

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. 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 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.

Application for Individual Life Insurance – Part 1

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;
- 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.
 - 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.



**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 _____
	<i>If none, please provide a government photo ID number, issuer, and expiration date in the Remarks section.</i>
	e. Relationship to Proposed Insured _____
	f. Is the Owner a U.S. Citizen? ☐ Yes ☐ No <i>If "No," please provide details in the Remarks section.</i>
	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 _____	
<i>If the Owner is a Trust, you <u>must</u> complete the Trust Certification form.</i>	

# 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 _____
	<i>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.</i>

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 _____	Percentage _____ %
_____ (spouse)	
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**	\$

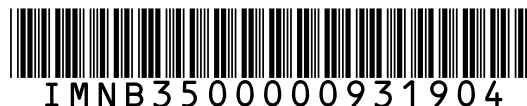
d. What are your expected monthly household expenses? \$ _____

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

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



**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
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: _____



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

Reprinted by Guardian, June, 2009

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

Life Insurance Buyer's Guide

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.

Life Insurance Buyer's Guide

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

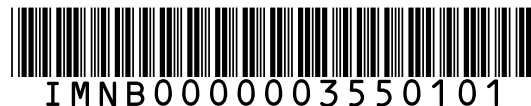
Printed Name

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



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.)



**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)



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

El Paso TX 79998-1588

Email: VULSolutions@glic.com

Customer Call Center: 1-888-GUARDIAN (482-7342)

Fax: 610-807-2940

Disability Income Insurance**Berkshire Life Insurance Company of America**

Policy Services

P.O. Box 981594

El Paso TX 79998-1594

Email: Diprocessing@glic.com

Customer Call Center: 1-888-GUARDIAN (482-7342)

Fax: 413-395-5992