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

GUARDIAN®

Individual Disability Insurance Supplement to the Application for Insurance | Policy Forms 1400 and 1500

1. Proposed Insured Information

a. Proposed Insured _____
First Middle Initial Last Name

b. Social Security Number _____

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

2. Premium Structure

☐ Level ☐ Graded ☐ Step Rate

3. Personal Disability Insurance

a. **Policy Form No.** _____

Monthly Indemnity $ _____

Elimination Period _____

Benefit Period _____

Occupational Class _____

b. **Supplemental Benefits**

☐ *3% Compound Cost of Living Adjustment*
☐ *6% Maximum Cost of Living Adjustment*
☐ *Four-Year Delayed Cost of Living Adjustment*
☐ *Catastrophic Disability Benefit* $ _____
☐ *Future Increase Option* $ _____
☐ *Social Insurance Substitute* $ _____
☐ *Other* _____

☐ *Residual Disability Benefit*
☐ *Partial Disability Benefit*
☐ *Graded Lifetime Indemnity for Total Disability*

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☐ **THE GUARDIAN LIFE INSURANCE COMPANY OF AMERICA**
Administrative Office: 3900 Burgess Place, Bethlehem, PA 18017
Administrative Office: 700 South Street, Pittsfield, MA 01201
(Please check appropriate company(ies). Any insurer checked above is herein referred to as the "Company.")

Application for Change or Reinstatement - Disability Insurance

1. INSURED INFORMATION

Insured's Name:

First Name _____ MI _____ Last Name _____

Policy Numbers: First Policy _____ Second Policy _____ Third Policy _____

Amount Paid With This Application $_____

Current Billing Address: _____

Telephone Number: _____ E-Mail Address: _____

2. CHANGE OF NAME (Complete Representations Section for Signatures)

Please Type or Print

From My Former Name: _____

To My New Name: _____

If the name changed is a corporate name, provide a copy of the vote of the board of directors certified by the corporation's secretary.

3. CORRECTION OF AGE – Attach Policy (Complete Representations Section for Signatures)

Correct Date of Birth: _____ ☐ Certified evidence attached.

4. CHANGE OF PREMIUM MODE TO (Complete Representations Section for Signatures)

☐ Annual ☐ Semiannual ☐ Quarterly ☐ Monthly by Automatic Payment Plan*

*Submit a sample voided check or savings deposit slip and Request for Guard-O-Matic Arrangement form.

5. CHANGES THAT DO NOT REQUIRE UNDERWRITING (Complete Representations Section for Signatures)

☐ Change premiums from Graded to Level.
☐ Reduce Monthly Indemnity or Benefit to $_____
☐ Reduce Indemnity or Benefit Period to _____
☐ Increase Elimination or Waiting Period to _____ days Accident, _____ days Sickness.
☐ Removal of Riders/Supplementary Benefits (specify) _____
☐ Suspension of Policy Due to Insured Entering Military Service (submit necessary documentation).
☐ Suspension of Policy Due to Unemployment (submit necessary documentation).
☐ Purchase COLA Incremental Monthly Indemnity (provide evidence of Full Time Gainful Employment).
☐ Change of Loss Payee on Business Reducing Term to _____
☐ Other (specify) _____

6. CHANGES THAT REQUIRE UNDERWRITING
(Unless otherwise indicated, complete Sections 7, 8, 9, 10 and Representations Section)*

- ☐ Decrease Elimination or Waiting Period _____
- ☐ Reinstatement
- ☐ Change Occupation Class to _____
- ☐ Reconsider Rating or Exclusion
- ☐ Addition of Rider Coverage: Rider Type _____ Elimination/Waiting Period _____
  Monthly Indemnity/Amount _____ Benefit Period _____
- ☐ Consider for Non-Smoker/No Tobacco Use (Sections 7, 8 and 10 are not required)
- ☐ Other _____

*In addition, for any changes to Overhead Expense, complete Section 11. For any changes to Disability Buy-Out, complete Section 12. For any changes to Business Reducing Term, complete Section 13.

7. OTHER DISABILITY INSURANCE COVERAGE ON THE PROPOSED INSURED

a. List all personal and business disability income insurance now in force, applied for, or eligible for within the next 12 months in all companies, including Guardian or Berkshire. **If none, check here ☐.**

Type of Insurance
- **DI** = Disability Income Insurance
- **OE** = Overhead Expense
- **DBO** = Buy-Out
- **KEY** = Key Person
- **RT** = Business or Personal Reducing Term
- **RP** = Retirement Protection

Category
- **IND** = Individual
- **G** = Group
- **A** = Association

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

Insurer:				
Type of Insurance:				
Category:				
Status:				
Policy Number (if known):				
Date insurance applied for, issued, or eligible for, if known:				
Benefit Amount:	$	$	$	$
Social Insurance Benefit:	$	$	$	$
Automatic Increase Option:	%	%	%	%
Future Increase Option:	$	$	$	$
Catastrophic Benefit:	$	$	$	$
Retirement Benefit:	$	$	$	$
Does employer pay premium and not include it as taxable income to you?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
If group coverage, is it convertible?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

b. Replacement

Is the insurance being applied for replacing this coverage?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Date of Replacement:				
Amount to be Replaced:	$	$	$	$

When issuing any insurance as a result of this application, the Company will rely on the fact that the Proposed Insured can and will permanently terminate the coverage as specified above and will not at any time reinstate this coverage. If the coverage is not terminated, benefits under any policy issued, changed or reinstated based upon this application may be reduced by the amount payable under such existing policies and premiums paid that exceed the pro-rata amount of the premiums for the benefits actually paid will be returned.

8. OCCUPATION INFORMATION OF THE PROPOSED INSURED

a. Occupation(s) _____

b. Give exact duties _____

c. Employer(s) _____

d. Nature of Business(es) _____

e. Annual earned income for each occupation $_____

f. Are you actively at work on a full-time basis in the occupation(s) listed above? ..... ☐ Yes ☐ No

g. Are you currently disabled and/or collecting disability benefits? ..... ☐ Yes ☐ No

9. UNDERWRITING INFORMATION OF THE PROPOSED INSURED

The following questions pertain to the insured to whom a policy or contract change is requested by this application.

		Yes	No
a.	Since the effective date of coverage:		
	(i) Have you changed your occupation or do you intend to do so?	☐	☐
	(ii) Have you had any illness, injury or surgical operation?	☐	☐
	(iii) Have you consulted a physician or any other practitioner, or has any lab, X-ray, or diagnostic testing been done other than an HIV test?	☐	☐
	(iv) Have you flown, or do you contemplate flying, as a pilot or crew member? (If "Yes," complete the Aviation Supplement.).....	☐	☐
	(v) Have you had disability, accident, medical, life or health insurance declined, postponed, modified, rated, cancelled or withdrawn a pending application, or had a renewal or reinstatement refused?.....	☐	☐
b.	Has there been any impairment in your health?.....	☐	☐
c.	Have you used tobacco in any form in the last 12 months?.....	☐	☐
d.	Do you intend to reside or travel outside of the U.S.? (If yes, indicate location, frequency, for work or pleasure, date of departure, length of stay.).....	☐	☐

e. The name, address, and telephone number of your physician. (If none, state so.)

Name _____

Address _____

f. This physician, or any other, was last consulted by you:

Date _____

Reason _____

Results _____

g. Height: _____ feet _____ inches Weight: _____ lbs.

h. If this is a request to reconsider a rating or exclusion, please provide complete up-to-date details supporting this request, including but not limited to, names of all physicians consulted, dates and details of any treatment received, and date of last symptoms.

_____

_____

_____

		Yes	No
i.	**Complete this section if applying for the Catastrophic Disability Benefit Rider.**		
	i. 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?	☐	☐
	ii. 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)?	☐	☐
	iii. Do you use any special medical equipment or appliances such as a wheelchair, pacemaker, oxygen tank, cane, catheter, or artificial limb?	☐	☐
	iv. 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?	☐	☐

Details of all questions answered "Yes." Identify by question number. Include diagnosis, dates, durations and names and addresses of all attending physicians and medical facilities.

10. PERSONAL FINANCIAL INFORMATION OF THE PROPOSED INSURED

a. **Earned Income.** Fill in the amounts requested for last year and two years ago using the Proposed Insured's individual and/or business income tax returns and supporting schedules. **Note:** Do not list income that is not reported to the IRS. Explain in Details and Special Requests, Section 14, any significant fluctuations between years. Describe any changes since the end of the most recent calendar year. Put loss amounts in parentheses.

	Actual Year-To-Date	Actual Filed Last Calendar Year	Actual Filed Two Calendar Years Ago
1. Non-owner employee salary, wages and bonus from Form W-2	$	$	$
2. Business owner salary, wages, and bonus from Form W-2	$	$	$
3. Sole Proprietor net income (after business expenses) from Form 1040, Schedule C	$	$	$
4. Share of Partnership or Sub-Chapter "S" corporation income (after business expenses) shown on Form 1040 or 1120 "S", Schedule K-1	$	$	$
5. Qualified pension plan contribution to include money purchase plan, profit sharing plan, simplified employee pension (SEP), employee stock ownership plan ESOP, 401k, 403b, SARSEP plan	$	$	$
6. Other earned income (explain source)	$	$	$
7. **Total Earned Income (add lines 1-6)**	$	$	$

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

Is your unearned income more than 10% of total earned income? ☐ Yes ☐ No
(If yes, complete below.)

Indicate all unearned income that exceeds 10% of total earned income in line 7 above.	$	$	$

Sources: _____

c. **Retirement Contributions**
Indicate qualified retirement plan contributions (including employer contributions). $_____

d. **Net Worth**
Does your net worth exceed $6 million? ☐ Yes ☐ No
If Yes, describe your net worth in detail. Net value is asset value less any outstanding debt or mortgage on the asset.

Cash, Savings, Stocks, Bonds $_____

Fair Market Value of your business (excluding goodwill) $_____

Personal Property $_____

Real Estate $_____

Other (explain) _____ $_____

e. **Bankruptcy**

i. Have you ever filed bankruptcy? ☐ Yes ☐ No

☐ Personal ☐ Business

ii. Date bankruptcy filed? _____

iii. Date bankruptcy discharged? _____

11. COMPLETE THIS SECTION IF APPLYING FOR CHANGES TO OVERHEAD EXPENSE INSURANCE

Monthly Expenses of the Business Entity

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

Rent $_____

Electricity, Telephone, Heat and Water _____

Laundry _____

Salaries of Employees* _____

Real Estate Taxes _____

Depreciation or Scheduled Installment Payments of Principal of Debt _____

Interest on Debt _____

Rent or Lease Expense of Furniture, Equipment _____

Other Normal, Necessary and Customary Fixed Expenses:

_____ _____

_____ _____

_____ _____

_____ _____

TOTAL $_____

*Excludes compensation for members of insured's profession.

12. COMPLETE THIS SECTION IF APPLYING FOR CHANGES TO DISABILITY BUY-OUT INSURANCE

a. Give names of all other stockholders or partners. (If there are any on whom Disability Buy-Out (DBO) is not carried or proposed, explain in Details and Special Requests, Section 14.)

Name	Title	% Owned	Amount of DBO in Force	Amount of DBO Proposed

b. Does a familial relationship exist among any of the above stockholders or partners? ☐ Yes ☐ No

If yes, describe _____

_____

c. What is the current Fair Market Value of the business organization? $_____

d. Indicate type of business organization:

☐ Professional Corporation/Personal Service Partnership ☐ Commercial Business

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

_____

_____

_____

f. Business Financial

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

13. COMPLETE THIS SECTION IF APPLYING FOR CHANGES TO BUSINESS REDUCING TERM

a. The insurance will cover the following business obligation:

☐ Business Loan ☐ Purchase Agreement ☐ Employment Contract

☐ Other (describe) _____

b. Date obligation took effect: _____ Date obligation will end: _____

c. To whom do you make your loan payments? _____

14. DETAILS AND SPECIAL REQUESTS

15. AMENDMENTS OR CORRECTIONS (For Home Office or Customer Service Office Use Only)

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Representations of the Proposed Insured and Owner

Those parties who sign below, agree that:

1. This application, any required Representations to the Medical Examiner, and any other supplements to the application will form the basis for, and become part of and attached to, any policy issued, changed or reinstated.
2. All of the statements that are part of the application and any other supplements to the 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 or new coverage that is issued based on this application.
5. The policy date is the date from which premiums are calculated and become due. Except as provided in a 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 and occupation of the Proposed Insured. If a request is made for coverage to commence as of a specified date, I understand that I may be waiving certain rights under the conditional receipt.
6. Any changes or corrections made by the Company and noted in the "Amendments or Corrections" section will be made only with the Owner's written consent.
7. It is agreed that the acceptance by the Company or its legal representatives of the premiums now in default shall not be taken as precedent for future similar action and that receipt of this application and premium tender at any agency office shall not bind the Company until this application is approved at its address shown above. I understand that if this is an application for reinstatement and written notice of disapproval is not provided within 45 days then coverage shall be reinstated as of the 45th day unless approved earlier.
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. I, the proposed insured, acknowledge receipt of the notice of Insurance Information Practices, the Fair Credit Reporting Act Pre-Notice, the Medical Information Bureau Pre-Notice and Medical Records.

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.

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

_____ _____
Signature of Named Insured Signature of Applicant/Owner if Other than Named Insured

_____
Witness

AGENT'S STATEMENT

		Yes	No
1.	a. Does this application involve a replacement as defined under applicable state law?	☐	☐
	b. If "Yes," did you deliver the appropriate Notice Regarding Replacement, where applicable?	☐	☐
	c. Did you deliver to the Insured the notice of Insurance Information Practices, which includes the Fair Credit Reporting Act Pre-Notice, the Medical Information Bureau Pre-Notice and Medical Records?	☐	☐

2. Commissions

Producer's Name	Producer's Code	Percentage	Manager/GA Code
_____	_____	_____%	__ __-__ __
_____	_____	_____%	__ __-__ __
_____	_____	_____%	__ __-__ __
_____	_____	_____%	__ __-__ __
_____	_____	_____%	__ __-__ __
_____	_____	_____%	__ __-__ __

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

Any person who knowingly, and with intent to defraud any insurance company or other person, files an application of insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and 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 _____ this _____ day of _____, _____.
City and State Day Month Year

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

_____ _____
Social Security Number of Soliciting Agent State(s) Where Licensed

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

_____ Signed _____
Date Submitted (Agency Personnel)

Life Customer Service Office
3900 Burgess Place
Bethlehem, PA 18017

Disability Customer Service Office
700 South Street
Pittsfield, MA 01201

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

Insurance Information Practices

The notification below must be completed and given to the Proposed Insured before the application is completed

Notice to _____
Proposed Insured

Thank you for your interest in insurance with our Company. This notice is given to you at the time you apply for life or disability insurance to tell you about the kinds of information we may obtain in connection with your application. Only qualified members of our Company's staff or its legal representatives will have access to your medical file to evaluate your eligibility for insurance or to service your claim for benefits under a policy. Your authorization will govern our request for information and any later disclosure of that information. We will treat all personal information about you as confidential. You have a right of access and correction with respect to this information. If you wish a more detailed explanation of our Information Practices, please send your written request to the Privacy Office of the Guardian Corporate Family at 7 Hanover Square, New York, NY 10004-2616.

Fair Credit Reporting Act Pre-Notice

When we begin to process your application, we may ask for a consumer report from a consumer reporting agency. All or part of that report may be an investigative consumer report. Such a report will include information about your character, general reputation, personal characteristics or mode of living, except as may be related directly or indirectly to your sexual orientation. It will be obtained through personal interviews with people who know you. You may ask to be interviewed in connection with this report. We may request later consumer reports, other than an investigative consumer report, at a future update, renewal or extension of the insurance for which you have applied. At your request, we will tell you if we have asked for a consumer report or an investigative consumer report in the initial processing of your application. If we have, we will tell you the name and address of the consumer reporting agency to which we have made our request for a report. You can obtain a copy of this report by contacting this consumer reporting agency. At your written request, we will give you more detailed information about the nature and scope of this kind of investigation.

Medical Information Bureau Pre-Notice

The Medical Information Bureau is a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another Bureau Member company for life or disability insurance, or if a claim for benefits is submitted to such company, the Bureau, upon request, will supply such company with the information in its files. Our Company, its legal representatives, or its reinsurers may make a brief report of objective findings about you to the Bureau.

If you so request of the Bureau, it will arrange to disclose the information it may have in your file. If you question the accuracy of the information in the Bureau's file, you may contact the Bureau and seek to correct the information according to procedures set forth in the Federal Fair Credit Reporting Act. The Bureau's address is Post Office Box 105, Essex Station, Boston, MA 02112, and its telephone number is 866-692-6901 (TTY 866-346-3642 for hearing impaired).

Medical Records

We may request information from health care providers or others who have records of your medical history, mental or physical condition, or treatment. Only qualified members of our Company's staff or its legal representatives will have access to your medical file to evaluate your eligibility for insurance or to service your claim for benefits under a policy. Your authorization will govern our request for information and any later disclosure of that information.

Personal Information Telephone Interview

We may phone you to verify or supplement information you have given us on your application. The call will be made from our underwriting office or from a consumer reporting agency acting for us.

GUARDIAN℠

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3900 Burgess Place
Bethlehem, PA 18017

Disability Customer Service Office
700 South Street
Pittsfield, MA 01201

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

Authorization to Obtain and Release Information

Name of Proposed Insured _____ Date of Birth _____

Address of Proposed Insured _____

_____

This Authorization complies with the HIPAA Privacy Rule

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

Medical Records and other information. I authorize any physician, medical or mental health professional, practitioner, hospital, clinic, other health facility, pharmacy, pharmacy benefit manager, consumer reporting agency, the Social Security Administration, the Medical Information Bureau, insurance or reinsurance company, or employer or other organization, institution or person that has any records or knowledge of me or my health to release any and all medical and non-medical information in its possession about me or my minor children, to the Company or its legal representatives. Medical information means all information in the possession of or derived from providers of health care regarding the medical history, pharmaceutical history, mental or physical condition, or treatment of me or my minor children. I understand that the information released may relate to the symptoms, evaluation, diagnosis, examination, treatment or prognosis of any mental or physical condition, including psychiatric conditions (but excluding psychotherapy notes).

I agree that this authorization shall be valid for two years from the date shown below and that a copy of the authorization shall be as valid as the original.

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

I understand that the Company or its legal representatives will use the information obtained by this authorization to determine eligibility for insurance or eligibility for benefits under an existing policy. I further understand that if I refuse to sign this authorization, the Company may not be able to process my application, or pay a claim in the case of coverage which is already in force. The Company or its legal representatives will not release any information obtained to any person or organization except to reinsurance companies, the Medical Information Bureau, Innovative Underwriters Services (a subsidiary of The Guardian Life Insurance Company of America), or other persons or organizations performing business or legal services in connection with an application, claim, or as may be lawfully permitted or required, or as I may further authorize.

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

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

_____
Signature of Proposed Insured or Personal Representative

_____
Personal Representative's Authority or Relationship to Proposed Insured

_____
Witness Signature