of Your Occupation and You are not Gainfully Employed.

Thereafter, Total Disability or Totally Disabled means that, solely due to Injury or Sickness, You are not able to perform the material and substantial duties of Any Occupation.

Working an average of more than 40 hours in a week, in itself, is not a material and substantial duty.

Any Occupation means any occupation for which You are or become reasonably suited by Your education, training or experience.

Your Occupation means the occupation (or occupations, if more than one) in which You are Gainfully Employed during the 12 months prior to the time You become Disabled. Your Occupation does not mean a specific job title, designation, industry, or job with a certain employer.

AUTOMATIC BENEFIT ENHANCEMENT RIDER AND/OR BENEFIT PURCHASE RIDER – There is no premium charge for the riders checked below.

☐ Automatic Benefit Enhancement Rider ABID – This rider provides for an Automatic Increase of 4% in the Monthly Benefit of the Policy on each of six consecutive Policy Anniversaries. This rider may be renewable at six-year intervals but not past Age 60.

This rider terminates when the first of the following occurs:

- We do not renew this rider; or
- You attain Age 60; or
- the date of refusal of a second consecutive Automatic Increase; or
- any date on which the Monthly Benefit equals or exceeds the maximum amount of allowable Monthly Benefit available based on Our underwriting guidelines in effect as of the Effective Date of the Policy or the last Rider Review Date, whichever is later; or
- a Rider Review Date if You are Disabled; or
- a Rider Review Date if the Policy is suspended for active military service or unemployment; or
- Our receipt of the Policyowner's written request to terminate this rider; or
- the Policy terminates.

☐ Benefit Purchase Rider BPID – This rider gives You the opportunity to apply for additional disability income insurance in future years despite any change in Your health. We will review Your eligibility for an Increase Policy on every third Policy Anniversary while this rider is in effect. An Increase Policy may also be applied for one time prior to a Review Date if You meet certain conditions.

Each Increase Policy applied for during a Benefit Purchase Period or as part of a Special Benefit Purchase Option Offer will be underwritten to determine the maximum amount of Monthly Benefit, if any, available to You. You do not have to provide evidence of Your medical insurability.

To keep this rider in effect, You must submit an application and other evidence of insurability during the Benefit Purchase Period.

This rider terminates when the first of the following occurs:

- an application for an Increase Policy and required evidence of insurability are not received during any Benefit Purchase Period; or
- less than 50% of Our offer for an Increase Policy is accepted; or
- the initial premium for any Increase Policy is not paid; or
- Our receipt of the Policyowner's written request to reduce the Monthly Benefit of the Policy to which this rider is attached; or
- Our receipt of the Policyowner's written request to terminate this rider; or
- You attain Age 55; or
- the Policy terminates.

OPTIONAL BENEFITS – The optional benefits applied for are checked below. There is a separate premium charge for each added benefit.

☐ Social Insurance Substitute Rider SIID – This rider provides a Social Insurance Substitute Benefit for Disability. The Social Insurance Substitute Benefit each month is equal to the Social Insurance Substitute Maximum Monthly Benefit if You receive no Legislated Benefits. If You receive any Legislated Benefits, the Social Insurance Substitute Benefit is zero.

Your Social Insurance Substitute Maximum Monthly Benefit is $_____per month.

This benefit will be added to the Monthly Benefit of the Policy in each month when such benefit is payable for Disability.

This rider may not be renewed after the Expiration Date.

☐ Two-Year Partial Disability Benefit Rider 2PID – This rider provides a benefit when You are Partially Disabled.

Partial Disability means that You are Gainfully Employed and are not Totally Disabled under the terms of the Policy but, solely due to Injury or Sickness, Your Loss of Income is at least 15% of Your Prior Income.

For each month of the first 12 months that You are eligible for a Partial Disability benefit in the same claim, the policy will pay an Enhanced Initial Monthly Benefit. If you continue to be Partially Disabled after the Enhanced Initial Monthly Benefit has been paid for 12 months, the policy pays a Monthly Partial Benefit.

Benefits for Partial Disability may be payable for up to 24 months in any one claim.

This rider may not be renewed after the Expiration Date.

☐ Enhanced Partial Disability Benefit Rider EPID – This rider provides a benefit when You are Partially Disabled.

Partial Disability means that You are Gainfully Employed and are not Totally Disabled under the terms of the Policy but, solely due to Injury or Sickness, Your Loss of Income is at least 15% of Your Prior Income.

For each month of the first 12 months that You are eligible for a Partial Disability benefit in the same claim, the policy will pay an Enhanced Initial Monthly Benefit. If you continue to be Partially Disabled after the Enhanced Initial Monthly Benefit has been paid for 12 months, the policy pays a Monthly Partial Benefit.

This rider may not be renewed after the Expiration Date.

☐ 3% Compound Cost Of Living Adjustment Rider 3CID – This rider provides, on the anniversary of a claim while benefits are payable, a 3% adjustment in Monthly Benefit that will be applicable to benefits paid for the next 12 months.

This rider may not be renewed after the Expiration Date.

☐ Future Increase Option Rider FOID – This rider provides the right to apply for additional disability insurance during an Option Period despite any change in Your health or occupation.

The Total Increase Option Amount is $_____.

Each Increase Policy applied for during an Option Period as a result of an Option Date, or a Special Option Date, will be underwritten to determine the maximum amount of Monthly Benefit available, if any. You must provide evidence of Your Income, employment and all other disability insurance with any insurer that is in force, which has been applied for, or for which You are eligible. We may require additional evidence of financial insurability. You do not have to provide evidence of Your medical insurability or occupation.

This rider terminates when the first of the following occurs:

- You attain Age 55; or
- the Total Increase Option Amount has been issued; or
- the premium for this rider remains unpaid for more than 31 days; or
- Our receipt of the Policyowner's written request to terminate this rider; or
- the Policy terminates.

☐ Short-Term Residual Disability Benefit Rider SRID – This rider provides one-half of the Monthly Benefit when You are Residually Disabled after a period of Total Disability. You must be Totally Disabled for the duration of the Elimination Period before You become Residually Disabled. The Monthly Residual Benefit of this rider is payable for up to six months in the same claim.

Residual Disability means that You are Gainfully Employed and You are not Totally Disabled under the terms of the Policy but, solely due to Injury or Sickness:

- You are unable to perform one or more of the material and substantial duties of Your Occupation; or
- You are unable to perform the material and substantial duties of Your Occupation for more than one-half of the time normally required.

This rider may not be renewed after the Expiration Date.

☐ Enhanced Catastrophic Disability Benefit Rider ECID – This rider provides a Catastrophic Disability Benefit if You are Catastrophically Disabled.

Catastrophically Disabled means that due to Injury or Sickness You are unable to perform two or more of the Activities of Daily Living without Human Standby Assistance, You are Cognitively Impaired or You are Irrecoverably Disabled. The Activities of Daily Living are Bathing, Dressing, Eating, Transferring, Toileting, and Continence.

$_____ Catastrophic Disability Benefit will be paid at the end of each month while You are Catastrophically Disabled.

Benefits start to accrue at the end of a Catastrophic Disability Elimination Period of _____.

The Catastrophic Disability Benefit Period is _____.

On the anniversary of a claim while the Catastrophic Disability Benefit is payable, We will adjust the Catastrophic Disability Benefit by 3% on a compound basis, not to exceed the Maximum Monthly Catastrophic Disability Benefit. Maximum Monthly Catastrophic Disability Benefit is equal to two times the Catastrophic Disability Benefit shown in the Schedule Page.

This rider may not be renewed after the Expiration Date.

☐ Basic Catastrophic Disability Benefit Rider BCID – This rider provides a Catastrophic Disability Benefit if You are Catastrophically Disabled.

Catastrophically Disabled means that due to Injury or Sickness You are Cognitively Impaired or You are Irrecoverably Disabled.

$_____ Catastrophic Disability Benefit will be paid at the end of each month while You are Catastrophically Disabled.

Benefits start to accrue at the end of a Catastrophic Disability Elimination Period of _____.

The Catastrophic Disability Benefit Period is _____.

This rider may not be renewed after the Expiration Date.

☐ 6% Maximum Cost Of Living Adjustment Rider 6CID – This rider provides, on the anniversary of a claim while benefits are payable, an adjustment in Monthly Benefit that will be applicable to benefits paid for the next 12 months. We will adjust Your Monthly Benefit based on changes in the Consumer Price Index for All Urban Consumers (CPI-U), but the adjustment to the Monthly Benefit will never be less than 3%, nor more than 6%.

This rider may not be renewed after the Expiration Date.

☐ Four-Year Delayed Cost Of Living Adjustment Rider 4CID – This rider provides, starting on the fourth anniversary of a claim while benefits are payable, a 3% adjustment in Monthly Benefit that will be applicable to benefits paid for the next 12 months.

This rider may not be renewed after the Expiration Date.

☐ Graded Lifetime Benefit for Total Disability Rider GLID – This rider provides lifetime benefits if You become Totally Disabled before Age 65 and remain continuously Totally Disabled in the same claim after the Expiration Date. The Lifetime Monthly Benefit Percentage is based on Your Age when the continuous Total Disability begins. The Lifetime Monthly Benefit Percentage decreases by 5% each year after Age 45.

This rider terminates when the first of the following occurs:

- You attain Age 65 and You are not Totally Disabled; or
- the premium for this rider remains unpaid for more than 31 days; or
- Our receipt of the Policyowner's written request to terminate this rider; or
- when the Lifetime Monthly Benefit is no longer payable; or
- the Policy terminates before the Expiration Date.

☐ Retirement Protection Plus (RPP) Disability Benefit Rider RPID – This rider provides an RPP Monthly Benefit payable to an irrevocable trust if You are Totally Disabled and not Gainfully Employed.

$_____ RPP Monthly Benefit will be paid at the end of each month while You are Totally Disabled and not Gainfully Employed.

Benefits start to accrue at the end of an RPP Elimination Period of _____.

The RPP Benefit Period is _____.

This rider terminates when the first of the following occurs:

- the RPP Expiration Date; or
- the premium for this rider remains unpaid for more than 31 days; or
- Our receipt of the Policyowner's written request to terminate this rider; or
- the Policy terminates.

☐ Lump Sum Disability Benefit Rider LSID – This rider provides a lump sum benefit at Age 60. The Lump Sum Benefit Amount will only be paid if the Policy and this rider are in force at Age 60, and if the sum of Contributing Payments is equal to or greater than the Qualifying Amount. The Lump Sum Benefit Amount is equal to the sum of Contributing Payments multiplied by 35%.

Contributing Payments are any Total Disability benefits, Residual Disability benefits, and Partial Disability benefits paid under the Policy up to Age 60.

Your Qualifying Amount is $_____.

This rider terminates when the first of the following occurs:

- the Lump Sum Benefit Amount has been paid; or
- You attain Age 60; or
- the premium for this rider remains unpaid for more than 31 days; or
- Our receipt of the Policyowner's written request to terminate this rider; or
- the Policy terminates.

☐ Basic Partial Disability Benefit Rider PTID –This rider provides a Monthly Partial Benefit when You are Partially Disabled.

Partial Disability or Partially Disabled means You are Gainfully Employed and You are not Totally Disabled under the terms of the Policy, but solely due to Injury or Sickness:

- You experience a Loss of Income that is at least 20% of Your Prior Income; and either
- You are unable to perform one or more of the material and substantial duties of Your Occupation; or
- You are able to perform all of the material and substantial duties of Your Occupation but not for the length of time they normally require.

During the first six months in which the Monthly Partial Benefit is payable, We will deem Your Loss of Income to be 50% of Your Prior Income or the actual percentage of loss, if greater.

This rider may not be renewed after the Expiration Date.

☐ Supplemental Benefit Term Rider SBID –This rider provides a Supplemental Monthly Benefit when You are Totally Disabled.

$_____ Supplemental Monthly Benefit will be paid at the end of each month while You are Totally Disabled.

Benefits start to accrue at the end of a Supplemental Benefit Elimination Period of _____.

This rider terminates when the first of the following occurs:

- the Supplemental Benefit Termination Date; or
- the premium for this rider remains unpaid for more than 31 days; or
- Our receipt of the Policyowner's written request to terminate this rider; or
- the Policy terminates.

4. EXCLUSIONS AND LIMITATIONS OF THE POLICY – We will not pay benefits for any Disability:

- caused by, contributed to by, or which results from, war or an act of war, whether declared or undeclared, while You are serving in the armed forces or a military auxiliary unit, either active or reserve; or
- caused by, contributed to by, or which results from, Your commission of, or attempt to commit, a felony, or Your participation in a riot or insurrection; or
- caused by, contributed to by, or which results from, Your being engaged in an illegal occupation or professional misconduct; or
- caused by, contributed to by, or which results from, an intentionally self-inflicted injury; or
- caused by, contributed to by, or which results from, a normal pregnancy until 90 days have elapsed from the date of Disability or the Elimination Period has been satisfied, if later; or
- due to any loss We have excluded by name or description.

LIMITATION WHILE OUTSIDE THE UNITED STATES, ITS POSSESSIONS, CANADA OR MEXICO **–** Benefits for Disability will be limited to a total of twelve months during Your lifetime unless You are living full time in the United States, its Possessions, Canada or Mexico for at least six consecutive months in each calendar year. United States refers to the 50 states that comprise the United States of America and the District of Columbia.

If benefits under the Policy have ceased because of this limitation and You return to the United States, its Possessions, Canada or Mexico, benefits may resume under the Policy if all terms and conditions of the Policy are satisfied.

If You continue to reside outside of the United States, its Possessions, Canada, or Mexico, premiums will become due beginning three months after benefits under the Policy have ceased.

PRE-EXISTING CONDITION LIMITATION – We will not cover any loss that begins in the first two years after the Effective Date from a Pre-existing Condition that was misrepresented or not disclosed in Your application.

Pre-existing Condition means a physical or mental condition:

- for which You received professional medical advice, diagnosis or treatment within two years before the Effective Date; or
- that caused symptoms within one year before the Effective Date for which a prudent person would usually seek professional medical advice, diagnosis or treatment.

MENTAL AND/OR SUBSTANCE-RELATED DISORDERS LIMITATION **–** If the Policy includes a Mental and/or Substance-Related Disorders Benefit Limitation, it is shown in the Schedule Page. Under this limitation, benefits We pay for a Disability caused by, contributed to by, or which results from, a Mental and/or Substance-Related Disorder are limited during Your lifetime to the number of months specified in the Schedule Page.

After We have paid benefits for a Disability caused by, contributed to by, or which results from, a Mental and/or Substance-Related Disorder for the number of months specified in the Schedule Page, We will not pay benefits for a Disability caused by, contributed to by, or which results from, a Mental and/or Substance-Related Disorder unless You are:

- continuously confined in a Hospital for treatment of a Disability caused by, contributed to by, or which results from, a Mental and/or Substance-Related Disorder; and
- under the regular care of a Physician.

Under no circumstance will We pay benefits for a Disability caused by, contributed to by, or which results from, a Mental and/or Substance-Related Disorder that We have excluded by name or description.

This limitation will not apply to Catastrophic Disability due to a Cognitive Impairment, as defined in the Basic Catastrophic Disability Benefit Rider or Enhanced Catastrophic Disability Benefit Rider, if attached to the Policy.

5. RENEWABILITY OF THE POLICY –After the Expiration Date, the Policy may be conditionally renewed on each Policy Anniversary, if:
   - You are not Disabled; and
   - You are Gainfully Employed Full Time for at least ten months each year; and
   - the premium is paid on time; and
   - the Policy is in force up to the Expiration Date.

   If the Policyowner renews the Policy after the Expiration Date, We can require satisfactory written proof that You have continued to be Gainfully Employed Full Time for at least ten months each year. Upon Our approval, We will issue a new Schedule Page.

   The only Coverage that will continue after the Expiration Date is for Total Disability, unless otherwise stated. The Benefit Period after the Expiration Date is shown in the Schedule Page.

   The premium at each renewal will be based on Our premium rates in effect for Your Age, gender, Class of Risk, Occupation Class, any special class rating under the Policy, and other factors We are adding on a class basis at that time. We have the right to change such premiums on a class basis on any Policy Anniversary.

   Any premium paid after the Expiration Date for a period not covered by the Policy will be refunded.

Guardian®

The Guardian Life Insurance Company of America ("Guardian")
The Guardian Insurance & Annuity Company, Inc. ("GIAC")
Berkshire Life Insurance Company of America ("Berkshire")
(Any insurer above, individually or collectively, is herein referred to as the "Company.")

BANK DRAFT AUTHORIZATION

(REQUEST FOR GUARD-O-MATIC ARRANGEMENT)

Please Print

1. Type of Request *(Check all the apply)*

- ☐ Establish a new Bank Draft Authorization for monthly payments
- ☐ Update Financial Institution Information on an existing Bank Draft Authorization
- ☐ Change draft date option and/or draft amount on an existing Bank Draft Authorization
- ☐ Add policy(ies) to existing Bank Draft Authorization:
  List one policy from existing arrangement: _____
- ☐ Revoke Bank Draft Authorization for Policy Number(s): _____

2. Financial Institution Information

Financial Institution Name: _____

Type of Account *(Check one):* ☐ Checking ☐ Savings ☐ Business _____
Type of Business

Transit/ABA Number *(Always 9 digits.)*

Account Number

Account Holder Information *(All fields required. Please print.):*

Full Title of Account (e.g. John Smith or The John Smith Irrevocable Trust dtd 01/02/2016): _____

☐ Individual ☐ Joint ☐ Trust ☐ Custodial ☐ Business ☐ Other: _____

Authorized Signer of Account: _____

Address: _____
Address City State Zip

Cell Phone Number: _____ Email: _____

3. Premium Arrangement Information

Please note the "Monthly Amount to Be Deducted" will be the monthly modal premium described in your policy. The "Effective Date of Change" will be the date your next premium payment is due.

Policy Number	Draft Date*	Insured Name	Monthly Amount to Be Deducted**	Effective Date of Change *(mm/yy)*	Control Number *(For Home Office Use Only.)*
	☐ 1st ☐ 15th		$		
	☐ 1st ☐ 15th		$		
	☐ 1st ☐ 15th		$		
	☐ 1st ☐ 15th		$		
	☐ 1st ☐ 15th		$		
	☐ 1st ☐ 15th		$		

* *Variable Life and Universal Life Policies allow for premium payments on the 15th only; Premium payments for Traditional Life and Disability Policies can be made on the 1st or the 15th of each month; If no selection is made, the draft date will default to the 15th of each month.*

** *For UL/VL policies only. Indicate an amount for UL/VL policies if the amount to be deducted will be different from the planned premium.*

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4. Loan Payment Information

Policy Number	Monthly Amount to Be Deducted*	Policy Number	Monthly Amount to Be Deducted*
	$		$
	$		$
	$		$

** Loan payments for policies administered by Berkshire will be made on or about the 15th of each month; For all other policies, loan payments will be made on the 1st business day of each month.*

5. Terms and Conditions

By the signature(s) below, I or we agree and consent to all of the terms and conditions stated herein.

1. The Company is authorized to debit the account or to initiate electronic funds transfer from the financial institution identified above on or about the 15th or 1st of each month to pay premiums due and/or to pay the policy loan on the policy(ies) identified above. If neither, or both the 1st or 15th is selected, the 15th will be the default date for drafting. Due to timing of the authorization, the initial transfer processed may result in more than one premium payment being withdrawn.
2. The Company is authorized to make monthly withdrawals from the specified account. The Company's treatment of each check or debit, and its' rights with respect to it, will be the same as if it were signed or initialed personally by the Authorized Signer of Account. If any check or debit is dishonored by the bank or financial institution for any reason, the premium payment will be reversed and the premium will not be considered paid. This may cause the policy to lapse in accordance with the provisions of the policy and result in the forfeiture of insurance.
3. Completion of this form shall not constitute a premium payment and/or loan payment. Multiple months' premiums may be required to bring the policy to a current due date.
4. This Bank Draft Authorization (Request for Guard-O-Matic Arrangement) may be terminated by the Policy Owner, the Company, or the Authorized Signer of Account (if different from Policy Owner) upon written notice. The Policy Owner or Authorized Signer of Account may cancel this Authorization by giving the Company 30 days' written notice. This Authorization is to remain in effect until the Company receives written notice of its revocation unless the Company ends it earlier.
5. If the Loan Payment Authorization is cancelled, any outstanding loans will remain unpaid.
6. The Company may try a second time for any withdrawal returned due to insufficient funds. The Company may terminate this Authorization immediately by written notice in the event any withdrawal or electronic fund transfer is dishonored for any reason.
7. A confirmation statement for premium payments paid for non-variable products through this Bank Draft Authorization will not be sent. Information provided by the bank or financial institution may be helpful to reconcile the deductions.
8. For details on the bank draft monthly payments, please refer to the Policy Owner's annual benefits statement, policy, or product prospectus, as applicable. For any questions about the policy or about the amounts to be drafted to pay premiums or loan principal, please contact the servicing agent on the policy or the Customer Call Center at the number provided below.
9. For Universal or Variable Universal Life Insurance, the policy is designed to have flexible premiums. Policy Owners should consider paying the necessary amount each month to keep the policy in force. The Policy Owner will receive notification if additional payments are required to keep the policy from lapsing.
10. The Company should be provided with 30 days' advance notification of any change in the banking information provided above. If advance notification cannot be provided, sufficient funds should be left in the account identified above in this form to honor charges until the Company's records are changed.
11. Any change in name or address of the Authorized Signer of Account or Policy Owner must be communicated immediately to the Company.
12. If this service is no longer in effect, premiums will be due according to the most frequent payment mode offered for the policy. Loan repayments scheduled under the Loan Payment Arrangement will no longer be automatically deducted. Any future loan repayment will be the Policy Owner's responsibility.
13. Any bank fees are the responsibility of the Authorized Signer of Account.

5. Terms and Conditions (Continued)

14. I/we authorize Guardian and its officers, directors, agents, employees and representatives to make any inquiries that Guardian considers necessary to validate the account identified above and/or investigate any dispute involving your premium payment, which may include verifying the information I/we provide and/or that Guardian acquired against third party databases.

15. I/we authorize Guardian (or its agent or representative) to initiate one or more debits by electronic fund transfers (withdrawals), and I/we authorize the financial institution that holds my/our account to deduct such payments, in the amounts and frequency designated in your then-current premium payment mode.

☐ By checking this box, the person(s) signing below authorizes the Company to communicate electronically regarding this transaction.

(Note: If the email entered is different from the email we have on file, you will need to update your email address via the customer portal at guardianlife.com)

_____ _____

Signature of Policy Owner Date

_____ _____

Signature of Bank Account Owner (Required if different from Policy Owner) Date

Life Insurance

The Guardian Life Insurance Company of America
Individual Life Service and Administration
P.O. Box 981590
El Paso TX, 79998-1590

Email: ILSolutions@glic.com
Customer Call Center: 1-888-GUARDIAN (482-7342)
Fax: 610-807-2720

The Guardian Insurance & Annuity Company
Park Avenue Variable Life
P.O. Box 981588
El Paso TX 79998-1588

Email: VULSolutions@glic.com
Customer Call Center: 1-888-GUARDIAN (482-7342)
Fax: 610-807-2940

Disability Income Insurance

Berkshire Life Insurance Company of America
Policy Services
P.O. Box 981594
El Paso TX 79998-1594

Email: Diprocessing@glic.com
Customer Call Center: 1-888-GUARDIAN (482-7342)
Fax: 413-395-5992