

Application for Individual Life Insurance – Part 1

(For Producer Use Only)

This form facilitates a variation of processes with different paperwork requirements. Use these suggestions as a guide for completing the form depending on the process (see Page 2 for Juvenile Insureds). The tables below indicate which sections on the Application for Individual Life – Part 1 are mandatory for your case (*highlighted in bold font on light green background*) as well as additional sections and/or documents (*marked with a plus sign*) that may be required. If changing an inforce policy, exercising a Guaranteed Insurability Option, or converting term coverage, please use the appropriate Individual Life Insurance Change Request and Term Conversion/Exchange Form. For all applications, regardless of age, whenever insured and owner/applicant differs we require the signature on both the insured and owner/applicant line(s).

Any changes to these answers must be initialed by the Applicant/Owner and Producer. A Producer has no authority to waive, change or limit any question on the application.

When Completing as an Adult Insured Age: Greater than 14 years and 6 months	Then Complete Sections: A, B, C, D, E, F, I, J, K, L, M, N, R, S (if applicable) and
+ Additional forms required for Adult Insured	-Medical Supplement Part II (state specific); -Authorization Form; -Producer Certificate
+ For Joint / Other Individual Owner(s)	-Section C (#1)
+ For Trust/Charity/ Business Entity Ownership	-Section C (#2); -Complete the Trust Certification (Trust Ownership); -Complete the Employee Owned Life Insurance Supplement (Business Entity Ownership)
+ For Whole Life and Term Life Products	-Section G-1
+ For Universal/Variable Universal Life Products	-Section G-2; -Variable Life Supplement, state specific; -Provide applicant with Patriot Act Notice (Notice to Applicants for Variable Life Insurance form); -Explanation of Investment/Request to Exchange Investment – Variable Life Insurance -New Account forms required to open a books and records account in NetX360. NOTE: A concurrent submission in NetX360 containing all VUL and Park Avenue Securities paperwork will be required. This should be submitted under the TQP office range.
+ For Survivorship Products	-Section G-3
+ For Alternate/Additional Life Policy	-Section H

NOTE:

- Review Sections O and P then complete when necessary;
- The Notice of Information Practices must be left with the Proposed Insured.

In addition to the forms listed above, the following forms may be required dependent on the particulars of the case:

- Aviation Supplement, Avocation Supplement, Alcohol/Drug Use Supplement, Foreign Travel Supplement, Personal and or Business Financial Supplement;
- Replacement Forms (state specific);
- Illustration Certification, if used in lieu of Illustration;
- Guard-O-Matic Form, if requesting GOM mode;

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- Conditional Receipt
 - If accepting cash with application; there are specific conditions that appear on the Receipt form under which the receipt cannot be used. In addition to the conditions on the Receipt form, note that we do not allow cash with application for variable life policies, survivorship type policies, or any policy where the face amount is over \$5,000,000.
 - An illustration (signed or unsigned) must be submitted with the application and must match what the client is applying for (base policy and riders) in section G of the application.
 - The amount of money to be collected must be at least 1/12 of the annual premium shown on the illustration.
 - NOTE: There is no Conditional Receipt in Kansas and cash cannot be accepted with the application;
- Other miscellaneous disclosure forms, depending on the product and state

NOTE: All forms may not be contained in the application package but are available on the iPipeline system.

When Completing as a Juvenile Insured Age: 30 days – 14 years and 6 months		Then Complete Sections: A, C, D, E, F, I, J, K, L, N, R, S (if applicable) and
+	Additional forms required for Juvenile Insured	-Medical Supplement Part II (state specific); -Authorization Form, signed by parent or legal guardian; -Producer Certificate
+	For Policies owned by Other Individual(s) (i.e., Grandparent)	-Section C (#1); -Grandparent Ownership Form (state specific, for Grandparent Ownership)
+	For Trust Ownership	-Section C (#2); -Trust Certification
+	For Uniform Transfer to a Minor	-Section C (#3); -UGMA/UTMA Certification
+	For Whole Life and Term Life Products	-Section G-1
+	For Variable Universal Life	-Section G-2; -Variable Life Supplement, state specific; -Provide applicant with Patriot Act Notice (Notice to Applicants for Variable Life Insurance form); -Explanation of Investment/Request to Exchange Investment – Variable Life Insurance -New Account forms required to open a books and records account in NetX360. NOTE: A concurrent submission in NetX360 containing all VUL and Park Avenue Securities paperwork will be required. This should be submitted under the TQP office range.
+	Applying for Applicant's Waiver Benefit or the Combined Waiver Benefit	Adult Applicant <u>must also</u> complete: -Additional Insured Supplement; -Medical Supplement Part II (state specific); -Authorization Form
+	For Alternate/Additional Life Policy	-Section H

NOTE:

- Review Sections O and P then complete when necessary;
- The Notice of Information Practices must be left with the Proposed Insured.

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In addition to the forms listed on the prior page, the following forms may be required dependent on the particulars of the case:

- Aviation Supplement, Avocation Supplement, Alcohol/Drug Use Supplement, Foreign Travel Supplement, Personal and or Business Financial Supplement;
- Replacement Forms (state specific);
- Illustration Certification, if used in lieu of Illustration;
- Based on amount requested M172 or medical records may be required;
- Guard-O-Matic Form, if requesting GOM mode;
- Conditional Receipt if accepting cash with application; there are specific conditions that appear on the Receipt form under which the receipt cannot be used. In addition to the conditions on the Receipt form, note that we do not allow cash with application for variable life policies, survivorship type policies, or any policy where the face amount is over \$5,000,000. **NOTE:** There is no Conditional Receipt in Kansas and cash cannot be accepted with the application;
- Other miscellaneous disclosure forms, depending on the product and state.

NOTE: All forms may not be contained in the application package but are available on the iPipeline system.



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

Application for Individual Life Insurance - Part 1

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.

Please print. The Owner and/or Proposed Insured must initial any changes.

SECTION A: Proposed Insured Information

1. First Name _____ MI _____ Last Name _____ Suffix _____
 2. Previous Name (**ONLY** if changed in the last 5 years)
First Name _____ MI _____ Last Name _____
 3. Date of Birth (mm/dd/yyyy) _____
 4. Place of Birth _____
 5. Social Security Number _____
 6. Gender: ☐ Male ☐ Female
 7. Are you a U.S. Citizen? ☐ Yes ☐ No If "No," are you a permanent resident (green card holder)? ☐ Yes ☐ No
If you are not a U.S. Citizen or permanent resident, please complete the Foreign Travel and Residence Supplement.
If you are a permanent resident (green card holder), please provide a copy of your green card.
 8. Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed
 9. Driver's License Number _____ Driver's License State _____
If none, please provide a government photo ID number, issuer, and expiration date in the Remarks section.
 10. Street Address (Primary Residence) _____
City _____ State _____ Zip _____
 11. How long have you lived at this address? _____ years
 12. If mailing address is same as street address, check here ☐. If different, please provide mailing address below.
Mailing Address _____
City _____ State _____ Zip _____
 13. Preferred Phone _____ ☐ Cell ☐ Home ☐ Work
Alternate Phone (optional) _____ ☐ Cell ☐ Home ☐ Work
 14. E-mail Address _____
- Note: If there are multiple Proposed Insureds, you may need to complete the Additional Insured Supplement.

SECTION B: Proposed Insured Employment Information

1. ☐ Employed (Complete rest of section) ☐ Retired ☐ Homemaker ☐ Unemployed ☐ Disabled ☐ Student
☐ Other _____
2. Name of Employer _____
3. Street Address _____
City _____ State _____ Zip _____
4. Business Phone _____
5. Business Website _____
6. Occupation _____
7. Job Title _____
8. Nature of the Business _____
9. Years Employed _____
If employed for less than 1 year, please provide the below information for your previous employer.
10. Name of Previous Employer _____
11. Occupation _____
12. Years Employed _____



SECTION C: Owner Information (Complete ONLY if the Proposed Insured is not to be the sole Owner)

Owner Type: ☐ Other Individual (Complete # 1) ☐ Charity (Skip to #2)
☐ Joint Ownership* (Complete # 1) ☐ Business Entity (Skip to # 2)
☐ Trust (Skip to # 2) ☐ UGMA/UTMA - Owner is a minor (Skip to # 3)

*If there are Joint Owners, include Primary Owner below and provide Additional Owner information in the Remarks section.

# 1 - Other Individual(s)	a. First Name _____ MI _____ Last Name _____
	b. Date of Birth (mm/dd/yyyy) _____ c. Social Security Number _____
	d. Driver's License # and State _____ If none, please provide a government photo ID number, issuer, and expiration date in the Remarks section.
	e. Relationship to Proposed Insured _____
	f. Is the Owner a U.S. Citizen? ☐ Yes ☐ No If "No," please provide details in the Remarks section.
	g. Preferred Phone _____ ☐ Cell ☐ Home ☐ Work Alternate Phone (optional) _____ ☐ Cell ☐ Home ☐ Work
	h. E-mail Address _____
	i. Street Address _____ City _____ State _____ Zip _____
	j. If mailing address is same as street address, check here ☐ . If different, please provide mailing address below. Mailing Address _____ City _____ State _____ Zip _____

# 2 - Trust, Charity or Business Entity	a. Full Name _____
	b. Is entity established or organized under the laws of a state of the U.S.? ☐ Yes ☐ No
	c. Tax ID Number _____
	d. Phone _____ e. E-mail Address _____
	f. Street Address _____ City _____ State _____ Zip _____
	g. If mailing address is same as street address, check here ☐ . If different, please provide mailing address below. Mailing Address _____ City _____ State _____ Zip _____
	If the Owner is a Trust, you <u>must</u> complete the Trust Certification form.

# 3 - Uniform Transfer to a Minor	a. Custodian: First Name _____ MI _____ Last Name _____
	b. Minor: First Name _____ MI _____ Last Name _____
	c. Minor's Date of Birth (mm/dd/yyyy) _____
	d. Minor's Social Security Number _____ If the Owner is a minor child, you <u>must</u> complete the Uniform Gifts to Minors Act (UGMA)/ Uniform Transfers to Minors Act (UTMA) Certification form.

SECTION D: Change of Ownership

1. Have you entered into or is there a plan to enter into an agreement with any group of investors who will obtain any right, title or interest in any policy issued on the life of the Proposed Insured as a result of this application? ☐ Yes ☐ No
2. Are you planning to or do you (the Owner/Applicant) have a plan to borrow money to pay the premiums for this policy or have someone else pay these premiums in return for an assignment of policy values back to them? ☐ Yes ☐ No
3. Have you or the Proposed Insured been offered "free insurance" or any inducement such as a cash payment, gifts, loan proceeds in excess of the amount necessary to fund the policy, or anything else of value as an encouragement to apply for this life insurance policy? ☐ Yes ☐ No

If "Yes" to any of the above questions, please complete the Policyowner Statement form.

SECTION E: Beneficiary Information

1. ☐ Sole Beneficiary is the same as the Owner. (If checked, skip this section.)
☐ Beneficiary shares are to be equal across beneficiary types. (If this box is not checked, complete the percentage section for each beneficiary with the appropriate percentage.)

Note: For Beneficiary Type, indicate either Primary, Contingent, or Tertiary. If unequal shares, please ensure that the % for all the beneficiaries in each type (Primary, Contingent, Tertiary) total 100%. Please use whole numbers only.

Multiple beneficiaries are permitted. Complete the appropriate section below (Section 2 for individually named beneficiaries (up to 3), Section 3 for a trust, charity or business entity, Section 4 for class designations or Section 5 for other types of designations). If the sole beneficiary is a Trust, Charity or Business Entity or a class designation, skip the Individual Beneficiary section and complete **only** the appropriate section below. If additional space is needed, please enter information into the Remarks section.

* Per Stirpes – If elected below, if a beneficiary dies before the insured, any amount that would have been paid to that beneficiary, if living, will be paid in equal shares to the surviving children of that beneficiary. If per stirpes is designated, payment of that amount will be made to the surviving children, if any, before any other contingent beneficiary.

2. Complete **only** if the beneficiary is a named individual. If UTMA/UGMA, please complete the Beneficiary Designation form.

Individual Beneficiary 1	a. Full Name _____	b. Date of birth (mm/dd/yyyy) _____
	c. Beneficiary Type (see above): ☐ Primary ☐ Contingent ☐ Tertiary	
	d. ☐ Per Stirpes*	
	e. Relationship to Proposed Insured _____	f. Percentage _____ %
	g. Social Security Number _____	
	h. Phone _____	
	i. If address is same as Owner, check here ☐ . If different, please provide mailing address below. Mailing Address _____ City _____ State _____ Zip _____	

Individual Beneficiary 2	a. Full Name _____	b. Date of birth (mm/dd/yyyy) _____
	c. Beneficiary Type (see above): ☐ Primary ☐ Contingent ☐ Tertiary	
	d. ☐ Per Stirpes*	
	e. Relationship to Proposed Insured _____	f. Percentage _____ %
	g. Social Security Number _____	
	h. Phone _____	
	i. If address is same as Owner, check here ☐ . If different, please provide mailing address below. Mailing Address _____ City _____ State _____ Zip _____	

SECTION E: Beneficiary Information (continued)

Individual Beneficiary 3	a. Full Name _____	b. Date of birth (mm/dd/yyyy) _____
	c. Beneficiary Type (see above): ☐ Primary ☐ Contingent ☐ Tertiary	
	d. ☐ Per Stirpes*	
	e. Relationship to Proposed Insured _____	f. Percentage _____ %
	g. Social Security Number _____ h. Phone _____	
	i. If address is same as Owner, check here ☐ . If different, please provide mailing address below. Mailing Address _____ City _____ State _____ Zip _____	

3. Complete **only** if the beneficiary is a Trust, Charity or Business Entity other than the Owner.

Trust, Charity or Business Entity	a. Full Name _____
	b. Beneficiary Type (see above): ☐ Primary ☐ Contingent ☐ Tertiary
	c. Percentage _____ %
	d. Is entity established or organized under the laws of a state in the U.S.? ☐ Yes ☐ No
	e. Phone _____ f. E-mail Address _____
	g. Tax ID Number _____ h. Contact Person _____
i. Mailing Address _____ City _____ State _____ Zip _____	

4. Class Designations

☐ Children of the Proposed Insured (including adopted children)	Percentage _____ %
Beneficiary Type: ☐ Primary ☐ Contingent ☐ Tertiary	☐ Per Stirpes*

☐ Children (including adopted children) of the Proposed Insured's Marriage With _____ _____ (spouse)	Percentage _____ %
Beneficiary Type: ☐ Primary ☐ Contingent ☐ Tertiary	☐ Per Stirpes*

☐ Grandchildren of the Proposed Insured	Percentage _____ %
Beneficiary Type: ☐ Primary ☐ Contingent ☐ Tertiary	☐ Per Stirpes*

5. Other Designations

☐ Proposed Insured's Estate	Percentage _____ %
Beneficiary Type: ☐ Primary ☐ Contingent ☐ Tertiary	

☐ Trustee Under the Proposed Insured's Last Will & Testament <i>This designation means the then acting Trustee of the Trust under the Insured's Will that is probated. If no Will of the Insured is probated, or if there is no trust in effect under the Will that is probated, or if no trustee is qualified to receive the proceeds within six months of the Insured's death, proceeds will be paid to the Contingent Beneficiary, if living, otherwise to the owner or the estate of the owner.</i>	
Beneficiary Type: ☐ Primary ☐ Contingent ☐ Tertiary	Percentage _____ %

☐ Other _____	Percentage _____ %
Beneficiary Type: ☐ Primary ☐ Contingent ☐ Tertiary	

SECTION F: Purpose of Insurance

Please provide the purpose of the proposed insurance by checking one or more of the following, or describe in "Other".

- | | | | | |
|-------------------------------------|--|--|--|-------------------------------------|
| ☐ Buy-Sell | ☐ Deferred Compensation | ☐ Charitable Planning | ☐ Family Income | ☐ Mortgage |
| ☐ Key Person | ☐ Executive Bonus | ☐ Estate Planning | ☐ Split Dollar | ☐ Retirement |
| ☐ Education | ☐ Collateral for Debt | ☐ Wealth Accumulation | ☐ Other | _____ |

SECTION G-1: Proposed Insurance – Whole Life and Term Life Products (Single Life)

1. Plan of Insurance _____ 2. Base Policy Face Amount \$ _____

3. If dividend option Q or R is elected, please provide the following:

Base Policy Face Amount + Target Face Amount \$ _____ = Total Face Amount \$ _____

4. Riders

***There is no separate charge/premium for this rider. However, it is not available in all situations.**

- a. Waiver: ☐ Waiver of Premium ☐ Waiver of Premium Plus – **Level Term Only**
☐ Applicant's Waiver of Premium**

****If elected, the adult Applicant must also complete the Additional Insured Supplement.**

- b. ☐ Accelerated Benefit Rider (EABR/TABR)* *If elected, please refer to the Representations section. EABR when applied for on a whole life policy uses a lien approach for accelerations and there is a \$250 administrative fee for accelerations. TABR when applied for on term policies use a discount approach for accelerations.****
- c. ☐ Paid-Up Additions Rider (PUA)
Scheduled PUA Amount: ☐ Minimum ☐ Other amount \$ _____
Unscheduled PUA Amount \$ _____
- d. ☐ Waiver of Specified Amount (WSA)
☐ Scheduled PUA Amount ☐ Other \$ _____
- e. Guaranteed Insurability Options (GIO): ☐ GIO Plus ☐ GIO
GIO Option Amount \$ _____
- f. ☐ Whole Life Purchase Option (WLPO) – **Term Only**
Option Amount: ☐ Maximum ☐ Other \$ _____
- g. ☐ Extended Conversion Rider – **Term Only**
- h. ☐ 10 Year Renewable Term (RTR10) Term Face Amount \$ _____
- i. ☐ Lifetime Protection Builder Term (15 Year Decreasing Term) Face Amount \$ _____
- j. ☐ Long Term Care (LTC) Rider*** \$ _____ *If elected, please complete the LTC Supplement.*
- k. ☐ Select Security* (Amendment to Owner Provision) *If elected, please complete the Select Security supplement.*
- l. ☐ Exchange of Insureds*
- m. ☐ Accidental Death Benefit (ADB) ADB Face Amount \$ _____
- n. ☐ DuoGuard (Survivor Insurance Purchase Option Rider) *If elected, please list the names and amounts for the Designated Lives. Please also complete a separate Additional Insured Supplement for each Designated Life.*

- o. ☐ Other _____

***Receipt of accelerated death benefits may affect eligibility for public assistance programs such as medical assistance (Medicaid), Aid to Families with Dependent Children and Supplemental Security Income. No health care facility, as defined in Section 20 of the Public Health Law, can require any person to accelerate payment of a death benefit as a condition of admission to such health care facility or for providing any care in such facility.

SECTION G-1: Proposed Insurance – Whole Life and Term Life Products (continued)

5. Dividends *(If none are selected, the default option for Whole Life is Option D - Paid-Up Additional Insurance. For Term Life, while eligible to receive dividends, it is not likely that any will be paid. The available dividend options for Term Life are A, B and C. The default option is C – Left at Interest.)*

- Basic: ☐ A - Paid in Cash*
☐ B - Reduce Premiums*
☐ C - Left at Interest*
☐ D - Paid-Up Additional Insurance
- Term: ☐ Q - One Year Term Insurance *If elected, please enter the Target Face Amount in Plans section above.*
☐ R - One Year Term Insurance *If elected, please enter the Target Face Amount in Plans section above.*
☐ Level Increases _____ % ☐ Compound Increases _____ %

**For Dividend Options A, B or C, you may wish to complete the tax withholding form to ensure appropriate taxes are withheld from any taxable portion of your distributions. If no tax withholding form is completed, no withholding will occur.*

SECTION G-2: Proposed Insurance – Universal Life/Variable Universal Life Products (Single Life)

1. Plan of Insurance _____ **2.** Base Policy Face Amount \$ _____

3. Death Benefit Option *Note: Not all options may be available with all products.*

- ☐ Level ☐ Increasing ☐ Return of Premium

4. Section 7702 Test *Note: The choice of 7702 Test may not apply to all policies.*

Section 7702 of the Internal Revenue Code defines Life Insurance and specifies the rules under which the growth of life insurance policy cash values is excludible from gross income. If the plan being applied for provides a choice of test under 7702 to qualify the policy as life insurance, please check one of the tests shown below. Once a test is elected, it cannot be changed. If there is a choice of Test and none is elected, the Guideline Premium Test will be used.

- ☐ Guideline Premium Test ☐ Cash Value Accumulation Test

5. Initial Premium \$ _____ Planned Modal Premium \$ _____

6. Riders

***There is no separate charge/premium for this rider. However, it is not available in all situations.**

- a. ☐ Secondary Guarantee Coverage Rider
- b. ☐ Accelerated Benefit Rider (EABR)* *If elected, please refer to the Representations section. This rider uses a lien approach for accelerations and there is a \$250 administrative fee for accelerations.***
- c. ☐ Alternate Net Cash Surrender Value Benefit
- d. ☐ Waiver of Monthly Deductions
- e. ☐ Disability Benefit Rider** (Waiver of Specified Amount) Monthly Specified Amount \$ _____
- f. ☐ Guaranteed Insurability Option (GIO/WLPO) Option Amount \$ _____
- g. ☐ Accidental Death Benefit (ADB) ADB Face Amount \$ _____
- h. ☐ Select Security Rider (Amendment to Owner Provision) *If elected, please complete the Select Security supplement.*
- i. ☐ Exchange of Insureds
- j. ☐ Additional Sum Insured *(Do NOT include this amount in Base Face Amount shown above.)* \$ _____

******This rider does not necessarily protect the policy from lapsing.

*******Receipt of accelerated death benefits may affect eligibility for public assistance programs such as medical assistance (Medicaid), Aid to Families with Dependent Children and Supplemental Security Income. No health care facility, as defined in Section 20 of the Public Health Law, can require any person to accelerate payment of a death benefit as a condition of admission to such health care facility or for providing any care in such facility.

SECTION G-3: Proposed Insurance – Survivorship Products (EstateGuard WL, SUL, etc.)

1. Plan of Insurance _____ 2. Base Policy Face Amount \$ _____

3. If dividend option Q or R is elected, please provide the following:

Base Policy Face Amount + Target Face Amount \$ _____ = Total Face Amount \$ _____

4. Universal Life Only

a. Death Benefit Option *Note: Not all options are available with all products.*

☐ Level ☐ Increasing ☐ Return of Premium

b. Section 7702 Test *Note: The choice of 7702 Test may not apply to all policies.*

Section 7702 of the Internal Revenue Code defines Life Insurance and specifies the rules under which the growth of life insurance policy cash values is excludible from gross income. If the plan being applied for provides a choice of test under 7702 to qualify the policy as life insurance, please check one of the tests shown below. Once a test is elected, it cannot be changed. If there is a choice of Test and none is elected, the Guideline Premium Test will be used.

☐ Guideline Premium Test ☐ Cash Value Accumulation Test

c. Initial Premium \$ _____ Planned Modal Premium \$ _____

5. Riders

***There is no separate charge/premium for this rider. However, it is not available in all situations.**

a. ☐ 15 Year Decreasing Term (Death Waiver) (available on one or both of the base policy Insureds)

☐ 1st Insured _____

☐ 2nd Insured _____

b. ☐ Policy Split Option

c. ☐ Paid-Up Additions Rider (PUA)

Scheduled PUA Amount: ☐ \$100 ☐ Other amount \$ _____

Unscheduled PUA Amount \$ _____

d. ☐ Four Year Term Rider for SUL (on both of the base policy Insureds) Term Amount \$ _____

e. ☐ Single Life Term/RTR 85 (Available on one or both of the base policy Insureds.) Face Amount \$ _____

☐ 1st Insured _____

☐ 2nd Insured _____

f. Second to Die DuoGuard (Beneficiary Insurance Purchase Option rider) (List names & amounts for Designated Lives. Complete a separate Additional Insured Supplement for each Designated Life.)

g. ☐ First to Die DuoGuard (Survivor Insurance Purchase Option rider) (Available on one or both of the base policy Insureds.) Face Amount \$ _____

☐ 1st Insured _____

☐ 2nd Insured _____

h. ☐ Accelerated Benefit Rider (EABR)*. *If elected, please refer to the Representations section. EABR when applied for on a whole life policy uses a lien approach for accelerations and there is a \$250 administrative fee for an acceleration. ***

i. ☐ Other _____ ☐ Other _____

**Receipt of accelerated death benefits may affect eligibility for public assistance programs such as medical assistance (Medicaid), Aid to Families with Dependent Children and Supplemental Security Income. No health care facility, as defined in Section 20 of the Public Health Law, can require any person to accelerate payment of a death benefit as a condition of admission to such health care facility or for providing any care in such facility.

SECTION G-3: Proposed Insurance – Survivorship Products (EstateGuard WL, SUL, etc.)

8. Dividends *(If none selected, the default option is Option D - Paid-Up Additional Insurance)*

- Basic: ☐ A - Paid in Cash*
☐ B - Reduce Premiums*
☐ C - Left at Interest*
☐ D - Paid-Up Additional Insurance
- Term: ☐ Q - One Year Term Insurance *If elected, please enter the Target Face Amount in Plans section above.*
☐ R - One Year Term Insurance *If elected, please enter the Target Face Amount in Plans section above.*
☐ Level Increases _____ % ☐ Compound Increases _____ %

**For Dividend Options A, B or C, you may wish to complete the tax withholding form to ensure appropriate taxes are withheld from any taxable portion of your distributions. If no tax withholding form is completed, no withholding will occur.*

SECTION H: Alternate/Additional Life Policy

Owner: If the "Alternate Policy" box is checked below, you are indicating that you are applying for either the policy applied for in Sections G-1 through G-3 or the policy indicated below. You do not intend to have both policies to be issued and placed in force. If the "Additional Policy" box is checked, you are indicating that you are applying for both the policy shown in Sections G-1 through G-3 and the policy indicated below. The total amount of insurance you are applying for is the sum of both face amounts.

- ☐ Alternate Policy: Plan of Insurance _____ Face Amount \$ _____
Details (Riders, Benefits, Dividend Options, etc.): _____

- ☐ Additional Policy: Plan of Insurance _____ Face Amount \$ _____
Details (Riders, Benefits, Dividend Options, etc.): _____

SECTION I: Premiums

1. Who is to pay premiums? ☐ Owner ☐ Insured ☐ Other *If "Other" elected, please provide the below information.*

a. Name _____

b. Reason for Paying Premiums _____

c. Social Security Number _____ d. Relationship to Proposed Insured _____

e. Street Address _____

City _____ State _____ Zip _____

2. **Mode:** ☐ Annual

☐ Monthly Automatic Bank Draft (GOM)

☐ New *If elected, please complete the appropriate request form.*

☐ Add to Owner's existing GOM Service Existing Policy/Control Number _____

☐ Semi-Annual

☐ Quarterly

☐ Monthly (List bill only – this may not be available for all products.)

☐ New – Billing Name _____

☐ Existing – Account Number _____

☐ Common Billing Date _____

3. Automatic Premium Loan (if available): ☐ Yes ☐ No *If left blank, default will be NO.*

4. Will premiums be paid in advance (PPIA) under the company's PPIA program? ☐ Yes ☐ No
If "Yes," please complete PPIA form.

5. Will money be submitted with this application?

☐ Yes, in the amount of \$ _____. *If elected, please refer to the Representations section.*

☐ No

6. Secondary Addressee Designation

Do you want to designate a secondary addressee for the purpose of notification of past due premium payments and/or possible lapse in coverage? ☐ Yes ☐ No *If "Yes," please provide the name and address of the designated secondary addressee below.*

Name _____

Mailing Address _____

City _____ State _____ Zip _____

7. Policy Date

The policy date will be automatically determined based on the issue date of the policy unless the backdating option is elected. *Note: You will be required to pay premiums from the elected date. See the Representations section of this application for more information on the impact of such request.*

☐ Backdate to save age

Note: If electing to backdate to save age, the policy date will be one day prior to your six-month birthday.

SECTION J: Financial Information of Owner

1. To the best of your knowledge and belief, is the applied for policy in accordance with your insurance objectives and your anticipated financial needs? ☐ Yes ☐ No
2. To the best of your knowledge and belief, do you believe you have the financial ability to continue making premium payments on this policy? ☐ Yes ☐ No
3. Have you ever filed for personal or business bankruptcy? ☐ Yes ☐ No

If "Yes": ☐ Personal ☐ Business Date of Discharge (mm/dd/yyyy) _____

If bankruptcy has not been discharged, please provide the chapter/type of bankruptcy and the date it was filed in the Remarks section.

4. Personal Finances:

Personal Finances	Proposed Insured	Owner (if other than Insured)
Net Worth	\$	\$
Expected Earned Income (This Year)	\$	\$
Expected Unearned Income (This Year)	\$	\$
Actual Income (Last Calendar Year)	\$	\$
Actual Unearned Income (Last Calendar Year)	\$	\$

Business Finances (Complete **only** if the policy is for business coverage.)

5. Type of Business (Check One): ☐ Limited Liability Co. ☐ Sole Proprietor ☐ Partnership ☐ S Corp ☐ C Corp
☐ Other _____

6.

Total Business Assets	\$
Total Business Liabilities	\$
Business Net Worth	\$
Business Net Profit After Taxes for Prior Year	\$
Business Net Profit After Taxes for 2 Years Prior	\$

7. How long has the business been established: ☐ Less than 1 year ☐ 1-5 years ☐ Greater than 5 years

8. What is the nature of the business? _____

9. What percentage of the business is owned by the Proposed Insured? _____ %

10. Is there business insurance applied for or in force on other key members of this firm? ☐ Yes ☐ No

If "Yes," please provide details: _____

SECTION K: Insurance History

Please list below all existing life insurance policies in force on the Proposed Insured. If none, check here ☐.

1. Guardian Policy(ies):

Policy Number	Individual (I) or Group (G)	Year Issued	Total Amount	Who Owns the Policy?
	☐ I ☐ G			
	☐ I ☐ G			
	☐ I ☐ G			
	☐ I ☐ G			

2. Non-Guardian Policy(ies):

Name of Company	Individual (I) or Group (G)	Year Issued	Total Amount	Who Owns the Policy?
	☐ I ☐ G			
	☐ I ☐ G			
	☐ I ☐ G			
	☐ I ☐ G			

3. Has the Proposed Insured ever had life, disability, accident or medical insurance declined, postponed, modified, rated or cancelled, have withdrawn a pending application, or had a renewal or reinstatement refused? *If "Yes," please provide full details in the Remarks section.* ☐ Yes ☐ No
4. Are any other life, disability or accident insurance products currently being applied for on the life of the Proposed Insured, or is there any plan to do so in the near future? *If "Yes," please include amount and company applied with, and whether this other insurance will be in addition to or in lieu of insurance with the Company.* ☐ Yes ☐ No
5. If the Proposed Insured is age 14 years and 6 months or less, what is the amount of insurance in force on the applicant?
\$ _____

SECTION L: Existing Insurance/Replacement

NOTE: Please complete the "Definition of Replacement" Form in ALL cases.

1. As a result of the proposed purchase of life insurance, have you (the Applicant/Owner) done, or do you intend on doing, any of the following to any existing life insurance policy or annuity contract that you own: lapse, partial lapse, surrender, forfeit, assignment to an insurer, termination of existing insurance; taking loans, withdrawals, or any other use of funds from your existing insurance (including a stoppage or reduction in premium payments) to pay the premiums on the new life insurance policy? ☐ Yes ☐ No

IMPORTANT: If "Yes," please complete the appropriate state replacement form(s). In addition, you must fully complete the information below for all policies for which you answered "Yes."

Policy Number	Issuing Company	Name of Insured	Face Amount of Policy

SECTION M: Personal History of Proposed Insured (Complete ONLY if age 16 and above)

These questions apply to the Proposed Insured. If "Yes" to Questions 2, 4, 5, and/or 8, please provide details in the Remarks section.

1. Are you, or do you intend to become, a member of the Armed Forces, including the Reserves, or are you on alert? *If "Yes," please complete the Military Status Supplement.* ☐ Yes ☐ No

2. Do you intend to change your occupation? ☐ Yes ☐ No

3. Do you intend to reside outside of the U.S. within the next 2 years? *If "Yes," please complete the Foreign Travel and Residence Supplement.* ☐ Yes ☐ No

4. Do you intend to travel outside of the U.S. within the next 2 years? ☐ Yes ☐ No

If "Yes": Country _____ Duration _____ Purpose of Travel _____
 Country _____ Duration _____ Purpose of Travel _____
 Country _____ Duration _____ Purpose of Travel _____

If additional space is needed, please provide details in the Remarks section.

5. Have you ever had your driver's license suspended or revoked, been convicted of operating a motor vehicle under the influence of alcohol or drugs, or within the past 5 years, have you been convicted of any motor vehicle moving violations? *If "Yes," please provide the date of violation, description of the violation and the penalty in the Remarks section.* ☐ Yes ☐ No

6. Within the last 2 years, have you flown as a licensed pilot, student pilot, or crew member in any type of aircraft, or do you intend to do so in the next 2 years? *If "Yes," please complete the Aviation Supplement.* ☐ Yes ☐ No

7. Within the last 2 years, have you participated in, or in the next 2 years do you intend to participate in, any of the following activities? *If "Yes," please complete the Avocation Supplement.* ☐ Yes ☐ No

☐ Mountain Climbing ☐ Rock Climbing ☐ Scuba Diving ☐ Hang Gliding
☐ Parachuting ☐ Skydiving ☐ Motor Vehicle Racing

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

9. 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.

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.			

SECTION N: Tax Certification

Under penalties of perjury I certify that:

- (1) The number shown on this form is my correct social security number or taxpayer identification number, and
- (2) I am not subject to backup withholding because:
 - (a) I am exempt from backup withholding, or;
 - (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or;
 - (c) the IRS has notified me that I am no longer subject to backup withholding, and;
- (3) I am a U.S. citizen (including a U.S. Resident Alien) or domestic business entity, and;
- (4) I am exempt from FATCA reporting*

Check the box below if you are unable to certify to #2 above and have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return.

☐ I am subject to backup withholding as a result of a failure to report all interest and dividends on my tax return.

**The Company requires FATCA (Foreign Account Tax Compliance Act) reporting only for certain non-U.S. payees that receive FATCA withholdable payments. You are not required to provide a FATCA exemption code.*

DO NOT COMPLETE IF APPLICANT IS A U.S. CITIZEN.

I am not a U.S. Citizen, U.S. Resident Alien or U.S. Entity and have attached a completed IRS Form W-8BEN, W-8BEN-E or other W-8 appropriate for my status. *Please obtain a current version of the form from www.irs.gov. A foreign person is subject to U.S. tax on U.S. sourced income and a mandatory 30% withholding may apply (for tax treaty information and eligibility for a reduced rate, please see IRS Publication 515).*

*Signature of Foreign Person or Individual Authorized to Sign
on Behalf of the Foreign Corporation or Entity*

Date

SECTION O: Remarks**(If needed, attach additional sheets)**

Question #	Details

SECTION P: Representations and Signatures of the Proposed Insured and Owner

Those parties who sign below, agree that:

1. This application, (Part I, Medical Supplement Part II, the Authorization, any amendments to the application, and any required supplements or questionnaires) will form the basis for, and will be attached to and become a part of, any policy issued. All of the statements that are part of the application are correctly recorded, and are complete and true to the best of the knowledge and belief of those persons who made them.
2. No producer, broker or medical examiner has any right to accept risks, make, void or change contracts, change the terms of this application, waive or modify any of the Company's rights or requirements or extend the time for any payment. No information acquired by any Representative of the Company shall bind the Company unless it shall have been set out in writing in this application.
3. For any policy that will be issued, the policy date is the date from which premiums are calculated and become due. Except as provided in the Conditional Temporary Coverage and Receipt (if an advance payment has been made and such Receipt has been issued and its terms complied with), no insurance coverage shall take effect unless and until the policy is delivered to and accepted by the Owner and all delivery requirements have been completed and the first premium is paid, and this delivery, acceptance and premium payment occurs (a) during the lifetime of the Proposed Insured, and (b) while all answers in this application are still true and complete, and (c) prior to any change in the health or insurability, of the Proposed Insured.
4. Backdating is the process whereby a policy is given a policy date that is earlier than the date a policy is issued. backdating requests involve saving age, as such your insurance age will be one year younger than your actual age and may result in a lower premium. However, by electing to backdate the policy (Section I, #7 of this application), the premium will be billed from a date that will result in you paying premium for a period of time during which the policy did not provide insurance coverage. You are not required to pay such premium, but by selecting to backdate the policy you will be doing so. You can avoid paying such premium by not requesting the policy be backdated. The amount of time you will be paying premium for the policy that did not provide coverage depends on the time it takes to underwrite, issue and deliver the policy, if a policy is issued. You can reduce the amount of time by promptly completing any requirements or paying a premium and obtaining a Conditional Temporary Coverage and Receipt.
5. 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.
6. If applying for a rider form that provides for the ability to accelerate the policy's death benefit for based on receiving long term care services for a chronic illness, the application for this rider is done so voluntarily and without coercion on the part of a third party.
7. That I have received a Life Insurance Buyer's Guide including, if applicable, an explanation of the use of life insurance cost indexes and a Simplified Product Explanation for Universal Life Insurance policies;
8. If applying for a rider form that provides for the ability to accelerate the death benefit for terminal illness and/or chronic illness, I (we) certify that I (we) have received a disclosure describing the benefits and conditions of such rider.
Receipt of accelerated death benefits may affect eligibility for public assistance programs and may be taxable.
9. Amendments will only be made with the Owner's written consent.

The Internal Revenue Service does not require your consent to any provision of this document other than the Tax Certification made in Section N.

Signed at _____
City and State Month/Day/Year

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

Signature of Applicant/Owner
(if other than Proposed Insured)

Signature of Witness
(for applications taken by mail – should not be the beneficiary)

Signature of Additional Owner

SECTION Q: Representations and Signatures of the Producer

- ☐ Check here if this application was sent to the Proposed Insured for signature by mail or e-mail. If so, the signature of the producer does not attest to the signature of the Proposed Insured.
- ☐ Check here if this application was taken in the presence of the Proposed Insured. I certify that I have taken this application in the presence of the Proposed Insured, and that I have truly and accurately recorded on this application the information supplied by the Proposed Insured.

Signature of Licensed Producer

License Number(s)

Producer's Name

State(s) where licensed



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

Life Insurance CLIENT PROFILE

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.

Guardian wants to evaluate whether the life insurance policy(ies) you are applying for meets your needs. In order to do that, we are requesting that you provide the following information in order to assist with our determination.

SECTION A: Client Information

Owner Type: ☐ Individual (Complete Section B #1 for Owner) ☐ Charity (Complete Section B #3)
☐ Trust ☐ Business Entity (Complete Section B #3)

If owner type is a Trust, how are the premiums associated with the policy(ies) being applied for being paid?

- ☐ Trust Assets (Complete Section B #2)
☐ Grantor of Trust (Complete Section B #1 based on grantor information)
☐ Non-grantor third party (Complete Section B #1 based on that individual)

Is premium financing or another form of borrowing (e.g. split dollar cases where premiums are borrowed from the business) used to pay the premiums under the policy? ☐ Yes ☐ No

SECTION B: Financial Information

1. Individual

a. Full Name _____

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

c. Personal Finances

Expected Earned Income (This Year)	\$
Expected Unearned Income (This Year)	\$
Approximate Earned Income (Last Calendar Year)	\$
Approximate Unearned Income (Last Calendar Year)	\$
Estimated Net Worth*	\$
Estimated Liquid Net Worth**	\$

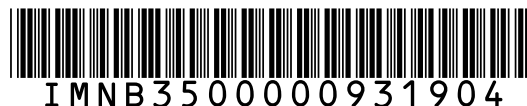
d. What are your expected monthly household expenses? \$ _____

e. Do you anticipate any financial events that are not reflected in questions c and d above?

☐ Yes ☐ No If "Yes," please provide details in Section E below.

*Net Worth is defined as the value of your assets minus your liabilities. Assets may include stocks, bonds, mutual funds, other securities, bank accounts and other personal and real property including the current value of your primary residence. Liabilities include any outstanding loans, credit card balances, taxes, mortgages, etc.

**Liquid Net Worth is defined as your net worth minus your assets that cannot be converted quickly and easily into cash, such as investment real estate, business equity, personal property, expected inheritances, and assets marked for other purposes. It can include assets that are readily convertible to cash, including checking, savings and brokerage accounts, IRAs, and 401(k)/403(b) accounts. Financial products and accounts with current surrender and early withdrawal penalties should be adjusted to reflect any current redemption charges or penalties.



SECTION B: Financial Information (continued)**2. Trust**

- a. Name of Trust _____
- b. Name of Trustee(s) _____
- c. Trust Finances
- | | |
|--|----|
| Estimated Trust Assets | \$ |
| Liquid Trust Assets | \$ |
| Estimated Total Trust Income (This Year) | \$ |
| Estimated Total Trust Income (Previous Year) | \$ |
- d. If recurring expenses are paid from the trust, please indicate the monthly amount: \$ _____
- e. Do you anticipate any financial events that are not reflected in the questions above?
☐ Yes ☐ No If "Yes," please provide details in Section E below.

3. Business Entity

- a. Name of Business _____
- b. Type of Business (Check one): ☐ Limited Liability Co. ☐ Sole Proprietor ☐ Partnership ☐ S Corp
☐ C Corp ☐ Other _____
- c. How long has the business been established? ☐ Less than 1 year ☐ 1-5 years ☐ Greater than 5 years
- d. Business Finances
- | | |
|---|----|
| Current Assets | \$ |
| Current Liabilities | \$ |
| Business Net Profit After Taxes Prior Year | \$ |
| Business Net Profit After Taxes for 2 Years Prior | \$ |

4. What is your level of experience with the financial products below? (Skip if Business Entity or Trust assets are used to pay the premiums on the policy(ies) that is (are) being applied for.)

Financial Product	None	Limited	Extensive
Permanent Life Insurance	☐	☐	☐
Term Life Insurance	☐	☐	☐
Annuities	☐	☐	☐
Stocks/Bonds/Mutual Funds	☐	☐	☐
Qualified Plans (401(k), etc.)	☐	☐	☐
Certificates of Deposit	☐	☐	☐

5. Based on your current expectations, how long do you plan to keep your life insurance coverage?
☐ Lifetime ☐ Less than 5 years ☐ 5 -10 years ☐ 11-20 years ☐ 21-30 years
6. What is your estimated current combined city, state and federal tax bracket? (Skip if Business Entity or Trust assets are used to pay the premiums on the policy(ies) that is (are) being applied for.)
☐ Low (0-15%) ☐ Middle (15.1% - 32%) ☐ High (32.1% - 50%) ☐ Top (50.1% and above)
7. Is there any additional information that you feel is important for us to know to understand if the insurance coverage is appropriate for you? ☐ Yes ☐ No If "Yes," please provide details in Section E below.

SECTION C: Purpose of Insurance

1. Do you have a need for a death benefit provided by a life insurance policy? ☐ Yes ☐ No

If "No," please provide details in Section E below.

2. How do you intend to use the insurance policy(ies)? *(Check all that apply.)*

- Personal: ☐ Family Income ☐ Estate Planning ☐ Charitable Planning ☐ Retirement
☐ Mortgage ☐ Education ☐ Wealth Accumulation ☐ Collateral for Debt
☐ Other _____
- Business: ☐ Buy-Sell ☐ Deferred Compensation ☐ Key Person ☐ Executive Bonus
☐ Split Dollar ☐ Qualified Plan ☐ Other _____

3. How do you plan to pay the premiums for this insurance coverage? *(Check all that apply.)*

- ☐ Annual Income ☐ Existing Savings/Money Market ☐ Existing Life Insurance
☐ Inheritance ☐ Retirement Plan Assets ☐ Stocks, Bonds or Other Investments
☐ Gift ☐ Sale of a business, second home or other non-financial asset
☐ Other* _____

**If "Other" is selected, or if there is additional information you would like to provide on how you plan to pay for this coverage, please provide details in Section E below.*

SECTION D: Replacement

If any existing coverage has been or will be replaced with your planned purchase, as defined in the New York Department of Financial Services Definition of Replacement form, please answer the following questions. If no replacement is involved in this transaction, check here ☐ and skip the remainder of this section.

1. How many policies are being replaced? _____
2. What is the total current annual premium on the existing policy(ies)? \$ _____
3. What is the total current face amount under the existing policy(ies)? \$ _____
4. Does the replaced policy(ies) have a current cash value? ☐ Yes ☐ No
If "Yes," what is the total amount of cash value of the policy(ies) being replaced? \$ _____
5. Have you replaced or exchanged another life insurance policy or annuity contract within the last 36 months?
☐ Yes ☐ No *If Yes, please provide additional information in Section E below including how many replacements.*

SECTION E: Other Information

SECTION F: Client Acknowledgements and Signature

I understand that some life insurance policies have non-guaranteed elements that are subject to change at the Company's sole discretion. I further understand and am willing to accept that:

- These non-guaranteed elements are typically associated with permanent life insurance policies and include components such as dividends for whole life policies and the cost of insurance rates and credited interest rates for universal life policies;
- Some term life insurance policies also include scheduled premiums that may be changed;
- Where relevant, these non-guaranteed elements are outlined in the illustration that I have been provided and that was explained to me by my producer;
- Premiums are payable as stated in the policy; however, illustrations may show non-guaranteed elements being applied to reduce the amount and number of premiums payable and that a reduction in those non-guaranteed elements may result in paying premiums longer and/or paying higher premiums than those shown on the sales illustration.

In addition, by signing below, I acknowledge and agree that:

- My producer has explained the rationale for the insurance policy(ies) being applied for, the amount of coverage and the features, the benefits and limitations of the policy(ies) that he or she has recommended, and I understand and agree with his/her recommendation;
- I have the financial ability to continue making premium payments for the insurance policy(ies) for which I have applied;
- A copy of this signed client profile will be provided to me as part of the application process.
- If I am purchasing permanent life insurance, I understand that loans or withdrawals will impact policy cash values and death benefits;
- To the best of my knowledge, the information that I have provided on this form is current and accurate and I believe that the insurance policy(ies) I have applied for is (are) consistent with my insurance planning objectives and appropriate for my financial situation.

Client Signature

Date

Client Signature

Date

SECTION G: Producer Representations and Signature

By signing below, I acknowledge that:

- I have reasonable grounds to believe that the information provided on this form by the applicant applying for this insurance coverage is accurate and complete;
- I have discussed the features, benefits and limitations of the insurance policy(ies) applied for with the applicant.
- I have considered whether an adverse change in health rating or tax liability would negatively impact the applicant applying for this insurance coverage;
- Based on what I know of the applicant applying for this insurance coverage at this time, the policy being applied for will provide a benefit to the consumer over the life of the policy(ies) and is appropriate to meet the financial and other objectives of the applicant;
- A copy of this completed form will be provided to the applicant as part of the application process;
- If I am an agent with a Field Representative contractual relationship (FR Contract) with The Guardian Life Insurance Company of America (Guardian), I have provided the Guardian Financial Representative Disclosure to the applicant.

Signature of Producer

Date

Producer's Name



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

Producer Certification

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.

Please print.

SECTION A: Proposed Insured Information

This Producer's Certification is to be used with the application for life insurance on the life of (*Proposed Insured*):

First Name _____ MI _____ Last Name _____

Date of Birth (mm/dd/yyyy) _____ for the application dated on _____.

SECTION B: Producer's Certification

1. Is the sale of this product being made in conjunction with a specific corporate marketing initiative? Please check one of the following (select the most appropriate):

☐ No Marketing Initiative ☐ Wealth Steps ☐ Business Resource Center ☐ CPA Referral

☐ Living Balance Sheet ☐ DI to Life Program ☐ Take Advantage/Rapid App ☐ Other _____

- 2a. Is there a current Individual Disability Income application pending with Berkshire? ☐ Yes ☐ No

- 2b. Has an individual Disability Income application been submitted to Berkshire within the past 6 months? ☐ Yes ☐ No

If "Yes" to either question 2a or 2b, please provide the policy number and other details in the Remarks section.

- 3a. How long have you known the Proposed Insured/Applicant? _____ years
the Proposed Owner? _____ years

- 3b. Have you seen the Proposed Insured by live video (virtual conference) or in person within the last 30 days? ☐ Yes ☐ No

4. If the Proposed Insured is not gainfully employed, please provide the amount of insurance on premium payor's life and relationship to the Proposed Insured: _____

5. If the beneficiary is an estate, explain why, and who will ultimately receive the proceeds of the policy: _____

6. Do you have knowledge of any existing life insurance policy or annuity contract in force on the Proposed Insured? ☐ Yes ☐ No

7. Do you have knowledge or reason to believe that replacement of an existing life insurance policy or annuity may be involved by reason of this transaction? ☐ Yes ☐ No

8. Will the sale of this policy involve the use of Premium Financing? ☐ Yes ☐ No
If "Yes," please provide the name of the lending institution and other details in the Remarks and Additional Instructions section.

- 9a. Did every person signing this application communicate in English well enough to understand and answer each question in English? *If "No," please answer questions 9b, 9c, and 9d.* ☐ Yes ☐ No

- 9b. Who acted as interpreter? _____

- 9c. If English was not used as the primary language, which language and/or dialect was the sales interview conducted in? _____

- 9d. For the purpose of completing any Personal Information Telephone Interview, the Proposed Insured can converse comfortably in: _____

10. Was a preliminary inquiry previously submitted to Underwriting in connection with this application? ☐ Yes ☐ No
If "Yes," please provide Application (policy) number: _____



SECTION B: Producer's Certification (continued)

11. Is the premium for this policy to be paid by a person or entity other than the Owner? ☐ Yes ☐ No
If "Yes," please provide a letter of authorization (with all required signatures) and also provide payor's Tax ID number.

ONLY answer questions 12-14 if the proposed insured is under age 15.

- 12a. How much do you think the Applicant is worth? \$ _____
- 12b. What do you believe the Applicant's annual income to be? \$ _____
- 12c. What is the total amount of life insurance in force on the life of the Applicant? \$ _____
13. Did you see the Proposed Insured at the time this application was completed? ☐ Yes ☐ No
- a. Did he/she appear to be in good health at the time? ☐ Yes ☐ No
- b. Did he/she appear to have any kind of physical disability? ☐ Yes ☐ No
14. Give names of brothers and sisters of Proposed Insured who are under the age of 18, and date of birth and insurance in force and applied for on each.

Name	Date of Birth	Insurance Inforce/Applied For
_____	_____	_____
_____	_____	_____
_____	_____	_____

15. Was this application signed and dated in a state other than the state in which the Owner lives or works? *If "Yes," please provide details in the Remarks and Additional Instructions section.* ☐ Yes ☐ No
16. What underwriting requirements are being submitted?
- Medical Supplement (Choose One): ☐ eMed and Physical Measurements ☐ Paramedical Examination
- Other Medical Requirements: ☐ EKG ☐ Stress EKG ☐ Blood ☐ Urine ☐ APS
17. Is the entity applying for the coverage a Captive Insurance Company, an entity that is a subsidiary of a Captive, or a life insurance trust that has entered into a split dollar arrangement with Captive or a subsidiary of the Captive? ☐ Yes ☐ No

SECTION C: Remarks and Additional Instructions

SECTION D: Commissions

Producer's Name	Producer's Code	Servicing Producer (Check 1)	Producer's Social Security Number	Percentage
		☐		
		☐		
		☐		
		☐		
		☐		
		☐		

SECTION E: Signatures

Unless this application was taken by mail as indicated in the Representations section, I certify that I have taken this application in the presence of the Proposed Insured (and Owner, if Other than the Proposed Insured, for Variable Life) and that I have truly and accurately recorded on this application the information supplied by the Proposed Insured.

For all applications: The answers to all questions on this application are full, complete and true to the best of my knowledge and belief. I represent that, to the best of my knowledge and belief, the insurance being applied for is suitable for the Owner's insurance needs and financial objectives. I know nothing unfavorable about this risk which is not fully set forth in these papers. The writing Producer or broker is duly appointed and licensed in the state in which this application was signed and for the product(s) proposed.

Signed at _____
City and State Month/Day/Year

Type or print Producer's/Dealer's name Signature of Soliciting Producer

Signature of Approved Registered Principal
(For Variable Life Only) Signature of General Producer



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

NOTICE OF AIDS VIRUS (HIV) ANTIBODY TESTING AND CONSENT FOR TESTING

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

THE TESTS

To evaluate your eligibility for insurance benefits, you may be asked to provide a sample of your blood, urine or oral fluid for testing and analysis. One of the tests to be performed on this sample would be a test to determine the presence of antibodies to the Human Immunodeficiency Virus (HIV), also known as the AIDS Virus. The HIV antibody test is actually a series of tests done by a medically accepted procedure.

MEANING OF TEST RESULTS

While positive HIV antibody test results do not mean that you have AIDS, they do mean that you are at seriously increased risk of developing AIDS or AIDS-related conditions. Federal authorities say that persons who are HIV antibody positive should be considered infected with the AIDS virus and capable of infecting others. Positive HIV antibody test results will adversely affect your insurance application. Individuals receiving a positive test result may wish to consider further independent testing.

DISCLOSURE OF TEST RESULTS

All test results will be treated confidentially. The results will be reported to the insurance company indicated above. The results also may be reported to that insurance company's affiliates, agents, or insurers in connection with insurance you have or have applied for. In addition, if your HIV antibody test is abnormal (positive), a generic code signifying a non-specific test abnormality may be made known to the Medical Information Bureau (MIB, Inc.) as described in the notice given you at the time of application. We will not otherwise disclose the fact that a test has been done or the results of the test except as may be required by law or as authorized by you.

AUTHORIZATION FOR NOTIFICATION

If you wish, you may indicate an individual to whom you would like to have test results sent in the event that your application for insurance is declined. You may choose to have the results sent directly to yourself or to another individual. (You may wish to have them sent to your physician or to another trained person so that Guardian, GIAC or Berkshire can have him or her tell you the test results and explain their meaning.)

Please indicate your choice by check mark:

- ☐ Send the test results to my physician or another person.

Name of Physician or Other Person: _____

Address: _____

- ☐ Send the test results to me directly at the following address: _____

FOR FURTHER INFORMATION

Please read the Red Cross publication entitled "AIDS: The Facts" provided to you by the insurer indicated above. In New York State, call 1-800-541-AIDS (2437) for further information about AIDS, the meaning of HIV-related test results, and the availability and location of HIV-related counseling services.

CONSENT

I have read and I understand this Notice of AIDS virus (HIV) Antibody Testing and Consent for Testing. For my information, I have been given written material about AIDS. I voluntarily consent to the withdrawal of blood from me by needle, or finger prick or the withdrawal of urine or oral fluid, the testing of my blood, urine or oral fluid for HIV antibodies, and the disclosure of the test results as described above.

NAME OF PROPOSED INSURED (PLEASE PRINT)

DATE

SIGNATURE OF PROPOSED INSURED OR, IF PROPOSED
INSURED LACKS LEGAL CAPACITY, THAT OF INDIVIDUAL
AUTHORIZED TO CONSENT

STATE OF RESIDENCE





Customer Service Office
Mailing Address
6255 Sterner's Way
Bethlehem, PA 18017-9464

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.

DEPARTMENT OF FINANCIAL SERVICES OF THE STATE OF NEW YORK
DEFINITION OF REPLACEMENT

IN ORDER TO DETERMINE WHETHER YOU ARE REPLACING OR OTHERWISE CHANGING THE STATUS OF EXISTING LIFE INSURANCE POLICIES OR ANNUITY CONTRACTS, AND IN ORDER TO RECEIVE THE VALUABLE INFORMATION NECESSARY TO MAKE A CAREFUL COMPARISON IF YOU ARE CONTEMPLATING REPLACEMENT, THE AGENT OR BROKER IS REQUIRED TO ASK YOU THE FOLLOWING QUESTIONS AND EXPLAIN ANY ITEMS THAT YOU DO NOT UNDERSTAND.

AS PART OF YOUR PURCHASE OF A NEW LIFE INSURANCE POLICY OR A NEW ANNUITY CONTRACT, HAS EXISTING COVERAGE BEEN, OR IS IT LIKELY TO BE:

1. LAPSED, SURRENDERED, PARTIALLY SURRENDERED, FORFEITED, ASSIGNED TO THE INSURER REPLACING THE LIFE INSURANCE POLICY OR ANNUITY CONTRACT, OR OTHERWISE TERMINATED? YES ☐ NO ☐
2. CHANGED OR MODIFIED INTO PAID-UP INSURANCE; CONTINUED AS EXTENDED TERM INSURANCE OR UNDER ANOTHER FORM OF NONFORFEITURE BENEFIT; OR OTHERWISE REDUCED IN VALUE BY THE USE OF NONFORFEITURE BENEFITS, DIVIDEND ACCUMULATIONS, DIVIDEND CASH VALUES OR OTHER CASH VALUES? YES ☐ NO ☐
3. CHANGED OR MODIFIED SO AS TO EFFECT A REDUCTION EITHER IN THE AMOUNT OF THE EXISTING LIFE INSURANCE OR ANNUITY BENEFIT OR IN THE PERIOD OF TIME THE EXISTING LIFE INSURANCE OR ANNUITY BENEFIT WILL CONTINUE IN FORCE? YES ☐ NO ☐
4. REISSUED WITH A REDUCTION IN AMOUNT SUCH THAT ANY CASH VALUES ARE RELEASED, INCLUDING ALL TRANSACTIONS WHEREIN AN AMOUNT OF DIVIDEND ACCUMULATIONS OR PAID-UP ADDITIONS IS TO BE RELEASED ON ONE OR MORE OF THE EXISTING POLICIES? YES ☐ NO ☐
5. ASSIGNED AS COLLATERAL FOR A LOAN OR MADE SUBJECT TO BORROWING OR WITHDRAWAL OF ANY PORTION OF THE LOAN VALUE, INCLUDING ALL TRANSACTIONS WHEREIN ANY AMOUNT OF DIVIDEND ACCUMULATIONS OR PAID-UP ADDITIONS IS TO BE BORROWED OR WITHDRAWN ON ONE OR MORE EXISTING POLICIES? YES ☐ NO ☐
6. CONTINUED WITH A STOPPAGE OF PREMIUM PAYMENTS OR REDUCTION IN THE AMOUNT OF PREMIUM PAID? YES ☐ NO ☐

IF YOU HAVE ANSWERED YES TO ANY OF THE ABOVE QUESTIONS, A REPLACEMENT AS DEFINED BY NEW YORK INSURANCE REGULATION 60 HAS OCCURRED OR IS LIKELY TO OCCUR AND YOUR AGENT OR BROKER IS REQUIRED TO PROVIDE YOU WITH THE **IMPORTANT** NOTICE REGARDING REPLACEMENT OR CHANGE OF LIFE INSURANCE POLICIES OR ANNUITY CONTRACTS. YOU WILL ALSO RECEIVE A COMPLETED DISCLOSURE STATEMENT NO LATER THAN THE TIME YOUR NEW POLICY OR NEW CONTRACT IS DELIVERED.

Date: _____ Signature of Applicant: _____

Date: _____ Signature of Applicant: _____

TO THE BEST OF MY KNOWLEDGE, A REPLACEMENT IS INVOLVED IN THIS TRANSACTION: YES ☐ NO ☐

Date: _____ Signature of Agent or Broker: _____





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

Accelerated Benefit Rider Summary and Disclosure Statement

The insurer identified below will be herein referred to as the "Company."
THE GUARDIAN LIFE INSURANCE COMPANY OF AMERICA

NOTE: RECEIPT OF ACCELERATED DEATH BENEFITS MAY AFFECT ELIGIBILITY FOR PUBLIC ASSISTANCE PROGRAMS AND MAY BE TAXABLE.

NOTICE TO BUYER: This rider may not cover all of the costs associated with the chronic illness of the insured. The buyer is advised to review carefully the rider benefits.

This Disclosure Statement provides a brief summary of the important features of an Accelerated Benefit Rider; it does not alter any of the rider's provisions. The actual provisions of the rider set forth its full details and conditions.

EFFECTS OF AN ACCELERATED BENEFIT PAYMENT ON A LIFE INSURANCE POLICY

WHEN AN ACCELERATED BENEFIT IS PAID, A LIEN IS CREATED AGAINST THE POLICY EQUAL TO THE AMOUNT OF THE ACCELERATED BENEFIT WE PAY, PLUS LIEN CARRYING CHARGES TO THE NEXT POLICY ANNIVERSARY. ANY LIEN CREATED WILL BEAR CARRYING CHARGES, WHICH ARE PAYABLE IN ADVANCE ON THE DATE THE LIEN WAS CREATED AND ON EACH SUBSEQUENT POLICY ANNIVERSARY. The interest rate varies depending on the amount of the outstanding lien. If the outstanding lien is less than or equal to the cash value of the policy plus the cash value of any additions discounted to the date the lien carrying charges are determined, the lien carrying charge rate is equal to the lesser of the fixed loan interest rate then in effect under the policy or an adjustable loan interest rate as allowed by law. The rate for any amount of an outstanding lien which exceeds the cash value of the policy plus the cash value of additions discounted to the date the lien carrying charges are determined is equal to an adjustable loan interest rate as allowed by law. The adjustable loan interest rate is based on the Moody's corporate bond yield average published by Moody's Investors Service, Inc., or any successor thereto, as of the calendar month ending two months before the first day of the month of the policy anniversary.

THE CASH SURRENDER VALUE, LOAN VALUE, AND DEATH PROCEEDS PAYABLE WILL BE REDUCED BY ANY LIEN OUTSTANDING DUE TO THE PAYMENT OF AN ACCELERATED BENEFIT. IN ADDITION, THE DIVIDEND PAYABLE WILL BE AFFECTED BY ANY OUTSTANDING LIEN AND LIEN CARRYING CHARGES DURING THE POLICY YEAR. HOWEVER, THE POLICY'S FACE AMOUNT AND CASH VALUE ARE NOT AFFECTED BY ANY OUTSTANDING LIEN. WHILE A LIEN IS OUTSTANDING, THE POLICY WILL REMAIN IN FORCE AND THE FULL POLICY PREMIUM WILL STILL BE DUE (UNLESS THE POLICY IS PAID-UP OR PREMIUMS ARE THEN BEING WAIVED UNDER A WAIVER OF PREMIUM RIDER). HOWEVER, IF THE TOTAL LOAN PLUS OUTSTANDING LIEN, INCLUDING LIEN CARRYING CHARGES, EXCEEDS THE POLICY'S FACE AMOUNT PLUS THE FACE AMOUNT OF ANY ADDITIONS, THEN THE POLICY AND ANY OTHER RIDERS WILL END.

Upon receipt of a request for an accelerated benefit payment, guardian will notify the owner and any irrevocable beneficiary of the effect that such payment will have on policy benefits and values. We are prohibited from paying an accelerated benefit for a period of 14 days from the date we send such notification.

TAX CONSEQUENCES

Although the payments made under this rider are intended to qualify for favorable tax treatment under section 101(g) of the Federal Internal Revenue Code, payments under this rider may be taxable. The owner should consult a competent tax advisor to determine the current tax consequences before requesting any accelerated proceeds.

GOVERNMENT ENTITLEMENTS

YOUR ELIGIBILITY FOR PUBLIC ASSISTANCE PROGRAMS, SUCH AS MEDICAL ASSISTANCE (MEDICAID), AID TO FAMILIES WITH DEPENDENT CHILDREN, AND SUPPLEMENTAL SECURITY INCOME ("SSI") MAY BE AFFECTED BY HAVING AN ACCELERATED BENEFIT RIDER AS PART OF YOUR LIFE INSURANCE POLICY OR BY RECEIVING AN ACCELERATED BENEFIT PAYMENT. Exercising the option to receive an accelerated benefit payment and receiving such payment before applying for these programs, or while other government benefits are being received, may affect initial or continued eligibility. The appropriate social services agency (for example, the Medicaid Unit of the local Department of Public Welfare and Social Security Administration Office) should be consulted for more information concerning how receipt of an accelerated benefit payment will affect the eligibility of the recipient and/or the recipient's spouse or dependents.



LIMITS OF AN ACCELERATED BENEFIT RIDER

THE ACCELERATED BENEFIT RIDER IS NOT HEALTH, NURSING HOME, OR LONG TERM CARE INSURANCE, AND IT IS NOT INTENDED OR DESIGNED TO ELIMINATE YOUR NEED FOR SUCH COVERAGE. There are no restrictions or limits on the use of an accelerated benefit payment. An accelerated benefit payment may not be enough to cover your medical, nursing home or other bills.

OTHER OPTIONS

Even though it is attached to a policy, an Accelerated Benefit Rider does not have to be exercised. An Accelerated Benefit Rider provides you with an additional means of accessing cash under a life insurance policy, although it is not the only method of doing so. **Alternatively, you may elect to receive a loan (if available under your policy) or to make a surrender.**

DEFINITIONS

Activities of Daily Living: This means the basic human functional abilities which relate to the insured's ability to live independently. They are bathing, continence, dressing, eating, toileting and transferring.

Chronically Ill or Chronic Illness: This means that the insured has been certified, within the preceding 12 months, by a Physician as: (a) being permanently unable to perform (without Substantial Assistance from another individual) two or more Activities of Daily Living due to loss of functional capacity; or (b) requiring substantial supervision from another individual to protect the insured from threats to health and safety due to permanent Severe Cognitive Impairment.

Severe Cognitive Impairment: This means a deterioration or loss of intellectual capacity that is: (a) comparable to (and includes) Alzheimer's disease and similar forms of irreversible dementia; and (b) measured by clinical evidence and standardized tests that reliably measure impairment.

Substantial Assistance: This means Hands-on Assistance or Standby Assistance. Hands-on Assistance means the physical assistance of another person without which the individual would be unable to perform the Activity of Daily Living. Standby Assistance means the presence of another person within arm's reach of the individual that is necessary to prevent, by physical intervention, injury to the individual while he or she is performing an Activity of Daily Living.

Terminally Ill or Terminal Illness: This means that the insured has been certified by a physician as having an illness or physical condition which can reasonably be expected to result in death within 12 months.

THE ACCELERATED BENEFIT PAYMENT

An accelerated benefit payment may be made to the owner of a life insurance policy if the owner provides proof acceptable to Guardian that the insured is either chronically ill or terminally ill as defined above. This proof includes a physician's certification regarding the insured's medical condition. Guardian must receive at its home office the owner's written request for an accelerated benefit payment and the physician's certification regarding the insured's medical condition.

The accelerated benefit payment will be paid to the owner in a lump sum. However, multiple accelerations can be requested (up to 4 per policy year).

LIMITATIONS OR CONDITIONS ON ELIGIBILITY OF BENEFITS

Accelerated Benefit payments are limited by the Total Lien Limit and, for chronic illness accelerations, by the Annual Lien Limit. The owner may take a maximum of 4 liens per policy year. If the policy was issued as part of a pension plan, in order for an Accelerated Benefit to be paid, the policy must be out of the pension plan and individually owned. The policy must be in force other than as extended term insurance on the date the accelerated benefit is requested. However, an acceleration on account of terminal illness will be permitted while the policy is in force as extended term insurance provided such insurance is more than one year from its date of expiry. Guardian must receive at its home office the written consent of any assignee and any irrevocable beneficiary to the payment of the accelerated benefit. And, when a lien is outstanding under the policy, no changes may be made to the plan or amount of the policy.

ANNUAL LIEN LIMIT

When accelerated benefits are paid on account of the Chronic Illness of the insured, Guardian imposes a maximum limit on the amount the owner may receive in a single calendar year. This maximum amount for base policy face amounts of \$250,000 and greater is the Per Diem Limitation declared each year by the Internal Revenue Service, multiplied by 365. In the first year in which accelerated benefits are paid Guardian will prorate this amount for the portion of the calendar year in which the insured is eligible for benefits.

If the face amount of the policy is less than \$250,000, the Annual Lien Limit is reduced proportionally based on the ratio of the policy's face amount to \$250,000.

When a claim is made for a chronic illness accelerated benefit, New York State Regulations may require us to reduce or limit the payment, depending on whether the owner has received similar payments from our policy and other insurance sources during the same calendar year.

There is no Annual Lien Limit for accelerated benefits paid because of the Terminal Illness of the insured.

TOTAL LIEN LIMIT

The Total Lien Limit is the policy's Cash Value as of the date to which premiums have been paid plus:

- For Terminal Illness: 80% of the Net Amount at Risk
- For Chronic Illness: a percentage of the Net Amount at Risk, varying by age, as follows

Age	Percentage
Up to 67	20%
68	24%
69	28%
70	32%
71	36%
72	40%
73	44%
74	48%
75	52%
76	56%
77	60%
78	64%
79	68%
80	72%
81	76%
82 and over	80%

The percentage will be locked in, at the insurance attained age, when the first accelerated benefit payment is made.

Net Amount at Risk: Net Amount at Risk on a given date means the face amount of the base policy plus any additions, less the cash value of the base policy and any additions, as of the date to which premiums have been paid.

ADMINISTRATIVE FEE

A one-time Administrative Fee will be charged the first time that an Accelerated Benefit is paid under this rider. This charge is associated with Guardian's administrative costs for processing an Accelerated Benefit payment to the owner. This charge is \$250, and it is deducted from the Accelerated Benefit payable, and it is included in the lien that is created as a result of that payment.

COST

There is no additional premium charged to add an Accelerated Benefit Rider to a life insurance policy. There is a one-time administrative fee deducted from the first acceleration if the rider is exercised. Also, any lien created through the exercise of this rider will accrue lien carrying charges.

TERMINATION

This Accelerated Benefit Rider will terminate on the earliest of:

- The date the life insurance policy terminates;
- The date of the insured's death;
- Upon receipt of proper written request for cancellation at Guardian's home office. This rider must be sent to the home office for cancellation. However, if there is a lien outstanding, the rider cannot be cancelled unless the lien is repaid;

If unpaid lien carrying charges are added to an existing lien, and the resulting lien, together with any outstanding loan, equals or exceeds the policy face amount plus the face amount of any additions, this policy and rider will terminate.

However, the owner will have 31 days from the date on which this occurs to pay the unpaid lien carrying charges and/or loan interest to prevent this from happening and keep the policy and rider in force.

If this policy terminates while there is a lien outstanding, there is no further recourse to the policyowner.

Generic Illustration of Accelerated Benefit Rider

The following are 2 generic sample illustrations showing the potential effect of using the Accelerated Benefit Rider. The first sample shows a chronic illness acceleration, and the second shows a terminal illness acceleration. These samples show a single accelerated benefit being paid at the beginning of the 11th policy year. These samples are not intended to relate to the specific policy the applicant is applying for. The following assumptions were made in preparing these samples:

- The insured is a 45 year old male in the Preferred Plus premium class;
- The policy is a Whole Life 100 policy with a Face Amount of \$1,000,000, and no Paid-Up Additions Rider;
- Acceleration occurs at age 55;
- The cash values and death benefit values shown below are based on guaranteed values. This sample illustration does not reflect any dividends;

Sample Chronic Illness Acceleration

The sample assumes the owner is electing the maximum benefit allowed under the rider. For the chronic illness acceleration, benefits payable are limited by both the Total Lien Limit and an Annual Lien Limit, which is based on the IRS per diem limitation. The acceleration shown below is based on the full Annual Lien Limit.

Age	Premium Payable	Accelerated Benefit Paid ¹	Policy Face Amount	Policy Guaranteed Cash Value	Lien Amount ²	Net Death Benefit ³	Net Cash Surrender Value ⁴
55	\$ 18,178	\$ 117,477	\$ 1,000,000	\$ 177,900.00	\$ 127,145.16	\$ 872,854.84	\$ 50,754.84
56	\$ 18,178		\$ 1,000,000	\$ 199,500.00	\$ 137,316.77	\$ 862,683.23	\$ 62,183.23
57	\$ 18,178		\$ 1,000,000	\$ 221,380.00	\$ 148,302.11	\$ 851,697.89	\$ 73,077.89
58	\$ 18,178		\$ 1,000,000	\$ 243,550.00	\$ 160,166.28	\$ 839,833.72	\$ 83,383.72
59	\$ 18,178		\$ 1,000,000	\$ 266,000.00	\$ 172,979.59	\$ 827,020.41	\$ 93,020.41
60	\$ 18,178		\$ 1,000,000	\$ 288,720.00	\$ 186,817.95	\$ 813,182.05	\$ 101,902.05
61	\$ 18,178		\$ 1,000,000	\$ 311,650.00	\$ 201,763.39	\$ 798,236.61	\$ 109,886.61
62	\$ 18,178		\$ 1,000,000	\$ 334,770.00	\$ 217,904.46	\$ 782,095.54	\$ 116,865.54
63	\$ 18,178		\$ 1,000,000	\$ 357,990.00	\$ 235,336.82	\$ 764,663.18	\$ 122,653.18
64	\$ 18,178		\$ 1,000,000	\$ 381,280.00	\$ 254,163.76	\$ 745,836.24	\$ 127,116.24
65	\$ 18,178		\$ 1,000,000	\$ 402,900.00	\$ 274,496.86	\$ 725,503.14	\$ 128,403.14
66	\$ 18,178		\$ 1,000,000	\$ 424,470.00	\$ 296,456.61	\$ 703,543.39	\$ 128,013.39
67	\$ 18,178		\$ 1,000,000	\$ 445,980.00	\$ 320,173.14	\$ 679,826.86	\$ 125,806.86
68	\$ 18,178		\$ 1,000,000	\$ 467,460.00	\$ 345,786.99	\$ 654,213.01	\$ 121,673.01
69	\$ 18,178		\$ 1,000,000	\$ 488,890.00	\$ 373,449.95	\$ 626,550.05	\$ 115,440.05
70	\$ 18,178		\$ 1,000,000	\$ 510,220.00	\$ 403,325.95	\$ 596,674.05	\$ 106,894.05
71	\$ 18,178		\$ 1,000,000	\$ 531,330.00	\$ 435,592.03	\$ 564,407.97	\$ 95,737.97
72	\$ 18,178		\$ 1,000,000	\$ 552,110.00	\$ 470,439.39	\$ 529,560.61	\$ 81,670.61
73	\$ 18,178		\$ 1,000,000	\$ 572,390.00	\$ 508,074.54	\$ 491,925.46	\$ 64,315.46
74	\$ 18,178		\$ 1,000,000	\$ 592,090.00	\$ 548,720.50	\$ 451,279.50	\$ 43,369.50
75	\$ 18,178		\$ 1,000,000	\$ 611,170.00	\$ 592,618.14	\$ 407,381.86	\$ 18,551.86
76	\$ 18,178		\$ 1,000,000	\$ 629,650.00	\$ 640,027.59	\$ 359,972.41	\$ (10,377.59)
77	\$ 18,178		\$ 1,000,000	\$ 647,620.00	\$ 691,229.80	\$ 308,770.20	
78	\$ 18,178		\$ 1,000,000	\$ 665,170.00	\$ 746,528.18	\$ 253,471.82	
79	\$ 18,178		\$ 1,000,000	\$ 682,380.00	\$ 806,250.44	\$ 193,749.56	
80	\$ 18,178		\$ 1,000,000	\$ 699,240.00	\$ 870,750.47	\$ 129,249.53	
81	\$ 18,178		\$ 1,000,000	\$ 715,660.00	\$ 940,410.51	\$ 59,589.49	
82	---		\$ 1,000,000	\$ 731,510.00	\$ 1,015,643.35	\$ (15,643.35)	

NOTES:

1. This is the dollar amount of the accelerated benefit actually paid. This amount assumes that the IRS per diem limitation for chronic illness accelerated benefit payments will grow each year at 3%. The per diem limit is indexed for inflation by the IRS each year, but not necessarily at 3%. The benefit amount shown also reflects the deduction of the one-time administrative charge of \$250.
2. This is the lien amount created against the policy. It begins as the requested lien amount (assumed to be the Annual Lien Limit) with interest to the end of the year. The values in this column assume that lien carrying charges are not paid by the owner, but rather allowed to accumulate at interest. The interest rate used in this calculation is 8%. A different rate may apply as described on page 1 of this form.
3. The net death benefit shown is the policy face amount minus the outstanding lien.
4. The net cash surrender value shown is the amount available to the owner as either a policy loan, or upon a surrender of the policy for cash.

Sample Terminal Illness Acceleration

The sample assumes the owner is electing the maximum benefit allowed under the rider. For a terminal illness acceleration, this is the Total Lien Limit.

Age	Premium Payable	Accelerated Benefit Paid ¹	Policy Face Amount	Policy Guaranteed Cash Value	Lien Amount ²	Net Death Benefit ³	Net Cash Surrender Value ⁴
55	\$ 18,178	\$ 835,330	\$ 1,000,000	\$ 177,900.00	\$ 902,426.40	\$ 97,573.60	\$ 0
56	\$ 18,178		\$ 1,000,000	\$ 199,500.00	\$ 974,620.50	\$ 25,379.50	\$ 0
57	\$ 18,178		\$ 1,000,000	\$ 221,380.00	\$ 1,052,590.00	\$ (52,590.00)	\$ 0

NOTES:

1. This is the dollar amount of the accelerated benefit actually paid, and reflects the deduction of the one-time administrative charge of \$250.
2. This is the lien amount created against the policy. It begins as the requested lien amount (assumed to be the Total Lien Limit) with interest to the end of the year. The values in this column assume that lien carrying charges are not paid by the owner, but rather allowed to accumulate at interest. The interest rate used in this calculation is 8%. A different rate may apply as described on page 1 of this form.
3. The net death benefit shown is the policy face amount minus the outstanding lien.
4. The net cash surrender value shown is the amount available to the owner as either a policy loan, or upon a surrender of the policy for cash.



THE GUARDIAN LIFE INSURANCE COMPANY OF AMERICA
Customer Service Office
6255 Sterner's Way
Bethlehem, PA 18017-9464
1-888-GUARDIAN

**APPLICATION SUPPLEMENT
REPLACEMENT OF EXISTING ACCIDENT AND HEALTH INSURANCE**

You are applying for a whole life insurance policy with an accelerated benefit rider that permits the death benefit to be accelerated on account of the insured's chronic illness. Such a rider is an accelerated benefit rider on a life insurance policy. It is not long-term care or health insurance, nor is it intended to be a replacement for such insurance. Nevertheless, we are required under New York Insurance Regulations to ask you these questions as part of the application process.

1. Do you currently have in force any accident or health insurance policy, or life insurance policy that includes an accelerated benefit rider that permits acceleration on account of chronic illness? ☐ Yes ☐ No
(If Yes, please complete the table below. Please also answer the Questions 2 and 3.)
2. As a result of the proposed purchase of new life insurance, have you or do you plan to lapse or otherwise terminate an inforce accident or health insurance policy, or an accelerated benefit rider on a life insurance policy that permits acceleration on account of chronic illness? ☐ Yes ☐ No (If Yes, please indicate in the table below those policies that will be lapsed or terminated.)

Inforce Accident/Health Insurance or Life Insurance with Accelerated Benefits

Policy Number	Issuing Company/Source of Insurance	Type of Policy	Being Replaced?
			☐ Yes
			☐ Yes
			☐ Yes
			☐ Yes

3. Do any of the above insurance products provide payments on account of the chronic illness of the insured that are paid on a per diem or other periodic basis without regard to actual expenses incurred? ☐ Yes ☐ No

If Yes, please indicate which policies _____

Please sign and date this form signifying both that you were presented this form and also that the responses and information shown above is complete and accurate to the best of your knowledge and belief.

Signature of Applicant

Date

AGENTS: Please certify, by signing and dating below:

I have reviewed the current accident and health insurance coverage of the applicant, and find that the indicated replacement, or the additional coverage of the type and amount applied for, is appropriate for the applicant's needs.

Signature of Agent

Date

(Original – Home Office; 1st Copy – Applicant; 2nd Copy – Agency)



THE GUARDIAN LIFE INSURANCE COMPANY OF AMERICA 10 Hudson Yards, New York, NY 10001
THE GUARDIAN INSURANCE & ANNUITY COMPANY, INC. 10 Hudson Yards, New York, NY 10001
BERKSHIRE LIFE INSURANCE COMPANY OF AMERICA 700 South Street Pittsfield, MA 01201

Full legal 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 14 ½.

I hereby authorize the disclosure and/or release of all the information described 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, and 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, the Veteran's Administration, the Social Security Administration, the Department of Motor Vehicles, state agency, MIB, LLC, 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 including social media. The information obtained using this authorization may be compiled and/or interpreted by those listed above and/or a third party.

Investigative consumer reports. I authorize the Company or its legal representatives to obtain or have prepared investigative consumer reports 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 and/or release my entire medical record without restriction. I understand that the information disclosed and/or released could contain reference to, or results of, sexually transmitted diseases, genetic testing or epigenetic testing, or genetic or epigenetic 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 will be valid for twenty-four (24) months from the date shown below. However, this time limit may be shorter if so required by applicable law in the state where the policy is delivered or issued for delivery. I agree that a copy of this Authorization will be as valid as the original. I agree that if I sign this Authorization electronically, including via voice authorization, then it will be equally as effective and valid as if I had signed it through traditional means. I understand, however, that I am under no obligation to sign this Authorization electronically.

I know that I may revoke this Authorization in writing, at any time, by sending a written request for revocation to the Head of Underwriting 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.

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 representatives may use the information to perform actuarial or research studies, analytics, review internal processes or experience, and/or conduct a legally permissible contestability review. 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 disclose and/or release any information obtained using this Authorization to any person or organization except to reinsurance companies, MIB, LLC., 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, or 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 and/or released 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 policyowner, 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 MIB, LLC.

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 and the MIB Pre-Notice. 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 Proposed Insured is under age 14 ½)

**Customer Service Office****Mailing Address**

P.O. Box 981590

El Paso, TX 79998-1590

Insurance Information Practices

THE GUARDIAN LIFE INSURANCE COMPANY OF AMERICA

THE GUARDIAN INSURANCE & ANNUITY COMPANY, INC.

BERKSHIRE LIFE INSURANCE COMPANY OF AMERICA

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, LLC 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, LLC, 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, LLC

If you make a request of MIB, LLC, 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, LLC and seek to correct the information according to procedures set forth in the Federal Fair Credit Reporting Act. MIB, LLC'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, LLC 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.

Life Insurance Buyer's Guide

This guide can help you when you shop for life insurance. It discusses how to:

- Find a Policy That Meets Your Needs and Fits Your Budget
- Decide How Much Insurance You Need
- Make Informed Decisions When You Buy a Policy

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Pub 4313

Prepared by the National Association of Insurance Commissioners

The National Association of Insurance Commissioners is an association of state insurance regulatory officials. This association helps the various insurance departments to coordinate insurance laws for the benefit of all consumers.

This guide does not endorse any company or policy.

IMPORTANT THINGS TO CONSIDER

1. Review your own insurance needs and circumstances. Choose the kind of policy that has benefits that most closely fit your needs. Ask an agent or company to help you.
2. Be sure that you can handle premium payments. Can you afford the initial premium? If the premium increases later and you still need insurance, can you still afford it?
3. Don't sign an insurance application until you review it carefully to be sure all the answers are complete and accurate.
4. Don't buy life insurance unless you intend to stick with your plan. It may be very costly if you quit during the early years of the policy.
5. Don't drop one policy and buy another without a thorough study of the new policy and the one you have now. Replacing your insurance **may be costly.**
6. Read your policy carefully. Ask your agent or

company about anything that is not clear to you.

7. Review your life insurance program with your agent or company every few years to keep up with changes in your income and your needs.

Buying Life Insurance

When you buy life insurance, you want coverage that fits your needs.

First, decide how much you need - and for how long - and what you can afford to pay. Keep in mind the major reason you buy life insurance is to cover the financial effects of unexpected or untimely death. Life insurance can also be one of many ways you plan for the future.

Next, learn what kinds of policies will meet your needs and pick the one that best suits you.

Life Insurance Buyer's Guide

Then, choose the combination of policy premium and benefits that emphasizes protection in case of early death, or benefits in case of long life, or a combination of both.

It makes good sense to ask a life insurance agent or company to help you. An agent can help you review your insurance needs and give you information about the available policies. If one kind of policy doesn't seem to fit your needs, ask about others.

This guide provides only basic information. You can get more facts from a life insurance agent or company or from your public library.

WHAT ABOUT THE POLICY YOU HAVE NOW?

If you are thinking about dropping a life insurance policy, here are some things you should consider:

- If you decide to replace your policy, don't cancel your old policy until you have received the new one. You then have a minimum period to review your new policy and decide if it is what you wanted.
- It may be costly to replace a policy. Much of what you paid in the early years of the policy you have now, paid for the company's cost of selling and issuing the policy. You may pay this type of cost again if you buy a new policy.
- Ask your tax advisor if dropping your policy could affect your income taxes.

- If you are older or your health has changed, premiums for the new policy will often be higher. You will not be able to buy a new policy if you are not insurable.
- You may have valuable rights and benefits in the policy you now have that are not in the new one.
- If the policy you have now no longer meets your needs, you may not have to replace it. You might be able to change your policy or add to it to get the coverage or benefits you now want.
- At least in the beginning, a policy may pay no benefits for some causes of death covered in the policy you have now.

In all cases, if you are thinking of buying a new policy, check with the agent or company that issued you the one you have now. When you bought your old policy, you may have seen an illustration of the benefits of your policy. Before replacing your policy, ask your agent or company for an updated illustration. Check to see how the policy has performed and what you might expect in the future, based on the amounts the company is paying now.

HOW MUCH DO YOU NEED?

Here are some questions to ask yourself:

- How much of the family income do I provide? If I were to die early, how would my survivors, especially my children, get by? Does anyone else depend on me financially, such as a parent, grandparent, brother or sister?

Life Insurance Buyer's Guide

- Do I have children for whom I'd like to set aside money to finish their education in the event of my death?
- How will my family pay final expenses and repay debts after my death?
- Do I have family members or organizations to whom I would like to leave money?
- Will there be estate taxes to pay after my death?
- How will inflation affect future needs?

As you figure out what you have to meet these needs, count the life insurance you have now, including any group insurance where you work or veteran's insurance. Don't forget Social Security and pension plan survivor's benefits. Add other assets you have: savings, investments, real estate and personal property. Which assets would your family sell or cash in to pay expenses after your death?

WHAT IS THE RIGHT KIND OF LIFE INSURANCE?

All policies are not the same. Some give coverage for your lifetime and others cover you for a specific number of years. Some build up cash values and others do not. Some policies combine different kinds of insurance, and others let you change from one kind of insurance to another. Some policies may offer other benefits while you are still living. Your choice should be based on your needs and what you can afford.

There are two basic types of life insurance: **term insurance** and **cash value insurance**. Term insurance generally has lower premiums in the early years, but does not build up cash values that you can use in the future. You may combine cash value life insurance with term insurance for the period of your greatest need for life insurance to replace income.

Term Insurance covers you for a term of one or more years. It pays a death benefit only if you die in that term. Term insurance generally offers the largest insurance protection for your premium dollar. It generally does not build up cash value.

You can renew most term insurance policies for one or more terms even if your health has changed. Each time you renew the policy for a new term, premiums may be higher. Ask what the premiums will be if you continue to renew the policy. Also ask if you will lose the right to renew the policy at some age. For a higher premium, some companies will give you the right to keep the policy in force for a guaranteed period at the same price each year. At the end of that time you may need to pass a physical examination to continue coverage, and premiums may increase.

You may be able to trade many term insurance policies for a cash value policy during a conversion period - even if you are not in good health. Premiums for the new policy will be higher than you have been paying for the term insurance.

Life Insurance Buyer's Guide

Cash Value Life Insurance is a type of insurance where the premiums charged are higher at the beginning than they would be for the same amount of term insurance. The part of the premium that is not used for the cost of insurance is invested by the company and builds up a cash value that may be used in a variety of ways. You may borrow against a policy's cash value by taking a policy loan. If you don't pay back the loan and the interest on it, the amount you owe will be subtracted from the benefits when you die, or from the cash value if you stop paying premiums and take out the remaining cash value. You can also use your cash value to keep insurance protection for a limited time or to buy a reduced amount without having to pay more premiums. You also can use the cash value to increase your income in retirement or to help pay for needs such as a child's tuition without canceling the policy. However, to build up this cash value, you must pay higher premiums in the earlier years of the policy. Cash value life insurance may be one of several types; whole life, universal life and variable life are all types of cash value insurance.

Whole Life Insurance covers you for as long as you live if your premiums are paid. You generally pay the same amount in premiums for as long as you live. When you first take out the policy, premiums can be several times higher than you would pay initially for the same amount of term insurance. But they are smaller than the premiums you would eventually pay if you were to keep renewing a term policy until your later years.

Some whole life policies let you pay premiums for a shorter period such as 20 years, or until age 65. Premiums for these policies are higher since the premium payments are made during a shorter period.

Universal Life Insurance is a kind of flexible policy that lets you vary your premium payments. You can also adjust the face amount of your coverage. Increases may require proof that you qualify for the new death benefit. The premiums you pay (less expense charges) go into a policy account that earns interest. Charges are deducted from the account. If your yearly premium payment plus the interest your account earns is less than the charges, your account value will become lower. If it keeps dropping, eventually your coverage will end. To prevent that, you may need to start making premium payments, or increase your premium payments, or lower your death benefits. Even if there is enough in your account to pay the premiums, continuing to pay premiums yourself means that you build up more cash value.

Variable Life Insurance is a kind of insurance where the death benefits and cash values depend on the investment performance of one or more separate accounts, which may be invested in mutual funds or other investments allowed under the policy. Be sure to get the prospectus from the company when buying this kind of policy and **STUDY IT CAREFULLY**. You will have higher death benefits and cash value if the underlying investments do well. Your benefits and cash value will be lower or may disappear if the investments you chose

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didn't do as well as you expected. You may pay an extra premium for a guaranteed death benefit.

LIFE INSURANCE ILLUSTRATIONS

You may be thinking of buying a policy where cash values, death benefits, dividends or premiums may vary based on events or situations the company does not guarantee (such as interest rates). If so, you may get an illustration from the agent or company that helps explain how the policy works. The illustration will show how the benefits that are not guaranteed will change as interest rates and other factors change. The illustration will show you what the company guarantees. It will also show you what could happen in the future. Remember that nobody knows what will happen in the future. You should be ready to adjust your financial plans if the cash value doesn't increase as quickly as shown in the illustration. You will be asked to sign a statement that says you understand that some of the numbers in the illustration are not guaranteed.

FINDING A GOOD VALUE IN LIFE INSURANCE

After you have decided which kind of life insurance is best for you, compare similar policies from different companies to find which one is likely to give you the best value for your money. A simple comparison of the premiums is not enough. There are other things to consider. For example:

- Do premiums or benefits vary from year to year?
- How much do the benefits build up in the policy?
- What part of the premiums or benefits is not guaranteed?
- What is the effect of interest on money paid and received at different times on the policy?

Once you have decided which type of policy to buy, you can use a cost comparison index to help you compare similar policies. Life insurance agents or companies can give you information about several different kinds of indexes that each work a little differently. One type helps you compare the costs between two policies if you give up the policy and take out the cash value. Another helps you compare your costs if you don't give up your policy before its coverage ends. Some help you decide what kind of questions to ask the agent about the numbers used in an illustration. Each index is useful in some ways, but they all have shortcomings. Ask your agent which will be most helpful to you. Regardless of which index you use, compare index numbers only for similar policies — those that offer basically the same benefits, with premiums payable for the same length of time.

Remember that no one company offers the lowest cost at all ages for all kinds and amounts of insurance. You should also consider other factors:

- How quickly does the cash value grow? Some policies have low cash values in the early years that build quickly later on. Other policies have a more level cash value build-up. A year-by-year display of values and benefits can be very helpful. (The agent or company will give you a policy summary or an illustration that will show benefits and premiums for selected years.)
- Are there special policy features that particularly suit your needs?
- How are nonguaranteed values calculated? For example, interest rates are important in determining policy returns. In some companies, increases reflect the average interest earnings on all of that company's policies regardless of when issued. In others the return for policies issued in a recent year, or group of years, reflects the interest earnings on that group of policies; in this case, amounts paid are likely to change more rapidly when interest rates change.

Life Insurance Buyer's Guide

NEW YORK ADDENDUM TO LIFE BUYER'S GUIDE

After you have decided which kind of life insurance fits your needs, look for a good buy. Your chances of finding a good buy are better if you use two types of index numbers that have been developed to aid in shopping for life insurance. One is called the "Surrender Cost Index" and the other is the "Net Payment Cost Index". It will be worth your time to try to understand how these indexes are used, but in any event, use them only for comparing the relative costs of similar policies. LOOK FOR POLICIES WITH LOW COST INDEX NUMBERS.

WHAT IS COST?

"Cost" is the difference between what you pay and what you get back. If you pay a premium for life insurance and get nothing back, your cost for the death protection is the premium. If you pay a premium and get something back later on, such as a cash value, your cost is smaller than the premium.

The cost of some policies can also be reduced by dividends; these are called "participating" policies. Companies may tell you what their current dividends are, but the size of future dividends is unknown today and cannot be guaranteed. Dividends actually paid are set each year by the company.

Some policies do not pay dividends. These are called "guaranteed cost" or "nonparticipating" policies. Every feature of a guaranteed cost policy is fixed so that you know in advance what your future cost will be.

The premiums and cash values of a participating policy are guaranteed, but the dividends are not. Premiums for participating policies are typically higher than for guaranteed cost policies, but the cost to you may be higher or lower, depending on the dividends actually paid.

WHAT ARE COST INDEXES?

In order to compare the cost of policies, you need to look at:

1. Premiums
2. Cash Values
3. Dividends

Cost Indexes use one or more of these factors to give you a convenient way to compare relative costs of similar policies. When you compare costs, an adjustment must be made to take into account that money is paid and received at different times. It is not enough to just add up the premiums you will pay and to subtract the cash values and dividends you expect to get back. These indexes take care of the arithmetic for you. Instead of having to add, subtract, multiply and divide many numbers yourself, you just compare the index numbers which you can get from life insurance agents and companies.

1. *Life Insurance Surrender Cost Index.* This index is useful if you consider the level of the cash values to be of primary importance to you. It helps you compare costs if at some future point in time, such as 10 or 20 years, you were to surrender the policy and take its cash value.

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2. Life Insurance Net Payment Cost Index. This index is useful if your main concern is the benefits that are to be paid at your death and if the level of cash values is of secondary importance to you. It helps you compare costs at some future point in time, such as 10 or 20 years, if you continue paying premiums on your policy and do not take its cash value.

There is another number called the Equivalent Level Annual Dividend. It shows the part dividends play in determining the cost index of a participating policy. Adding a policy's Equivalent Level Annual Dividend to its cost index allows you to compare total costs of similar policies before deducting dividends. However, if you make any cost comparisons of a participating policy with a nonparticipating policy, remember that the total cost of the participating policy will be reduced by dividends, but the cost of the nonparticipating policy will not change.

HOW DO I USE COST INDEXES?

The most important thing to remember when using cost indexes is that a policy with a small index number is generally a better buy than a comparable policy with a larger index number. The following rules are also important:

1. Cost comparisons should only be made between similar plans of life insurance. Similar plans are those which provide essentially the same basic benefits and require premium payments for approximately the same period of time. The closer policies are to being identical, the more reliable the cost comparison will be.
2. Compare index numbers only for the kind of policy, for your age and for the amount you intend to buy. Since no one company offers the lowest cost for all types of insurance at all ages and for all amounts of insurance, it is important that you get the indexes for the actual policy, age and amount which you intend to buy. Just because a Shopper's Guide tells you that one company's policy is a good buy for a particular age and amount, you should not assume that all of that company's policies are equally good buys.
3. Small differences in index numbers could be offset by other policy features, or differences in the quality of service you may expect from the company or its agent. Therefore, when you find small differences in cost indexes, your choice would be based on something other than cost.
4. In any event, you will need other information on which to base your purchase decision. Be sure you can afford the premiums, and that you understand its cash values, dividends and death benefits. You should also make a judgement on how well the life insurance company or agent will provide service in the future, to you as a policyholder.
5. These life insurance cost indexes apply to new policies and should not be used to determine whether you should drop a policy you have already owned for a while, in favor of a new one. If such a replacement is suggested, you should ask for information from the company which issued the old policy before you take action.



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, General Agents, Professional Associate Brokers, and Protégés, 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

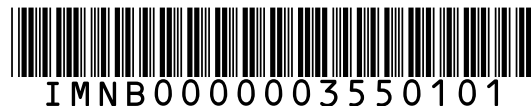
Printed Name

Date

Date

☐ NMI

☐ RMI





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

Qualified Retirement Plan/IRA Distribution Acknowledgment Form

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.

The purpose of this Acknowledgment Form is to determine if certain disclosures are required to be provided to you if your Producer makes a recommendation to take a distribution from a qualified retirement plan or individual retirement account (IRA) to pay premiums on a life insurance policy for which you have applied. In order to ensure you receive the proper information from your Producer, please answer the following question:

Has your Producer recommended that you take a current or future distribution from your qualified retirement plan or IRA to pay the current or future premiums on a life insurance policy for which you have applied? ☐ Yes ☐ No

If you answered "**Yes**" above, by signing below you acknowledge that you have received the Disclosure Form entitled, "Disclosures to Individuals Purchasing Life Insurance with a Distribution from a Qualified Retirement Plan or Individual Retirement Account."

If you answered "**No**" above, by signing below you acknowledge that your Producer has not recommended that you take a current or future distribution from a qualified retirement plan or IRA to pay current or future premiums on a life insurance policy for which you have applied.

Signature of Owner or Plan Participant

Date

By signing below, the Producer certifies that the information above is accurate and, if the owner or plan participant answered "**Yes**" above, the Producer further certifies that the required Disclosure Form entitled "Disclosures to Individuals Purchasing Life Insurance with a Distribution from a Qualified Retirement Plan or Individual Retirement Account" was provided to the owner or plan participant.

Signature of Producer

Date





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

WHOLE LIFE ACCELERATED DEATH BENEFIT RIDER SUMMARY AND DISCLOSURE STATEMENT

NOTE: RECEIPT OF ACCELERATED DEATH BENEFITS MAY AFFECT ELIGIBILITY FOR PUBLIC ASSISTANCE PROGRAMS AND MAY BE TAXABLE.

NOTICE TO BUYER: this rider may not cover all of the costs associated with the chronic illness of the insured. The buyer is advised to receive carefully the rider benefits.

This Disclosure Statement provides a brief summary of the important features of an Accelerated Death Benefit Rider; it does not alter any of the rider's provisions. The actual provisions of the rider set forth its full details and conditions.

EFFECTS OF AN ACCELERATED DEATH BENEFIT PAYMENT ON A LIFE INSURANCE POLICY

WHEN AN ACCELERATED DEATH BENEFIT IS PAID, A LIEN IS CREATED AGAINST THE POLICY EQUAL TO THE AMOUNT OF THE ACCELERATED DEATH BENEFIT WE PAY, PLUS LIEN CARRYING CHARGES TO THE NEXT POLICY ANNIVERSARY. ANY LIEN CREATED WILL BEAR CARRYING CHARGES WHICH ARE PAYABLE IN ADVANCE ON THE DATE THE LIEN WAS CREATED AND ON EACH SUBSEQUENT POLICY ANNIVERSARY. The interest rate varies depending on the amount of the outstanding lien. If the outstanding lien is less than or equal to the cash value of the policy plus the cash value of any additions discounted to the date the lien carrying charges are determined, the lien carrying charge rate is equal to the lesser of the fixed loan interest rate as described in the policy or an adjustable loan interest rate as allowed by law. The rate for any amount of an outstanding lien which exceeds the cash value of the policy plus the cash value of additions discounted to the date the lien carrying charges are determined is equal to an adjustable loan interest rate as allowed by law. The adjustable loan interest rate is based on the Moody's Corporate Bond Yield Average published by Moody's Investors Service, Inc., or any successor thereto, as of the calendar month ending two months before the first day of the month of the policy anniversary.

THE CASH SURRENDER VALUE, LOAN VALUE, AND DEATH PROCEEDS PAYABLE WILL BE REDUCED BY ANY LIEN OUTSTANDING DUE TO THE PAYMENT OF AN ACCELERATED DEATH BENEFIT. HOWEVER, THE POLICY'S FACE AMOUNT AND CASH VALUE ARE NOT AFFECTED BY ANY OUTSTANDING LIEN. IN ADDITION, ANY DIVIDEND PAYABLE WILL BE AFFECTED BY ANY OUTSTANDING LIEN AND LIEN CARRYING CHARGES DURING THE POLICY YEAR. WHILE A LIEN IS OUTSTANDING, THE POLICY WILL REMAIN IN FORCE AND THE FULL POLICY PREMIUM WILL STILL BE DUE (UNLESS THE POLICY IS PAID- UP OR PREMIUMS ARE THEN BEING WAIVED UNDER A WAIVER OF PREMIUM RIDER). HOWEVER, IF THE TOTAL LOAN PLUS OUTSTANDING LIEN, INCLUDING LIEN CARRYING CHARGES, EXCEEDS THE POLICY'S FACE AMOUNT PLUS THE FACE AMOUNT OF ANY ADDITIONS, THEN THE POLICY AND ANY OTHER RIDERS WILL END.

Upon receipt of a request for an accelerated death benefit payment, Guardian will notify the owner and any irrevocable beneficiary of the effect that such payment will have on policy benefits and values.

TAX CONSEQUENCES

Although the payments made under this rider are intended to qualify for favorable tax treatment under Section 101(g) of the federal internal revenue code, payments under this rider may be taxable. the owner should consult a competent tax advisor to determine the current tax consequences before requesting any accelerated proceeds.



GOVERNMENT ENTITLEMENTS

YOUR ELIGIBILITY FOR PUBLIC ASSISTANCE PROGRAMS, SUCH AS MEDICAL ASSISTANCE (MEDICAID), AID TO FAMILIES WITH DEPENDENT CHILDREN, AND SUPPLEMENTAL SECURITY INCOME ("SSI") MAY BE AFFECTED BY HAVING AN ACCELERATED DEATH BENEFIT RIDER AS PART OF YOUR LIFE INSURANCE POLICY OR BY RECEIVING AN ACCELERATED DEATH BENEFIT PAYMENT. Exercising the option to receive an accelerated death benefit payment and receiving such payment before applying for these programs, or while other government benefits are being received, may affect initial or continued eligibility. The appropriate social services agency (for example, the Medicaid Unit of the local Department of Public Welfare and Social Security Administration Office) should be consulted for more information concerning how receipt of an accelerated death benefit payment will affect the eligibility of the recipient and/or the recipient's spouse or dependents.

LIMITS OF AN ACCELERATED DEATH BENEFIT RIDER

THE ACCELERATED DEATH BENEFIT RIDER IS NOT HEALTH, NURSING HOME, OR LONG TERM CARE INSURANCE, AND IT IS NOT INTENDED OR DESIGNED TO ELIMINATE YOUR NEED FOR SUCH COVERAGE. There are no restrictions or limits on the use of an accelerated death benefit payment. An accelerated death benefit payment may not be enough to cover your medical, nursing home or other bills.

OTHER OPTIONS

Even though it is attached to a policy, an Accelerated Death Benefit Rider does not have to be exercised. An Accelerated Death Benefit Rider provides you with an additional means of accessing cash under a life insurance policy, although it is not the only method of doing so. **Alternatively, you may elect to receive a loan (if available under your policy) or to make a surrender.**

DEFINITIONS

Activities of Daily Living: This means the basic human functional abilities which relate to the insured's ability to live independently. They are bathing, continence, dressing, eating, toileting and transferring.

Chronically Ill or Chronic Illness: This means that the insured has been certified, within the preceding 12 months, by a Physician as: (a) being permanently unable to perform (without Substantial Assistance from another individual) two or more Activities of Daily Living due to loss of functional capacity; or (b) requiring substantial supervision from another individual to protect the insured from threats to health and safety due to permanent Severe Cognitive Impairment.

Severe Cognitive Impairment: This means a deterioration or loss of intellectual capacity that is: (a) comparable to (and includes) Alzheimer's disease and similar forms of irreversible dementia; and (b) measured by clinical evidence and standardized tests that reliably measure impairment.

Substantial Assistance: This means Hands-on Assistance or Standby Assistance. Hands-on Assistance means the physical assistance of another person without which the individual would be unable to perform the Activity of Daily Living. Standby Assistance means the presence of another person within arm's reach of the individual that is necessary to prevent, by physical intervention, injury to the individual while he or she is performing an Activity of Daily Living.

Terminally Ill or Terminal Illness: This means that the insured has been certified by a physician as having an illness or physical condition which can reasonably be expected to result in death within 12 months.

THE ACCELERATED DEATH BENEFIT PAYMENT

An accelerated death benefit payment may be made to the owner of a life insurance policy if the owner provides proof acceptable to Guardian that the both insured's or the last surviving insured is either chronically ill or terminally ill as defined above. This proof includes but is not limited to a physician's certification regarding the insured's medical condition. Guardian must receive at its customer service office the owner's written request for an accelerated death benefit payment and the physician's certification and claim form regarding the insured's medical condition.

The accelerated death benefit payment will be paid to the owner in a lump sum. However, multiple acceleration can be requested up to 4 per policy year).

LIMITATIONS OR CONDITIONS ON ELIGIBILITY OF BENEFITS

Accelerated Death Benefit payments are limited by the Total Lien Limit and for chronic illness acceleration, by the Annual Lien Limit. The owner may take a maximum of 4 liens per policy year. The policy must be in force on the date the accelerated death benefit is requested. If the policy is in force as paid-up insurance on the date the first accelerated death benefit is requested, the amount of paid-up insurance must be at least \$100,000. Guardian must receive at its customer service office the written consent of any assignee and any irrevocable beneficiary to the payment of the accelerated death benefit.

And, when a lien is outstanding under the policy, no changes may be made to the plan or amount of the policy.

ANNUAL LIEN LIMIT

When accelerated death benefits are paid on account of the Chronic Illness of the insured(s), Guardian imposes a maximum limit on the amount the owner may receive in a single calendar year. This maximum amount for base policy face amounts of \$250,000 and greater is the Per Diem Limitation declared each year by the Internal Revenue Service, multiplied by 365. In the first year in which accelerated death benefits are paid Guardian will prorate this amount for the portion of the calendar year in which the insured is eligible for benefits.

If the face amount of the policy is less than \$250,000, the Annual Lien Limit is reduced proportionally based on the ratio of the policy's face amount to \$250,000.

There is no Annual Lien Limit for accelerated death benefits paid because of the Terminal Illness of the insured.

TOTAL LIEN LIMIT

The Total Lien Limit is the policy's Cash Value as of the date to which premiums have been paid plus:

- For Terminal Illness: 80% of the Net Amount at Risk
- For Chronic Illness: a percentage of the Net Amount at Risk, varying by the younger insured's rated age, as follows

Age	Percentage
Up to 67	20%
68	24%
69	28%
70	32%
71	36%
72	40%
73	44%
74	48%
75	52%
76	56%
77	60%
78	64%
79	68%
80	72%
81	76%
82 and over	80%

The percentage will be locked in, at the youngest chronically ill insured's attained rated age, when the first accelerated death benefit payment is made.

Net Amount at Risk: Net Amount at Risk on a given date means the face amount of the base policy plus any additions, less the cash value of the base policy and any additions, as of the date to which premiums have been paid.

ADMINISTRATIVE FEE

A one-time Administrative Fee of \$250 will be charged the first time that an Accelerated Death Benefit is paid under this rider. This charge is associated with Guardian's administrative costs for processing an Accelerated Death Benefit payment to the owner. This charge is deducted from the Accelerated Death Benefit payable, and it is included in the lien that is created as a result of that payment.

COST

There is no additional premium charged to add an Accelerated Death Benefit Rider to a life insurance policy. There is a one time administrative fee deducted from the first acceleration if the rider is exercised. Also, any lien created through the exercise of this rider will accrue lien carrying charges.

TERMINATION

This Accelerated Death Benefit Rider will terminate on the earliest of:

- The date the basic policy terminates;
- The date of the last surviving insured's death;
- Upon receipt of proper written request for cancellation at Guardian's customer service office. This rider must be sent to the customer service office for cancellation. However, if there is a lien outstanding, the rider cannot be cancelled unless the lien is repaid;
- Upon election of a policy value option providing for reduced paid-up insurance, if the amount of reduced paid-up insurance is less than \$100,000 and no accelerated death benefit has ever been paid under this rider; or
- The date the loan plus total lien, including lien carrying charges, exceeds the policy face amount plus the face amount of any additions. If this happens, this policy and any other riders also terminate.

If unpaid lien carrying charges are added to an existing lien, and the resulting lien, together with any outstanding loan, equals or exceeds the policy face amount plus the face amount of any additions, this policy and rider will terminate.

However, the owner will have 31 days from the date on which this occurs to pay the unpaid lien carrying charges and/or loan interest to prevent this from happening and keep the policy and rider in force. If this policy terminates while there is a lien outstanding, there is no further recourse to the policyowner.

Generic Illustration of Accelerated Benefit Rider

The following are 2 generic sample illustrations showing the potential effect of using the Accelerated Benefit Rider. The first sample shows a chronic illness acceleration, and the second shows a terminal illness acceleration. These samples show a single accelerated benefit being paid at the beginning of the 11th policy year. These samples are not intended to relate to the specific policy the applicant is applying for. The following assumptions were made in preparing these samples:

- The insureds are male and female both age 45 in the Preferred Plus premium class;
- The policy as a Face Amount of \$1,000,000, and no Paid-Up Additions Rider;
- Acceleration occurs at age 55;
- The cash values and death benefit values shown below are based on guaranteed values. This sample illustration does not reflect any dividends;

Sample Chronic Illness Acceleration

The sample assumes the owner is electing the maximum benefit allowed under the rider. For the chronic illness acceleration, benefits payable are limited by both the Total Lien Limit and an Annual Lien Limit, which is based on the IRS per diem limitation. The acceleration shown below is based on the full Annual Lien Limit.

Age	Premium Payable	Policy Guaranteed Cash Value	Policy Face Amount	Accelerated Benefit Paid ¹	Lien Amount ²	Net Cash Surrender Value ³	Net Death Benefit ⁴
55	11,318	98,390	1,000,000	131,400	136,916	0	863,084
56	11,318	111,700	1,000,000	0	142,393	0	857,607
57	11,318	125,450	1,000,000	0	148,088	0	851,912
58	11,318	139,650	1,000,000	0	154,012	0	845,988
59	11,318	154,290	1,000,000	0	160,172	0	839,828
60	11,318	169,390	1,000,000	0	166,579	2,811	833,421
61	11,318	184,930	1,000,000	0	173,242	11,688	826,758
62	11,318	200,920	1,000,000	0	180,172	20,748	819,828
63	11,318	217,360	1,000,000	0	187,379	29,981	812,621
64	11,318	234,230	1,000,000	0	194,874	39,356	805,126
65	11,318	251,550	1,000,000	0	202,669	48,881	797,331
66	11,318	269,300	1,000,000	0	210,776	58,524	789,224
67	11,318	287,490	1,000,000	0	219,207	68,283	780,793
68	11,318	306,100	1,000,000	0	227,975	78,125	772,025
69	11,318	325,130	1,000,000	0	237,094	88,036	762,906
70	11,318	344,570	1,000,000	0	246,578	97,992	753,422
71	11,318	364,370	1,000,000	0	256,441	107,929	743,559
72	11,318	384,520	1,000,000	0	266,699	117,821	733,301
73	11,318	405,000	1,000,000	0	277,367	127,633	722,633

74	11,318	425,750	1,000,000	0	288,461	137,289	711,539
75	11,318	446,760	1,000,000	0	300,000	146,760	700,000
76	11,318	467,990	1,000,000	0	312,000	155,990	688,000
77	11,318	489,420	1,000,000	0	324,480	164,940	675,520
78	11,318	511,000	1,000,000	0	337,459	173,541	662,541
79	11,318	532,690	1,000,000	0	350,957	181,733	649,043
80	11,318	554,420	1,000,000	0	364,996	189,424	635,004
81	11,318	576,080	1,000,000	0	379,595	196,485	620,405
82	11,318	597,590	1,000,000	0	394,779	202,811	605,221
83	11,318	618,800	1,000,000	0	410,570	208,230	589,430
84	11,318	639,590	1,000,000	0	426,993	212,597	573,007
85	11,318	659,800	1,000,000	0	444,073	215,727	555,927
86	11,318	679,300	1,000,000	0	461,836	217,464	538,164
87	11,318	697,970	1,000,000	0	480,309	217,661	519,691
88	11,318	715,720	1,000,000	0	499,522	216,198	500,478
89	11,318	732,500	1,000,000	0	519,503	212,997	480,497
90	11,318	748,270	1,000,000	0	540,283	207,987	459,717
91	11,318	763,120	1,000,000	0	561,894	201,226	438,106
92	11,318	777,130	1,000,000	0	584,370	192,760	415,630
93	11,318	790,400	1,000,000	0	607,745	182,655	392,255
94	11,318	803,240	1,000,000	0	632,054	171,186	367,946
95	11,318	815,880	1,000,000	0	657,337	158,543	342,663
96	11,318	827,860	1,000,000	0	683,630	144,230	316,370
97	11,318	839,130	1,000,000	0	710,975	128,155	289,025
98	11,318	849,550	1,000,000	0	739,414	110,136	260,586
99	11,318	859,040	1,000,000	0	768,991	90,049	231,009
100	11,318	867,520	1,000,000	0	799,750	67,770	200,250
101	11,318	875,230	1,000,000	0	831,740	43,490	168,260
102	11,318	882,210	1,000,000	0	865,010	17,200	134,990
103	11,318	888,580	1,000,000	0	899,610	0	100,390
104	11,318	894,520	1,000,000	0	935,595	0	64,405
105	11,318	900,370	1,000,000	0	973,019	0	26,981
106	11,318	906,650	1,000,000	0	1,011,939	0	0

NOTES:

1. This is the dollar amount of the accelerated benefit actually paid. This amount assumes that the IRS per diem limitation for chronic illness accelerated benefit payment is \$360. The per diem limit is indexed for inflation by the IRS each year.
2. This is the lien amount created against the policy. It begins as the requested lien amount (assumed to be the Annual Lien Limit) increased with the one-time administrative charge of \$250 and interest to the end of the year. The values in this column assume that lien carrying charges are not paid by the owner, but rather allowed to accumulate at interest. The interest rate used in this calculation is 4%. A different rate may apply as described on page 1 of this form.
3. The net cash surrender value shown is the amount available to the owner as either a policy loan, or upon a surrender of the policy for cash.
4. The net death benefit shown is the policy face amount minus the outstanding lien.

Sample Terminal Illness Acceleration

The sample assumes the owner is electing the maximum benefit allowed under the rider. For a terminal illness acceleration, this is the Total Lien Limit.

Age	Premium Payable	Policy Guaranteed Cash Value	Policy Face Amount	Accelerated Benefit Paid ¹	Lien Amount ²	Net Cash Surrender Value ³	Net Death Benefit ⁴
55	11,318	98,390	1,000,000	817,104	850,048	0	149,952
56	11,318	111,700	1,000,000	0	884,050	0	115,950
57	11,318	125,450	1,000,000	0	919,412	0	80,588
58	11,318	139,650	1,000,000	0	956,189	0	43,811
59	11,318	154,290	1,000,000	0	994,436	0	5,564
60	11,318	169,390	1,000,000	0	1,034,214	0	0

Notes

1. This is the dollar amount of the accelerated benefit actually paid.
2. This is the lien amount created against the policy. It begins as the requested lien amount (assumed to be the Total Lien Limit) increased with the one-time administrative charge of \$250 and interest to the end of the year. The values in this column assume that lien carrying charges are not paid by the owner, but rather allowed to accumulate at interest. The interest rate used in this calculation is 4%. A different rate may apply as described on page 1 of this form.
3. The net cash surrender value shown is the amount available to the owner as either a policy loan, or upon a surrender of the policy for cash.
4. The net death benefit shown is the policy face amount minus the outstanding lien.



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

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

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 not 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



The Guardian Life Insurance Company of America
A Mutual Company Established 1860

Customer Service Office
P.O. Box 981590, El Paso, TX 79998-1590
(1-888) GUARDIAN (1-888-482-7342)

Disability Income and Waiver of Policy Premium Benefit Rider

OUTLINE OF COVERAGE

Rider Form Number DIR NY

1. **READ THE RIDER CAREFULLY** – This outline of coverage briefly describes some of the important features of the rider. This is not the insurance contract and only the actual rider provisions will control. The rider itself sets forth, in detail, the rights and obligations of the Owner, the insured and Guardian Life Insurance Company of America. It is important that THE RIDER BE READ VERY CAREFULLY!
2. **DISABILITY INCOME PROTECTION** – This type of coverage is designed to provide benefits for a Disability resulting from Injury or Sickness, subject to any limitations set forth in the rider. Benefits are not provided for basic hospital, basic medical-surgical, or major medical expenses.
3. **BENEFITS OF THE RIDER** – The rider provides benefits for Total Disability, Partial Disability, and Waiver of Premium Benefits.

Monthly Benefit \$_____.

Benefits start to accrue at the end of an Elimination Period of 180 days.

The Benefit Period is 5 Years.

Definition of Total Disability or Totally Disabled:

- 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, the insured is not able to perform the Material and Substantial Duties of the insured's Occupation. The insured will be Totally Disabled even if the insured is Gainfully Employed in another occupation so long as, solely due to Injury or Sickness, the insured is unable to work in the insured's Occupation; and
- After we have paid benefits for two years and until we have paid benefits for five years in the same claim, Total Disability or Totally Disabled means that solely due to Injury or Sickness, the insured is not able to perform the Material and Substantial Duties of the insured's Occupation and the insured is not Gainfully Employed; and
- After we have paid benefits for five years in the same claim, Total Disability or Totally Disabled means that, solely due to Injury or Sickness, the insured is not able to perform the job duties generally required for Any Occupation.

Total Disability Benefit – When the insured is Totally Disabled, the Monthly Benefit is paid as follows:

- the insured must become Totally Disabled while this rider is in force; and
- the insured must satisfy the Elimination Period; and
- after the insured has satisfied the Elimination Period, the Monthly Benefit will be payable at the end of each month while the insured remains Totally Disabled; and



- the Monthly Benefit will stop at the end of the Benefit Period or on the date the insured is no longer Totally Disabled, if earlier.

We will not increase the Monthly Benefit because the insured is Totally Disabled from more than one cause at the same time.

Definition of Partial Disability or Partially Disabled:

Partial Disability or Partially Disabled means the insured is Gainfully Employed and the insured is not Totally Disabled under the terms of this rider, but solely due to Injury or Sickness:

- the insured experiences a Loss of Income that is at least 20% of the insured's Prior Income; and either
- the insured is unable to perform one or more of the Material and Substantial Duties of the insured's Occupation; or
- the insured is able to perform all of the Material and Substantial Duties of the insured's Occupation but not for the length of time they normally require.

Partial Disability Benefit - When the insured is Partially Disabled, we will pay the Monthly Partial Benefit as follows:

- the insured must become Totally Disabled while this rider is in force; and
- the insured must be Totally Disabled for the length of the Elimination Period; and
- the insured must provide us with proof of loss necessary to establish that the insured's Loss of Income is solely the result of the insured's Injury or Sickness; and
- the Monthly Partial Benefit will be payable at the end of each month while the insured is Partially Disabled; and
- the Monthly Partial Benefit will stop at the end of the Benefit Period or on the date the insured is no longer Partially Disabled, if earlier.

The Monthly Partial Benefit may never exceed Loss of Income, except as stated in the Enhancement to Monthly Partial Benefit provision.

We will not increase the Monthly Partial Benefit because the insured is Disabled from more than one cause at the same time.

Payment of Monthly Partial Benefit

The Monthly Partial Benefit will be determined by the formula (a) divided by (b) multiplied by (c), where:

- (a) is the insured's Loss of Income for the month in which the insured is Partially Disabled; and
- (b) is the insured's Prior Income; and
- (c) is the Monthly Benefit.

Enhancement to Monthly Partial Benefit - If the insured's Loss of Income is more than 75% of Prior Income in any month of Partial Disability while the Monthly Partial Benefit is payable, we will deem such loss to be 100%.

Waiver of Premium Benefit - The waiver of premium benefit waives premiums that become due under the Policy to which this rider is attached. This includes premiums for this rider and any other riders attached to the Policy unless otherwise stated in any such rider. We will also waive any one-year term charges under a One Year Term Insurance with Target Face Amount rider if an additional payment is needed in order to maintain the Target Face Amount. Premiums waived by us will not be deducted from the Policy proceeds.

Until we approve the claim under this rider, payment of premiums when due is required to avoid a lapse of insurance. Any premium due during a period of Disability which is paid and later waived will be refunded to the Owner. If Disability begins during the Grace Period, payment of the overdue premium is required to avoid a lapse of insurance before we approve any claim under this rider.

The waiver of premium benefit will begin after the insured has been continuously Totally Disabled for 90 days and all terms and conditions of this rider and the Policy have been met. Any premiums that become due under the Policy after such 90 days, but before the Elimination Period is satisfied, will be waived only while the insured is Totally Disabled.

Once the insured has satisfied the Elimination Period, any premiums that become due under the Policy will be waived while the insured is Totally Disabled or Partially Disabled; however, if the Monthly Benefit and/or the Monthly Partial Benefit has been paid for five years in the same claim, the waiver of premium benefit will continue only if:

- the insured is Totally Disabled in the same claim; and
- the Policy and this rider are in force.

Proof of loss for the waiver of premium benefit may be requested at reasonable intervals. Proof will be required not more often than once every 30 days during the first 2 years in the same claim, and not more than once in any 12-month period thereafter. This applies only to the waiver of premium benefit. This provision does not change in any way the proof of loss requirements for any other benefit under this rider, the Policy, or any other riders.

Lifetime Waiver Enhancement - All further premiums that become due under the Policy will be waived if:

- Total Disability begins before Age 60; and
- the insured remains continuously Totally Disabled until Age 65; and
- all premiums due between Age 60 and Age 65 have been waived under this rider.

Unless all premiums are then being waived under the Lifetime Waiver Enhancement provision, the waiver of premium benefit will end when any of the following occurs:

- the insured is no longer Disabled; or
- satisfactory proof of Disability is not provided to us as required; or
- the insured refuses or fails to attend an exam; or
- the date this rider terminates in accordance with the Rider Termination provision; or
- the date the insured becomes Partially Disabled during the Elimination Period.

Once the waiver of premium benefit ends, the Owner must resume payment of premiums when due to avoid a lapse of insurance.

If the insured is Disabled and receiving a Monthly Benefit and/or a Monthly Partial Benefit after this rider terminates, any premiums that become due under the Policy will be waived as long as:

- Disability continues; and
- a Monthly Benefit is being paid.

4. EXCLUSIONS AND LIMITATIONS OF THE POLICY – We will not pay benefits or waive premiums for any Disability caused by, contributed to by, or which results from:
- War, whether declared or undeclared, while the insured is in the military of any nation; or
 - the insured's commission of, or attempt to commit, a felony, or the insured's participation in a riot or insurrection; or
 - the insured being engaged in an illegal occupation; or
 - an intentionally self-inflicted injury; or
 - any loss we have excluded by name or description.

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

SUSPENSION, SURRENDER OR REVOCATION OF A PROFESSIONAL LICENSE OR CERTIFICATE - Suspension, surrender or revocation of a professional license or certificate does not alone constitute Disability.

OVERPAYMENT OF BENEFITS – In the event that an overpayment of benefits occurs, We have the right to either recoup the overpayment from future claim benefits or require reimbursement within 60 days of notification of overpayment.

5. **GUARANTEED RENEWABLE TO THE EXPIRATION DATE** – This rider is guaranteed renewable. This means as long as premiums are paid on time, we cannot change the terms or provisions under this rider, except for this rider's premiums. We can change this rider's premiums until the Rider Expiration date. Any premium changes will be changed by Risk Class and will apply to all Disability Income and Waiver of Policy Premium Benefit Riders insuring the same Risk Class.

MISSTATEMENTS OF AGE – If the insured's age is misstated on the application, coverage under this rider will be what the premium paid would have purchased based on the correct age. If we would not have issued the rider at the insured's correct age, there will be no coverage under this rider and we will refund all premiums paid for the period not covered by the rider.



The Guardian Life Insurance Company of America
A Mutual Company Established 1860

Customer Service Office
P.O. Box 981590, El Paso, TX 79998-1590
(1-888) GUARDIAN (1-888-482-7342)

Disability Income and Waiver of Policy Premium Benefit Rider

OUTLINE OF COVERAGE

Rider Form Number DIR NY

Name of Proposed Insured (please print) _____

I, the Proposed Insured, hereby admit I have received this outline of coverage for a Guardian Disability Income and Waiver of Policy Premium Benefit Rider.

Signed at _____ Proposed Insured _____
City State

Date _____

Witness _____



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

Disability Income Rider Application Supplement

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

THE GUARDIAN LIFE INSURANCE COMPANY OF AMERICA

SECTION A: Proposed Insured Information

1. First Name _____ MI _____ Last Name _____
2. Social Security Number _____ 3. Date of Birth (mm/dd/yyyy) _____

SECTION B: Disability Income Rider Information

1. Benefit Amount: \$ _____
2. Benefit Period: _____ 5 Years
3. Elimination Period: _____ 180 Days

SECTION C: Occupation and Business Information

1. Occupation of the Proposed Insured _____
2. Employment Status ☐ Employee (no ownership) ☐ Sole Proprietor or 1099 Employee
☐ Partner _____ % of ownership
☐ S-Corp Shareholder _____ % of ownership
☐ C-Corp Shareholder _____ % of ownership
3. Is the proposed insured a government employee (federal, state, municipal, county or town)? ☐ Yes ☐ No
4. Describe the specific duties of the Proposed Insured's occupation including, but not limited to: surgery; travel; sales; administrative duties; and supervisory duties. *If the space provided is not adequate, please provide additional details in Remarks Section G.*

Description of Specific Duties	% of Time Devoted to Each Duty (must equal 100%)	If protective gear or apparel is required, check here*
		☐
		☐
		☐
		☐
		☐
		☐

**If protective gear or apparel is required, please provide details in Remarks Section G.*

5. Does the Proposed Insured ever perform any manual duties specific to their occupation such as operating machinery, carrying or lifting objects in excess of 30 lbs., climbing ladders, or driving a delivery vehicle? *If "Yes," please provide details in Remarks Section G, including specific type of manual duty and frequency.* ☐ Yes ☐ No
6. Is the Proposed Insured presently employed and have they been continuously at work full-time (at least 30 hours per week) performing the usual duties of their occupation for the past 180 days? *If "No," please provide details in Remarks Section G.* ☐ Yes ☐ No



SECTION C: Occupation and Business Information (Continued)

7. Does the Proposed Insured have any other part-time or full-time occupations, jobs, or employment? ☐ Yes ☐ No
If "Yes," please provide details in Remarks Section G.
8. Does the Proposed Insured currently plan to change their occupation, occupational duties, job, or employment within the next six months? ☐ Yes ☐ No
If "Yes," please provide details in Remarks Section G.
9. How many people are employed by the Proposed Insured's employer/business/organization? _____

SECTION D: Other Insurance Coverage

1. Does the Proposed Insured have any disability insurance in force or applied for, or for which they are eligible within the next 12 months with any company including, but not limited to, The Guardian Life Insurance Company of America and Berkshire Life Insurance Company of America? (This includes any individual, group, or association disability insurance.) ☐ Yes ☐ No
If "Yes," list all coverages in the chart below.

Type: Individual Disability (IDI); Group Long-Term Disability (GLTD); Group Short-Term Disability (GSTD); Overhead Expense (OE); Disability Buy-Out (DBO); Retirement Protection (RP); Association (ASSOC); if other, please specify.

Include all sources of disability insurance whether individually-paid or employer-paid.

Company Name				
Type				
Status (In-Force, Applied For, Eligible For)				
Policy Number (if known)				
Benefit Amount	\$	\$	\$	\$
Benefit Period				
Employer-Paid*	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Is this coverage being replaced? If Yes, date and amount to be replaced	☐ Yes ☐ No Date: _____ \$	☐ Yes ☐ No Date: _____ \$	☐ Yes ☐ No Date: _____ \$	☐ Yes ☐ No Date: _____ \$

*"Employer-Paid" means the Proposed Insured's employer pays the premium and does not include it as taxable income to them.

SECTION E: Financial Information

1. Proposed Insured's Earned Income actually filed with the IRS Two Calendar Years Ago: \$ _____
2. If you would like to have the Annual Retirement Contributions made by the Proposed Insured's employer (such as to a 401(k) or 403(b)) considered as part of the Proposed Insured's Earned Income, please provide the following information. If no, check here ☐

Total Annual Retirement Contributions (Employer Contributions Only)

- a. Year-To-Date This Calendar Year: \$ _____
- b. Last Calendar Year: \$ _____
- c. Two Calendar Years Ago: \$ _____

SECTION F: Additional Information

1. Do any of the following apply? 1) The Proposed Insured's professional or occupational license or certification has ever been suspended, revoked, restricted, inactivated, or surrendered; or 2) The Proposed Insured has ever been disbarred; or 3) The Proposed Insured has ever been fined or sanctioned by an entity that oversees their profession? ☐ Yes ☐ No

SECTION G: Remarks Section

[illegible]

SECTION H: Representations of the Proposed Insured and Owner

Those parties who sign below agree that:

All of the statements that are part of this Supplement are correctly recorded and are complete and true to the best of the knowledge and belief of those persons who made them. Any misrepresentation or omission, if found to be material, may adversely affect acceptance of the risk or claims payment or may cause the Company to seek rescission of any policy, rider or coverage that is issued based on this Supplement. No producer or broker has any rights to make, void or change this Supplement, waive or modify any of the Company's rights or requirements, or determine eligibility for or alter the terms of the proposed rider. No insurance shall take effect unless and until: the policy and this rider are delivered and accepted by the Owner; the first premium is paid during the lifetime of the Proposed Insured; and there has been no change in the health, income level, status of employment, or occupation of the Proposed Insured.

I further acknowledge that I have received the Outline of Coverage for the rider being applied for.

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 Proposed Insured	Signature of Applicant/Owner (if other than Proposed Insured)
-------------------------------	--

Signature of Additional Owner

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

Bank Draft One-Time Use Authorization (Insurance Application Prepayment)

The companies listed below are hereinafter referred to as the "Company."

THE GUARDIAN LIFE INSURANCE COMPANY OF AMERICA

THE GUARDIAN INSURANCE & ANNUITY COMPANY, INC.

BERKSHIRE LIFE INSURANCE COMPANY OF AMERICA

I, _____, as of the date signed, authorize the Company to charge/withdraw from my designated bank account, a one-time payment in the amount outlined below for the purpose of submitting money with the insurance application for _____ (the Insured). I understand that this is a one-time payment authorization and I certify that I am an authorized signer on the bank account.

I further acknowledge and agree that by authorizing this one-time payment, no liability is created or assumed by the Company unless and until insurance becomes effective as outlined in the Conditions of Coverage, Conditional Receipt or Conditional Temporary Coverage Agreement, whichever is applicable.

Bank Name: _____

Bank State: _____

Bank ZIP Code: _____

Bank Routing Number: _____

Bank Account Holder Name: _____

Bank Account Number: _____

Bank Account Type: ☐ Checking ☐ Savings (for Life applications only)

Draft Amount: \$ _____

I authorize the Company to make any inquiries necessary to validate the bank account identified above which may include verifying the information I provide against third party databases.

Signature of Bank Account Owner

Date

Signature of Policy Owner (if different than Bank Account Owner)

Date





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

Conditional Temporary Coverage Agreement and Receipt

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.

The Conditional Temporary Coverage Agreement and Receipt is to be used with the application for insurance on the life of _____ (Proposed Insured) dated _____. The amount received is \$_____ from _____.

Provided that the above payment is equal to at least 1/12 of the annual premium for the insurance applied for in this application referred to above ("Minimum Payment"), the Company will provide conditional temporary life insurance coverage. The Company will pay a death benefit to the beneficiary named in the application if the Proposed Insured dies while coverage under this Agreement is in effect and subject to the terms and conditions stated herein. For Universal Life policies, the "annual premium" is the Target Premium for the insurance applied for. This Agreement does not guarantee that a life insurance policy will be issued and does not apply to additional benefits or riders applied for that provide coverage either for life insurance payable due to an accidental death or coverage other than life insurance including, but not limited to, those that provide disability, long term care or waiver of premium benefits.

IMPORTANT NOTE TO APPLICANT: This receipt is to be given for advance payment on first premium. All premium checks must be made payable to the Company. Do **not** make checks payable to the producer or leave the payee blank. Cash payments and money orders cannot be accepted.

IMPORTANT NOTE TO PRODUCER: This receipt may only be used if all of the following are true:

(a) The Proposed Insured answers "no" to both medical questions asked below; and (b) The Proposed Insured is not younger than 30 days old, and not older than 64 years, 6 months old; and (c) Payment is made concurrent with the signing of the application and such payment is at least equal to the Minimum Payment. *Note: Depending on the contractual provisions of the policy(ies) being applied for, the Minimum Payment referred to above may not be sufficient to put the policy(ies) in force; and (d) You have been in the presence of, or seen the Proposed Insured in person within the last 30 days.*

1. Has the Proposed Insured, within the last 24 months, been diagnosed by a licensed member of the medical profession as having cancer, heart disease, heart attack, chest pain, stroke, immune system disorder, alcohol or drug use? ☐ Yes ☐ No
2. Within the past 90 days, other than for normal childbirth, has the Proposed Insured been admitted or been advised to be admitted to a Hospital or other medical facility? ☐ Yes ☐ No

IF EITHER OF THESE QUESTIONS IS ANSWERED "YES" OR LEFT BLANK, THIS CONDITIONAL TEMPORARY COVERAGE AGREEMENT AND RECEIPT SHALL BE VOID AND THERE SHALL BE NO LIABILITY ON THE PART OF THE COMPANY.

Limitation on Coverage: The amount of life insurance available under this receipt cannot exceed the face amount of the insurance applied for in the application referred to above, including the face amount of any Renewable Term Rider and any Paid-up Additions Rider (but only for any Initial PUA payment that is paid in full on the date the application is signed).

Special Provision Relating to Additional and Alternate policies: If the application referred to above indicates that Alternate or Additional coverage has been requested, then the following provisions apply. If an Alternate policy has been requested, the temporary coverage under this Agreement will be deemed to relate to the insurance applied for in this application, and **not** the Alternate policy requested. If an Additional policy has been requested, coverage is available under this Agreement for both policies, provided the initial premium amount collected is equal to at least the sum of 1/12 of the annual premium for each of these policies. Otherwise, coverage will be provided only for the policy applied for in this application.

If the amount of coverage described above, combined with the amount of coverage under any other Conditional Temporary Coverage Agreement in effect on the Proposed Insured listed above, exceeds \$1,000,000, the maximum total amount of coverage payable under all such Agreements shall be \$1,000,000. **In no event will we pay more than \$1,000,000 in Conditional Temporary Coverage on a single insured, regardless of the amount of premium collected under all applications on that insured.**



Conditions:

The temporary insurance shall be effective on the later of:

- (a) the date of the application for insurance which includes the Application for Life Insurance Part I, the Authorization, any amendments to the application, and any required supplements or questionnaires ("Part I");
- (b) the date of any Medical Supplement for Individual Life and/or Disability Insurance Part II ("Part II");
- (c) the date of any reports from medical examiners, or any other medical examinations that are required by the Company's published underwriting rules; and
- (d) the date of any lab work that is required by the Company's published underwriting rules.

Coverage is not effective if the Part I or any Part II, including any reports from medical examiners, any other medical examinations and/or lab work, required by the Company's published underwriting rules, is not completed. Coverage ends 60 days after it is effective.

The Proposed Insured must be insurable as a standard or better risk under the Company's published underwriting rules, for the amount, plan and benefits applied for, without restriction or modification. Information required by the Company to determine insurability must be received at its Customer Service Office within 60 days of the date of this receipt.

Upon receipt of due proof that the Proposed Insured died within 60 days of the effective date of this receipt and:

- After the initially required Parts I and II have been received at the Company's Customer Service Office; and
- After the last date of the first medical examination or second medical examination if initially required by the Company's published underwriting rules.

Then the Company shall pay the benefit due under this Agreement to the beneficiary or beneficiaries named in the Part I. If more than one beneficiary is named in the application under this Agreement or there are other Conditional Temporary Coverage Agreements in effect on the same Proposed Insured, each named beneficiary will receive a share of the benefit under the Agreement, subject to the maximum defined in the Limitation on Coverage section of this Agreement, equal to his or her proportionate interest in the death benefit that would have been payable had the policy(ies) applied for been in force.

For the temporary insurance to be payable, there must be no material misrepresentation on this form or on any part of the application including, but not limited to, the Part I, the Part II, any reports from medical examiners, or any other medical examinations. Also, the insured's death must not have been the result of suicide. If the Proposed Insured dies within 60 days of the effective date of this receipt, but the temporary coverage is not payable because any of the above conditions were not met, the Company will refund the initial premium that was paid with the application without interest.

This receipt will be void if any check or draft given in exchange for the receipt is dishonored or there are insufficient funds to pay the required premium when first presented for payment.

Special rules for 1035 exchanges: If the applied for coverage is intended to be part of an exchange under Section 1035 of the Internal Revenue Code, and if the Proposed Insured is determined to be, within 60 days of the effective date of the receipt, a standard or better risk under the Company's underwriting rules, then coverage will not end 60 days after the receipt and the premium will not be refunded. Instead, the temporary coverage will continue until: (a) the policy is issued, or (b) the existing carrier indicates that the Company's request for the proceeds under the existing insurance cannot or will not be processed.

I (We) have read the terms of this receipt and have had them explained to me by the producer. I (We) understand that the insurance applied for shall not be effective unless and until the conditions of this receipt have been complied with exactly. If these conditions are not met, the Company shall have no liability under this receipt except to return the payment made without interest.

I (We) have received a copy of and read this Agreement and declare that all information I (We) have given is true and complete to the best of my (our) knowledge and belief. I (We) understand and agree to all its terms.

Signed at _____
City and State Month/Day/Year

Signature of Proposed Insured
(or parent or guardian if insured is under 18)

Signature of Owner
(if other than Proposed Insured)

Signature of Producer

(Leave one signed copy with the Applicant and submit one signed copy with the application.)



THE GUARDIAN LIFE INSURANCE COMPANY OF AMERICA
Customer Service Office
6255 Sterner's Way
Bethlehem, PA 18017-9464
1-888-GUARDIAN

NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND HEALTH INSURANCE

According to your application, you intend to lapse or otherwise terminate existing accident/health insurance or an accelerated benefit rider on a life insurance policy, and replace it with a life insurance policy with an accelerated benefit rider issued by The Guardian Life Insurance Company of America. Your new policy provides 10 days within which you may decide without cost whether you desire to keep the policy. In addition, the accelerated benefit rider itself can be cancelled at any time. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

1. Health conditions that you may presently have may be considered preexisting conditions and may not be immediately or fully covered under the new accelerated benefit rider. This could result in denial or delay of a claim for benefits under the new accelerated benefit rider, whereas a similar claim might have been payable under your present policy.
2. If the premium for your existing policy is based on your age when it was issued, you have built up equity in that policy which may be lost if you terminate it.
3. You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.
4. If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical/health history. Failure to include all material medical information requested on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, reread it carefully to be certain that all information has been properly recorded.

The above "Notice to Applicant" was delivered to me on:

Date

Applicant's Signature

I have reviewed the current health insurance coverage of the applicant and find that replacement and/or additional coverage of the type and amount applied for is appropriate for the applicant's needs.

Date

Agent's Signature

(Original – Home Office; 1st Copy – Applicant; 2nd Copy – Agency)

NY EABR REPL





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

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

"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
(or parent or guardian if insured is under 18)

Date





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

Supplement to Application for Insurance

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

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

Please print. *The Owner and/or Proposed Insured must initial any changes.*

SECTION A: Proposed Insured Information

First Name _____ MI _____ Last Name _____

Date of Birth (mm/dd/yyyy) _____

Use the below space to amplify and extend answers to questions in your application dated _____. Attach additional sheet if necessary.

Form #	Question #	Details

SECTION B: Signatures

I (We) represent that the answers as amplified and extended above are true and complete to the best of my (our) knowledge and belief and are part of my (our) application to the Company as described above.

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 Proposed Insured Signature of Applicant/Owner

Signature of Witness





THE GUARDIAN LIFE INSURANCE COMPANY OF AMERICA
THE GUARDIAN INSURANCE & ANNUITY COMPANY, INC.
BERKSHIRE LIFE INSURANCE COMPANY OF AMERICA
(Any insurer above, individually or collectively, is herein referred to as the
"Company.")

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

Visit guardianlife.com
Email ILSolutions@glic.com
Call 1-888-GUARDIAN (1-888-482-7342)
Fax 610-807-2720

TRUST CERTIFICATION

Please print.

(Page 1 of 3)

SECTION 1: Policy information

Policy number(s) _____

LIFE ONE

1. Name _____
First Middle Last

LIFE TWO

2. Name _____
First Middle Last

SECTION 2: Trust Information

1. Name of trust _____

2. Tax Identification number of trust _____

☐ **Applied for** (Check this box if you have applied for a number and are waiting for one to be issued. You have 60 days to submit a certified TIN in order to avoid backup withholding.)

3. The trust is: ☐ Irrevocable and is in full force and in effect;
☐ Revocable and is in full force and in effect;

4. Is this a grantor trust? ☐ Yes ☐ No

Consult with a tax advisor to determine whether your trust is a grantor trust (as described in Sections 671–679 of the Internal Revenue Code).

If yes, provide the following information.

Grantor's name _____

Grantor's SSN/TIN _____ Grantor's date of birth _____

Relationship between the grantor(s) and the trustee(s) _____

5. Trustee information*

- Provide name(s) of trustee(s) below.
- For online access, complete the additional information.
- Product availability and functionality on our website may vary for trust-owned policies.

Name of trustee _____ ☐ Online access

SSN _____ Phone number _____

Email _____

Name of trustee _____ ☐ Online access

SSN _____ Phone number _____

Email _____

***Should you have more than 2 trustee(s), include information on an additional blank page also signed and dated.**



SECTION 2: Trust Information (continued)

6. Transaction requests must be authorized by (Select one.):

☐ Any one trustee ☐ All trustees ☐ A majority of trustees

7. Who are the current beneficiaries of the trust? _____

8a. Effective date of trust _____

8b. Situs of trust (Required for new applications only): The trust is subject to the laws of the state of _____

9. Address of trust _____

10. Did you retain an attorney to prepare the trust document? ☐ Yes ☐ No

If yes, provide the name and address of attorney. If no, provide name and address of person who provided trust document.

Name of attorney/provider _____

Address of attorney/provider _____

SECTION 3: Certification

The trustee(s) declare and represent to the Company that the answers provided in this Trust Certification are accurate and complete and also certify, acknowledge, and agree that:

1. The trustee(s) is/are allowed by the terms of the trust to purchase life insurance and securities (if applicable);
2. The trust permits the trustee(s) to exercise all ownership rights provided by the policy issued by the Company to the trust, including but not limited to, the right to surrender, pledge or encumber the policy, or make withdrawals, and the trustee(s) is/are permitted to distribute the Policy to any beneficiary of the trust or to sell and transfer ownership of the policy pursuant to the sale;
3. Neither the Company nor anyone acting as an agent of the Company is responsible to determine the authority of the trustee(s) or inquire into, or review the provisions of the trust, and shall not be charged with knowledge of the terms of the trust;
4. The Company may rely on the evidence submitted with respect to any change of the trustee(s) and/or the appointment of a successor trustee, and is not responsible to determine that the change or the appointment of any additional or successor trustee(s) conforms with the trust provisions;
5. Beneficial interests under the trust can and will only be established for persons who (1) are related to the Proposed Insured(s) by blood or by law, (2) have a substantial interest in the Proposed Life Insured(s) engendered by love and affection, or (3) hold a lawful and substantial economic interest in the continued life of the Proposed Insured(s); and
6. Neither the Company nor its affiliates, employees, representatives, or agents have provided tax or legal advice and the trustee(s) have had the opportunity to consult with their own tax and/or legal advisors regarding the preparation of the Trust Certification.

SECTION 4: Tax Certification and Signatures

I agree the following certification applies unless I indicate in the box below that I am not a U.S. Entity. Under penalties of perjury I certify that:

1. The number shown on this form is my correct social security number or taxpayer identification number, and
2. I am not subject to backup withholding because:
 - a) I am exempt from backup withholding, or
 - b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or
 - c) the IRS has notified me that I am no longer subject to backup withholding, and
3. I am a U.S. citizen (including a U.S. Resident Alien) or domestic business entity, and
4. I am exempt from FATCA reporting*

Note: Check the box below if you are unable to certify to item #2 and have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return.

☐ I am subject to backup withholding as a result of a failure to report all interest and dividends on my tax return.

* Guardian requires FATCA (Foreign Account Tax Compliance Act) reporting only for certain non-U.S. payees that receive FATCA withholdable payments. You are not required to provide a FATCA exemption code.

If the trust is any of the below, please indicate:

- ☐ **A non-grantor trust created or organized under foreign law**
- ☐ **A grantor trust that is created or organized under foreign law**
- ☐ **A U.S. grantor trust and the grantor is a Non-Resident Alien individual**

I have attached a completed IRS Form W-8BEN, W-8BEN-E or other W-8 appropriate for my status. Please obtain a current version of the form from www.irs.gov. A foreign person is subject to U.S. tax on U.S. sourced income and a mandatory 30% withholding may apply (for tax treaty information and eligibility for a reduced rate, please see IRS Publication 515).

Signature of trustee

Date

☐ 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)

By signing below, you jointly and severally indemnify and hold the Company harmless from any liability for acting according to your instructions under the referenced Trust. Guardian will rely on this certification and will not be liable for action taken including any tax reporting performed pursuant to and in reliance on the representations made on this form.

The Internal Revenue Service does not require your consent to any provision of this document other than the tax certifications made in the W-9 Certification section above.

Signed at _____

City and state

Signature of trustee

Date

Signature of trustee

Date



**UNIFORM GIFTS TO MINORS ACT (UGMA)/
UNIFORM TRANSFERS TO MINORS ACT (UTMA) CERTIFICATION**

☐ **The Guardian Insurance & Annuity Company ("GIAC") ***

Regular Mail – Send To:

The Guardian Insurance & Annuity Company, Inc.
Retirement Solutions
P.O. Box 981592
El Paso, TX 79998-1592

Express Mail – Send To:

The Guardian Insurance & Annuity Company, Inc.
Retirement Solutions
6255 Sterner's Way
Bethlehem, PA 18017-9464

Questions/Customer Service

Call (800) 221-3253
M – F, 8:30 a.m. – 7:00 p.m. ET, **or**
Visit www.guardianlife.com
Fax (610) 807-6083 or (610) 807-7841

☐ **The Guardian Life Insurance Company of America ("Guardian") ***

Regular Mail – Send To:

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

Express Mail – Send To:

The Guardian Life Insurance Company of America
Individual Life Service and Administration
6255 Sterner's Way
Bethlehem, PA 18017-9464

Questions/Customer Service

Call (800) 441-6455
M – F, 8:00 a.m. – 6:00 p.m. ET, **or**
Visit www.guardianlife.com
Fax (610) 807-2720

*** The Company checked above is herein called "the Company."**

Please print.

(Page 1 of 2)

If this certification is for an inforce policy or contract, please indicate policy or contract number: _____

1. Contract/Policy Registration

Custodian

Name (First, Last, MI)	Social Security Number	Date of Birth	
Primary Residential Address (no P.O. Box)	City	State	Zip
Mailing Address (if different from Primary Residential Address)	City	State	Zip
Email	Daytime Phone		
Relationship to Minor			

Minor

Name (First, Last, MI)	Social Security Number	Date of Birth	
Primary Residential Address (no P.O. Box)	City	State	Zip
Mailing Address (if different from Primary Residential Address)	City	State	Zip
Email	Daytime Phone		

Contract/Policy Owner: _____ as Custodian for _____
(Name of Custodian) (Name of Minor)

under the _____
(Name of Enacting State) (Uniform Transfers to Minors Act – UTMA or Uniform Gifts to Minors Act – UGMA)

- Joint Custodianship is generally not permitted.
- Annuitant or Insured shall be the minor.



2. Successor Custodian Designation**Successor Custodian Information**

Upon resignation, incapacity, or death of the current Custodian, the Successor Custodian listed below is responsible for contacting the Company to initiate the change in custodianship. The Company may also require the Successor Custodian to provide certain documentation, depending on the reason for the change.

Successor Custodian

Name (First, Last, MI)	Phone		
Street Address	City	State	Zip

3. Acknowledgments and Signature(s)

- I acknowledge that the Custodial Contract/Policy has been established as an irrevocable gift or transfer of assets to the Minor which may only be used for the benefit of the Minor.
- I understand that the Custodial Contract/Policy legally belongs to the Minor and may only be used for the benefit of said Minor.
- I acknowledge that, if I am the current Custodian, I will notify the Company and submit any necessary documentation when the Minor has reached the age of majority in the state in which the custodial relationship was established so that I can be removed as Custodian.
- I understand that any withdrawal or policy loan activity that I request, as Custodian, may create a tax liability for the Minor.
- I authorize the appointment of the Successor Custodian listed above, who has been duly appointed to assume custodianship for the Minor listed above. This Successor Custodian Designation supersedes any earlier designation made and is effective only upon the resignation, legal incapacitation or death of the current Custodian. Upon one of these events, I authorize the Successor Custodian I have named to notify the Company. Until that time, the Company will continue to act on instructions it reasonably believes to have originated from me.

Custodian Signature

Date (mm/dd/yyyy)

Successor Custodian Signature (Required if Successor Custodian is appointed above)

Date (mm/dd/yyyy)



**Customer Service Office
Mailing Address**
P.O. Box 981590
El Paso, TX 79998-1590
1-888-GUARDIAN

Notice to Employers Purchasing Life Insurance on Employees Lives

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.

IMPORTANT

Failure to provide notification and obtain the proposed insured's consent before the issuance of the life insurance policy may cause the death benefit in excess of premiums paid to be subject to income taxation.

The Pension Protection Act of 2006 ("PPA") requires that employers provide notice to employees, as defined in the law to include directors and shareholders who may or may not be considered an "employee" in the traditional sense of the word, on whom they wish to purchase life insurance, and that the proposed insured consent to the employer's purchase of such life insurance. The proposed insured must fall into one of the specified categories of "employees", as noted below, and must provide the employer with his/her consent to be insured before the issuance of the life insurance policy, *if the Employer is to be allowed to exclude the death benefits payable under the policy from its gross income under IRC §101.*

The insured must consent before the issue date of the policy(ies). An authorized employer representative should countersign the consent indicating acceptance of the consent and accepting its reporting and record keeping responsibilities under PPA.

Notice To Employer:

The Pension Protection Act of 2006 ("PPA 2006"), IRC §101(j), provides that if the insured:

- 1) was an employee at any time during the 12 month period before the insured's death; or
- 2) is at the time the contract is issued
 - a) a director;
 - b) a highly compensated employee of the Employer within the meaning of IRC §414(q) – meaning any employee who was a 5-percent owner at any time during the year or the preceding year (without regard to paragraph (1)(B)(iii) thereof); or
- 3) is a highly compensated individual as defined in IRC 105(h)(5), meaning that he/she
 - a) is one of the Employer's five (5) highest paid officers; or
 - b) owns directly or indirectly (with application of IRC §318) ten (10%) percent or more in value of the stock of the employer; or
 - c) is among the highest paid thirty-five (35%) of all employees, or
- 4) an amount of the death benefit proceeds are
 - a) payable to a member of the insured's family (under IRC §267(c)(4)), or
 - b) a designated beneficiary other than the Employer, or
 - c) a trust established for the benefit of any member of the insured's family, or the estate of the insured,

the Employer must give Notification to the Employee, as defined above, of the proposed purchase of life insurance and the Employee must give written Consent to the Employer purchasing of life insurance on the Employee's life before the issuance of any policy, *if the Employer is to be allowed to exclude the death benefits payable under the policy from its gross income under IRC §101. The Employer should seek the advice of its own legal and tax advisors to determine if any of the above provisions apply to a given policy.*

Employer Record Keeping Responsibilities:

The Employer has the reporting and recordkeeping obligations listed below:

1. File an IRS form 8925 annually reporting:
 - a) The total number of employees at the end of the year;
 - b) The number of employees insured under employer owned contracts at the end of the year;
 - c) Total amount of insurance in force at the end of the year under such contracts;
 - d) Name, address, and Taxpayer ID of the Employer and the type of business in which it is engaged; and
 - e) Statement that the business has a valid consent for each insured Employee.
2. Maintain records of compliance with the Employee's Notice and Consent requirement and the Employer's reporting requirements.



IMNB0008002470103



Customer Service Office
Mailing Address
P.O. Box 981590
El Paso, TX 79998-1590
1-888-GUARDIAN

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.

Acknowledgement and Consent to Business (hereinafter Employer) Purchasing Life Insurance on Employee's/Director's/Shareholder's Life

(Cross out the categories that do not apply throughout this consent form)

The Employer intends to apply for life insurance coverage on the life of the Employee/Director/Shareholder, as each is named below. Pursuant to The Pension Protection Act of 2006 ("PPA 2006"), IRC §101(j), the Employer must give Notification to an Employee/Director/Shareholder of the proposed purchase of life insurance and the Employee/Director/Shareholder must give written Consent to the Employer purchasing of life insurance on the Employee's/Director's/Shareholder's life before the issuance of any policy, *if the Employer is to be allowed to exclude the death benefits payable under the policy from its gross income under IRC §101.*

1. Employer Information

Name of Employer _____

2. Employee/Director/Shareholder Information

Name _____

3. Employee/Director/Shareholder Acknowledgement of Notification & Consent:

Is acknowledged, understood and agreed by the Employee/Director/Shareholder that:

- (a) I have received Notice of my Employer's intent to purchase life insurance on my life. I hereby consent to be the insured under a life insurance policy or policies issued by Guardian Life Insurance Company of America or any of its subsidiaries on my life by the above Named Employer, who will be both the owner and beneficiary of such policy(ies);
- (b) I acknowledge that by consenting herein to the purchase of this life insurance, neither I nor my family/beneficiaries have any interest or rights to the benefits of such policy(ies);
- (c) The Employer or its successors will continue to be the owner and beneficiary of said policy(ies) indefinitely, including after 1) my employment with the Employer terminates, 2) my status as a director of the Employer terminates, or 3) my status as a shareholder of the Employer terminates;
- (d) The maximum aggregate face amount of the policy(ies) for which the employee could be insured at the time such contract(s) was(were) issued is \$_____. I acknowledge that as a result of my employer's purchase of life insurance on my life, the amount of future life insurance coverage that may be available to me may be reduced.

Dated: _____

Signature of Proposed Insured Employee/Director/Shareholder



Bank Draft Authorization

Any insurer below, individually or collectively, is herein referred to as the "Company."

THE GUARDIAN LIFE INSURANCE COMPANY OF AMERICA

THE GUARDIAN INSURANCE & ANNUITY COMPANY, INC.

BERKSHIRE LIFE INSURANCE COMPANY OF AMERICA

Please print.

(Page 1 of 3)

SECTION 1: Type of Request

- ☐ Establish a new bank draft authorization for periodic payments.
☐ Update financial institution information for 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): _____

SECTION 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 Account Holder _____

Address _____

Address City State Zip

Cell phone _____ Email _____

SECTION 3: Premium Arrangement Information

Please note the "Amount to Be Deducted" is only required for universal life/variable life policies. For traditional life and disability policies, the premium amount to be deducted is the 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 ¹	Insured Name	Amount to be Deducted ²	Premium Mode ³
			\$	☐ Monthly ☐ Annual ☐ Semi-Annual
			\$	☐ Monthly ☐ Annual ☐ Semi-Annual
			\$	☐ Monthly ☐ Annual ☐ Semi-Annual
			\$	☐ Monthly ☐ Annual ☐ Semi-Annual
			\$	☐ Monthly ☐ Annual ☐ Semi-Annual
			\$	☐ Monthly ☐ Annual ☐ Semi-Annual

¹ Policies beginning with S, V, and U are limited to the 15th. For other products, if no date is selected, due date will be used.

² 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.

³ If a change in premium mode results from your election, depending on the timing of this change additional funds may be required to be withdrawn to pay your policy to the next due date. S, V, and U policies are limited to monthly mode only.



SECTION 4: Optional Payment Information**Loan Repayment(s)**

Policy number	Amount	Draft date ¹	Mode
	\$		☐ Monthly ☐ Annual
	\$		☐ Monthly ☐ Annual
	\$		☐ Monthly ☐ Annual

¹ Loan repayments for certain policies (policy numbers beginning with "L") can only be made on or about the 15th of each month.

Loan Interest²

Policy number	Draft day	Policy number	Draft day	Policy number	Draft day

² Loan interest amount is determined by the amount due each anniversary and can only be paid annually on or around the anniversary. There is no need to specify a month, as that is determined by the anniversary and the day elected.

Purchase of Unscheduled Paid-Up Additions (PUA) Rider (for scheduled PUA changes please see the Policy Admin form)

Policy number	Amount ³	Draft date	Mode
	\$		☐ Monthly ☐ Annual
	\$		☐ Monthly ☐ Annual
	\$		☐ Monthly ☐ Annual

³ Payments under the Purchase of Paid-Up Additions (PUA) rider are subject to the minimum and maximum amounts defined in your rider form. If the maximum PUA payment has been reached in a given policy year, drafts for PUA will cease for that year, and will resume beginning in the following policy year.

Remarks _____

SECTION 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 specified account or to initiate electronic funds transfer from your chosen bank or financial institution on or about the date you selected and at the frequency selected to make a payment on the designated policy. Due to timing of the authorization, the initial electronic funds transfer processed may result in more than one payment being withdrawn.
2. The Company's treatment of each debit, and its' rights with respect to it, will be the same as if it were signed or initialed personally by the Authorized Account Holder. If any debit is dishonored by the bank or financial institution for any reason, the payment will be reversed and will not be considered paid. This may cause the policy to lapse or terminate in accordance with the provisions of the policy and result in the forfeiture of insurance.
3. Completion of this Bank Draft Authorization shall not constitute a payment. Multiple payments may be required to bring the policy to a current due date.
4. This Bank Draft Authorization may be terminated by the Policy Owner, the Company, or the Authorized Account Holder (if different from the Policy Owner). The Policy Owner or Authorized Account Holder 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. The Company may try a second time for any withdrawal returned due to insufficient funds. The Company may terminate this Authorization immediately in the event any withdrawal or electronic fund transfer is dishonored for any reason.
6. A confirmation statement for payments paid through this Bank Draft Authorization will not be sent. Information provided by the bank or financial institution may be helpful to reconcile the deductions.

SECTION 5: Terms and Conditions (continued)

7. If the premium mode selected is different than your current premium mode, you are authorizing the Company to change the premium mode for your policy for payment of future premiums. For details on the cost of paying premiums more frequently than annually, please refer to the Policy Owner's policy or product prospectus, as applicable.
8. 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.
9. The Company should be provided with 30 days' advance notification of any change to the banking information provided. If advance notification cannot be provided, sufficient funds should be left in the authorized account to honor charges until the Company's records are changed.
10. Any change in name or address of the Authorized Account Holder or Policy Owner must be communicated immediately to the Company.
11. If this service is no longer in effect, premiums will be due and billed according to the mode selected but no more frequently than quarterly. Any draft payments scheduled, regardless of type, will no longer be automatically deducted and future payments will be the Policy Owner's responsibility.
12. If this form is being used to set up recurring payments under the Purchase of Paid-Up Additions (PUA) rider, these payments will be considered unscheduled payments under the terms of such rider. They will not be paid by the Company under any Waiver of Specified Amount benefit in the event of disability.
13. Any bank fees are the responsibility of the Authorized Account Holder.
14. The Company and its officers, directors, agents, employees and representatives are authorized to make any inquiries that the Company considers necessary to validate the account identified and/or investigate any dispute involving your payment, which may include verifying the information I/we provide and/or that the Company acquired against third party databases.
15. The Company (or its agent or representative) are authorized to initiate one or more debits by electronic fund transfers (withdrawals), and the bank or financial institution that holds my/our account is authorized to deduct such payments, in the amounts and frequency designated.

Policy Owner email _____

- ☐ 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 Authorized Account Holder (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
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Email: VULSolutions@glic.com
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Disability Income Insurance

Berkshire Life Insurance Company of America
Policy Services
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