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

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

# Disability Insurance Application Instructions / Checklist

| THIS APPLICATION PACKAGE INCLUDES: | | |
|---|---|---|
| **Application for Insurance Part 1 – pages 1-8** | Complete Sections 1-8 in all cases. Do you have the correct state forms (must be where the applicant lives or works)? | ☐ |
| **Supplements to the Application for Insurance**<br>***At least one supplemental form must be included with every case submitted.*** | Do you have the correct supplement(s) fully completed for the appropriate type(s) of insurance applied for?<br>– Individual Disability Insurance (TDI) – 1 page<br>– Retirement Protection Plus (RPP) – 1 page*<br>– Overhead Expense (OE) – 2 pages<br>– Disability Buy-Out (DBO) – 2 pages<br>– PayGuard or Business Reducing Term (RT) – 1 page | ☐ |
| **Be sure to complete the proper RPP Assignment form and submit with the application.* | | |
| **Representations of Proposed Insured and Owner** | Signature of the proposed insured on this form confirms their agreement that the application is complete, correctly recorded and true to the best of his or her knowledge. | ☐ |
| **Notice of Insurance Information Practices** | Please provide this form to the applicant. | ☐ |
| **Authorization to Obtain/Release Information** | This form authorizes the Company to obtain medical and other information about the proposed insured. | ☐ |
| **Producer's Certification** | Agent must be licensed and appointed where application was signed. | ☐ |
| | If part of an association, include the endorsing agent. | ☐ |
| **Authorization for Disclosure of Protected Health Information (AA1542)** | Recommend your client complete this form as it provides underwriting the authority to discuss details of the case with the agent. | ☐ |
| **Application for Insurance Part 2 Non-Medical** | Obtain all appropriate signatures and submit with the application (not required if submitting through the TeleMed program except in California). | ☐ |
| **TeleMed** | Complete and submit the TeleMed Request form to the vendor. | ☐ |
| | Indicate TeleMed on the New Business Transmittal and submit with the application. | ☐ |
| | If this is not a TeleMed case or TeleMed - Interview Only is selected, you must complete the Part 2 Non-Medical and order the necessary medical requirements (i.e., paramed, labs, inspection, etc.). | ☐ |
| **Financial Information** | Section 7 of Part 1 must be completed in all cases. | ☐ |
| | Obtain W-2, recent paystub, tax return or employment agreement. | ☐ |
| | Financial verification is required in all cases, except residents applying within the resident limits and cases submitted through the Enhanced Quick Issue Program. | |
| **Conditional Receipt**<br>*A Conditional Receipt must be submitted with every prepayment. Refer to the Conditional Receipt Guidelines for information on our policy dating and prepayment refunding procedures.* | Obtain appropriate signatures, submit one copy with the application. | ☐ |
| | Do not accept a prepayment if questions 4m or 4n are "Yes" (see instruction on page 4 of Part 1). | ☐ |
| | Do not accept a prepayment if any questions 4o through 4r are "Yes." | ☐ |
| **Automatic Payment Plan** | If a new service, complete and submit the Request for Guard-O-Matic Arrangement form (R223). | ☐ |
| | Submit a copy of a canceled check or a savings deposit slip. | ☐ |
| **New Business Transmittal (AA1732)** | Submit a transmittal to specify instructions for processing the application. | ☐ |
| | If you are or recently have submitted a life insurance application with Guardian, please be sure to notify us of this Combo Case status on the New Business Transmittal. | ☐ |

*Additional forms may be required but are not part of this package. If relevant to this case, complete additional forms and submit with the application package.*

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

# Application for Insurance | Part 1

Please indicate all insurance applied for with this Part 1 Application and include the appropriate application supplement for each product selected to right.

☐ Individual Disability Insurance
☐ Individual Disability Insurance – Retirement Protection Plus Program
☐ Overhead Expense ☐ Disability Buy-Out
☐ Business Reducing Term/PayGuard

## 1. Proposed Insured Information

a. Proposed Insured

First Middle Initial Last Name

Suffix Previous Last Name

b. Gender ☐ Male ☐ Female

c. Social Security Number

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

e. Place of Birth

f. Are you a U.S. citizen? ☐ Yes ☐ No (If no, answer the following questions)

Visa Type Visa Duration

g. Home Address

(If mailing address is PO Box, include street address as well.)

City State ZIP

h. How long at this address?

i. Telephone Number

Home Phone Number Cell Phone Number

j. E-mail Address

k. If less than 2 years at current address, please furnish previous address:

Address

City State ZIP

## 2. Business Information

a. Name of Current Employer

b. Business Address

(If mailing address is PO Box, include street address as well.)

City State ZIP

*Business Phone*

*Business Website*

c. Occupation

d. Job Title

e. Nature of Business

f. How many years employed with your current employer?

(If less than 2 years, please furnish previous employer below.)

g. Former Employer

Address

City State ZIP

h. Occupation

i. Job Title

j. Nature of Business

## 3. Occupational Information

a. Describe, in order of importance, all duties of your occupation. Include all activities that are performed in connection with the duties of your occupation, including but not limited to travel, sales and supervisory.

| Description of Specific Duties | % of Time Devoted to Each Duty |
|---|---|
| | |
| | |
| | |

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

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

d. If you are a medical doctor or dentist, what percent of your gross income is derived from surgical procedures, such as catheterization, angioplasty, stent placement, pacemaker implant, endoscopy, or other surgical procedure? ____ %

e. Is this a home-based occupation? ☐ Yes ☐ No

If yes, what percentage of time do you spend working at home? ____ %

f. Number of years in this occupation ____

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

h. Have you been continuously at work full time performing the usual duties of your occupation for the past six months? ☐ Yes ☐ No If no, explain: ____

i. Do you supervise any employees? ☐ Yes ☐ No If yes, how many? ____

j. Are you a business owner? ☐ Yes ☐ No

k. What percentage of the business do you own? ____ %

l. What type of business do you own?
☐ Sole Proprietorship ☐ Partnership ☐ "S" Corporation
☐ Limited Liability Company (LLC) ☐ "C" Corporation
☐ Limited Liability Partnership (LLP)
☐ Other: ____

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

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

## 4. The Following Questions Apply to the Proposed Insured

(Please provide details in Section 8 Remarks and Special Requests to all "Yes" answers.)

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

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

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

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

e. Have you ever had a professional license suspended or revoked, or is such license under review, or have you ever been disbarred? ☐ Yes ☐ No

| | | |
|---|---|---|
| f. | Within the last three years, have you participated in any of the following, or do you plan in the future to participate in any of the following: piloting any type of aircraft; mountain climbing or rock climbing; scuba diving; hang gliding; parachuting or skydiving; motor vehicle racing; or other hazardous activity? (If yes to any, complete Aviation and/or Avocation Supplement.) | ☐ Yes ☐ No |
| g. | Within the past five years, have you had disability, accident, medical, life or health insurance declined, postponed, modified, rated, cancelled, rescinded, or have you withdrawn a pending application, or had a renewal or reinstatement refused? | ☐ Yes ☐ No |
| h. | Have you used tobacco, nicotine, or any nicotine delivery system in any form in the last 12 months? (If you have quit, date last used: _____) | ☐ Yes ☐ No |
| i. | Do you plan to apply for or are you currently applying for any other life, long-term care, disability or accident insurance? (In Section 8 Remarks and Special Requests, include amount applying for and company applying with, and whether this other insurance will be in addition to or in lieu of insurance with Berkshire or Guardian.) | ☐ Yes ☐ No |
| j. | Are you currently a member of, or do you plan on joining, any branch of the United States Military, including the Army, Navy, Air Force, Marine Corps, Coast Guard, National Guard, or any reserve military unit? | ☐ Yes ☐ No |
| k. | Are you currently employed by, or seeking employment with, any company or entity which provides military, paramilitary, or security services outside of the United States? | ☐ Yes ☐ No |
| l. | Have you been alerted to, received orders for, or had any indication of an overseas assignment or active service with any branch of the United States Military, including the Army, Navy, Air Force, Marine Corps, Coast Guard, National Guard, or any reserve military unit? | ☐ Yes ☐ No |
| m. | Have you ever had or been treated for cancer, heart attack, stroke, diabetes, or any disease of the liver, lungs, kidneys, or heart, or any disorder of the back or spine? | ☐ Yes ☐ No |
| n. | Are you currently receiving any medical advice, counseling or treatment for any medical, surgical or psychiatric condition? | ☐ Yes ☐ No |

**If questions 4m or 4n are left blank or answered "Yes," no prepayment should be taken and no Conditional Receipt issued.**

## Catastrophic Disability Benefit Rider – Complete the following questions if applying for this rider:

| | | |
|---|---|---|
| o. | Have you ever had an injury or sickness that caused a loss of: sight in both eyes; hearing in both ears; speech; or the use of two arms or two legs? | ☐ Yes ☐ No |
| p. | Do you need human assistance of any kind to perform everyday activities such as bathing, continence, dressing, eating, using the toilet or transferring (for example, from the chair to your bed)? | ☐ Yes ☐ No |
| q. | Do you use any special medical equipment or appliances, including but not limited to, a wheelchair, pacemaker, oxygen tank, cane, catheter, or artificial limb? | ☐ Yes ☐ No |
| r. | Have you ever received treatment, attention or advice for memory loss or confusion, Alzheimer's disease, stroke, senility, dementia, loss of speech or comprehension of spoken language? | ☐ Yes ☐ No |

**If any question listed in 4o through 4r is answered "Yes," no prepayment should be taken and no Conditional Receipt issued.**

## 5. Other Disability Insurance Coverage of the Proposed Insured

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

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

**Category**
**IDI** = Individual
**STD** = Group STD
**LTD** = Group LTD
**A** = Association

**Status**
**I** = In Force
**P** = Pending
**E** = Eligible For

| | | | |
|---|---|---|---|
| i. Company Name: | | | |
| ii. Type of Insurance: | | | |
| iii. Category: | | | |
| iv. Status: | | | |
| v. Date insurance applied for, issued, or eligible for (if known): | | | |
| vi. Policy Number (if known): | | | |
| vii. Benefit Amount: | $ | $ | $ |
| viii. Benefit Period: | | | |
| ix. Social Insurance Benefit: | $ | $ | $ |
| x. Automatic Increase Option: | % | % | % |
| xi. Future Increase Option (amount remaining): | $ | $ | $ |
| xii. Catastrophic Benefit: | $ | $ | $ |
| xiii. Retirement Benefit: | $ | $ | $ |
| xiv. Does employer pay premium and not include it as taxable income to you? | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |
| xv. If group coverage, is it convertible? | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |

b. Replacement

| | | | |
|---|---|---|---|
| Is the insurance being applied for replacing this coverage? | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |
| If yes, amount to be replaced?* | $ | $ | $ |
| Date for coverage to be replaced | | | |

**When issuing any insurance as a result of this application, the Company will rely on the fact that you can and will permanently terminate the coverage as specified above following the delivery of the policy and will not at any time reinstate the coverage. If the coverage is not terminated, benefits under any policy issued based upon this application may be reduced by the amount payable under such existing policies. Further, if the coverage is not terminated, the Company reserves all rights outlined in any policy issued.*

## 6. Personal Financial Information of the Proposed Insured

a. **Earned Income.** Fill in the amounts requested for last year and two years ago using your individual and/or business income tax returns and supporting schedules. **Note:** Do not list income that is not reported to the IRS. Explain in Section 8 Remarks and Special Requests, any significant fluctuations between years. Describe any changes since the end of the most recent calendar year. Put loss amounts in parentheses.

| | Column A<br>Year-To-Date This Calendar Year | Column B<br>Actual Filed Last Calendar Year | Column C<br>Actual Filed Two Calendar Years Ago |
|---|---|---|---|
| 1. Non-owner employee salary, wages and bonus from Form W-2 | $ | $ | $ |
| 2. Business owner salary, wages, and bonus from Form W-2 | $ | $ | $ |
| 3. Sole Proprietor net income (after business expenses) from Form 1040, Schedule C | $ | $ | $ |
| 4. Share of Partnership or Sub-Chapter "S" corporation income (after business expenses) shown on Form 1040 or 1120 "S", Schedule K-1 | $ | $ | $ |
| 5. Other earned income (explain source) | $ | $ | $ |
| 6. **Total Earned Income (add lines 1-5)** | $ | $ | $ |

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

*Is your unearned income more than 10% of total earned income (line 6 above)?* ☐ Yes ☐ No

| | Column A | Column B | Column C |
|---|---|---|---|
| If yes, indicate the unearned income amounts. | $ | $ | $ |

Sources: _____

c. **Retirement Contributions**

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

| | Column A | Column B | Column C |
|---|---|---|---|
| 2. Total Annual Contribution (including your contribution and employer contributions) | $ | $ | $ |

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

d. **Net Worth** Does your net worth exceed $6 million? ☐ Yes ☐ No If yes, itemize net worth below.

Cash, Savings, Stocks, Bonds $

Fair Market Value of your business (excluding good will) $

Personal Property $

Real Estate (excluding primary residence) $

Other $ Explain:

e. **Bankruptcy**

Have you ever filed bankruptcy? ☐ Yes ☐ No ☐ Personal ☐ Business

If yes, answer the following questions:

(a) *Date bankruptcy filed?*

(b) *Date bankruptcy discharged?*

## 7. Premiums

a. Mode
☐ Annual ☐ Semiannual ☐ Quarterly
☐ Automatic payment plan
(Complete the Request for Guard-O-Matic Arrangement form.)
☐ *New Service* ☐ *Add to My Existing Service*
☐ Monthly (list bill only – not available for all products)
☐ Other:

b. What percentage of premium will be paid by your employer? ☐ None ☐ 100% Other: %

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

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

e. Send premium notices to: ☐ Residence ☐ Owner's Address ☐ Business
☐ Other:
☐ *List Bill*
☐ New – Billing Name
Common Billing Date
☐ Existing Account #

f. Prepayment of Premium
☐ No money has been submitted with this application for proposed insurance.
☐ $ _____ has been submitted with this application for proposed insurance. *If money is submitted when this application is signed, the terms of the Conditional Receipt shall apply if conditions are met.*

g. Is the policy being applied for through an association of which you are a member? *Proof of membership may be required.* ☐ Yes ☐ No
Association Name

## 8. Remarks and Special Requests

Provide all details to any "yes" answers, identifying each detail by question number. Include, if applicable, diagnosis or symptoms, tests performed, dates, types and amounts of medication, length of disability, degree of recovery, and names and addresses of all physicians, medical or mental health professionals, counselors, psychotherapists, chiropractors, practitioners or hospitals. Also include in this section any special policy requests such as specific policy date other than as provided by the terms of this application.

## 9. Amendments or Corrections (For Home Office Use Only)

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# Individual Disability Insurance Supplement to the Application for Insurance

## 1. Proposed Insured Information

a. Proposed Insured _____
First Middle Initial Last Name

b. Social Security Number _____

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

## 2. Premium Structure

☐ Level ☐ Graded ☐ Step Rate

## 3. Personal Disability Insurance

a. **Policy Form No.** _____

*Monthly Indemnity* $ _____

*Elimination Period* _____

*Benefit Period* _____

*Occupational Class* _____

b. **Supplemental Benefits**

☐ *3% Compound Cost of Living Adjustment*
☐ *6% Maximum Cost of Living Adjustment*
☐ *Four-Year Delayed Cost of Living Adjustment*
☐ *Residual Disability Benefit*
☐ *Partial Disability Benefit*
☐ *Graded Lifetime Indemnity for Total Disability*
☐ *Catastrophic Disability Benefit* $ _____
☐ *Future Increase Option* $ _____
☐ *Social Insurance Substitute* $ _____
☐ *Other* _____

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# Retirement Protection Plus Program Individual Disability Insurance Supplement to the Application for Insurance

## 1. Proposed Insured Information

a. Proposed Insured _____
First Middle Initial Last Name

b. Social Security Number _____

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

## 2. Premium Structure

☐ Level ☐ Graded ☐ Step Rate

## 3. Disability Insurance As Part Of The Retirement Protection Plus Program

a. **Case No.**
*(Applicable with Income ProVider Only)* _____

b. **Policy Form No.** _____

*Monthly Indemnity* $ _____

*Elimination Period* ☐ 180 days ☐ 360 days

*Benefit Period* To Age 65

*Occupational Class* _____

c. **Supplemental Benefits**

☐ *3% Compound Cost of Living Adjustment*

☐ *6% Maximum Cost of Living Adjustment*

☐ *Modified Own Occupation (Applicable with Income ProVider Only)*

☐ *Future Increase Option* $ _____

☐ *Other* _____

_____

_____

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# Overhead Expense Insurance Supplement to the Application for Insurance

## 1. Proposed Insured Information

a. Proposed Insured _____
First Middle Initial Last Name

b. Social Security Number _____

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

## 2. Overhead Expense Insurance

a. *Monthly Benefit* $ _____

*Benefit Period* _____

*Elimination Period* _____

*Occupational Class* _____

b. **Supplemental Benefits**

☐ *Supplemental Overhead Expense Benefit*

☐ *Future Increase Option* $ _____

c. Your share of covered expenses? $ _____ and _____ % of total.

d. Are there other employees in the firm who generate revenue? ☐ Yes ☐ No

*If yes, what is the compensation for these employees, their title(s) and the percentage of gross revenue they generate?*

_____

_____

_____

e. **Owner Information (if other than the proposed insured)**

*Name of Owner* _____

*Address* _____

(If mailing address is PO Box, include street address as well.)

_____

_____
City State ZIP

*Social Security #/Tax ID #* _____

*Relationship to Proposed Insured* _____

## Overhead Expense Insurance Supplement to the Application for Insurance | *Continued*

f. **Monthly Expenses of the Business Entity**

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

| | |
|---|---|
| *Advertising* | $ |
| *Car and Truck Expenses* | |
| *Commissions and Fees* | |
| *Contract Labor* | |
| *Depreciation and Section 179 Expense Deduction* | |
| *Employee Benefit Programs* | |
| *Insurance* | |
| *Interest:* | |
| *Mortgage (Paid to Banks, etc.)* | |
| *Other* | |
| *Legal and Professional Services* | |
| *Office Expenses* | |
| *Pension and Profit Sharing Plans* | |
| *Rent or Lease (Other Business Property)* | |
| *Repairs and Maintenance* | |
| *Taxes and Licenses* | |
| *Utilities* | |
| *Employee Wages (excluding members of your profession)* | |

*Other Expenses (itemized):*

| | |
|---|---|
| | $ |
| | |
| | |
| | |

| | |
|---|---|
| ***TOTAL (Should agree with 2c.)*** | $ |
| *Proposed Insured Monthly Earned Income** | $ |

**Earned income is considered for and in accordance with Salary Replacement guidelines of 50% of the Proposed Insured's Earned Income not to exceed one-half of the total monthly overhead expense benefit or $10,000, whichever is less.*

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# Disability Buy-Out Insurance Supplement to the Application for Insurance

## 1. Proposed Insured Information

a. Proposed Insured

First Middle Initial Last Name

b. Social Security Number

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

## 2. Disability Buy-Out Insurance

a. Funding ☐ Lump Sum ☐ Monthly ☐ Down Payment

*Benefit Amount* Monthly: $ Lump Sum: $

*Benefit Period*

*Elimination Period*

*Occupational Class*

b. **Supplemental Benefits**

☐ *Future Increase Option* Monthly: $ Lump Sum: $

c. Type of disability buy-sell agreement (in force or to be drafted): ☐ Cross Purchase ☐ Entity Purchase ☐ Trusteed Cross Purchase

*Status of disability buy-sell agreement:* ☐ In force and dated ☐ Date to be executed

d. **Owner Information**

*Name of owner (first name, middle initial and last name) or name of trust, company or other owner:*

*Address*

(If mailing address is PO Box, include street address as well.)

City State ZIP

*Social Security #/Tax ID #*

*Owner's Relationship to Proposed Insured*

**Disability Buy-Out Insurance Supplement to the Application for Insurance** | *Continued*

*Please complete the following if owner is a trust:* Date of Trust (mm/dd/yyyy)

*Complete Names of Trustees*

e. Give names of all other stockholders or partners. (If there are any on whom Disability Buy-Out (DBO) is not carried or proposed, explain in the *Application for Insurance, Part 1, Section 8 Remarks and Special Requests*.)

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

f. Does a familial relationship exist among any of the above stockholders or partners? ☐ Yes ☐ No If yes, describe:

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

h. Business Financial Information

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

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# Reducing Term Insurance Supplement to the Application for Insurance

## 1. Proposed Insured Information

a. Proposed Insured _____
First Middle Initial Last Name

b. Social Security Number _____

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

## 2. Reducing Term Insurance

a. ☐ *Business Reducing Term* ☐ *PayGuard*

*Monthly Benefit Amount* $ _____

*Elimination/Waiting Period* _____

*Benefit Term* _____

*Occupational Class* _____

b. **For Business Reducing Term**

*Loss Payee* _____

*(Loss payee must be the individual or entity that the money is owed to.)* Tax ID

*Owner* _____

Tax ID

**Information About the Economic Need for this Insurance**

c. Explain the reason that the obligation was incurred
☐ Business Loan ☐ Employment Contract
☐ Purchase Agreement
☐ Other (describe): _____

*Details:* _____

d. Names of all debtors or guarantors: _____

e. Name and address of creditor or person to whom guarantees have been given: _____

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

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

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

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

I am responsible for payments for a total of _____ months

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# Business Reducing Term Disclosure

Important Information About The Guardian Business Reducing Term Disability Income Policy For Which You Have Applied

Thank you for applying for a Business Reducing Term Disability Income Insurance policy ("the Policy") offered by The Guardian Life Insurance Company of America, New York, New York ("Guardian"). The Policy provides disability coverage with respect to a loan or other financial obligation for which you are obligated to repay, according to the terms and conditions stated in the Policy. Because the Policy contains some unique features, we have provided this form to ensure that you have an understanding of some of its benefits, features and limitations. Specifically, please be advised:

- The monthly indemnity and length of time for which benefits are payable under Policy are underwritten and issued based on the specific loan, and corresponding repayment schedule, identified in the application for the Policy. Any renegotiation of this loan, or change in the loan's repayment schedule, including any increase in the periodic payment amount or lengthening of the loan term, may impact the extent to which Policy benefits are payable.
- Should the insurable interest or economic need for the Policy no longer exist or be reduced, Guardian may, with proper notification in advance of any Policy anniversary, refuse to renew the Policy, or require a reduction in the benefit limits as a condition of renewal.
- The Loss Payee for the Policy is the bank or other lender identified in the application for the Policy.

If you any questions or concerns regarding the coverage provided by the Policy, please contact your agent or broker. This Business Reducing Term Disclosure form does not alter the terms, conditions, limitations, or exclusion(s) (if any), of any policy that may be issued.

By signing this form, I acknowledge my receipt of this form.

Signed this _____ day of _____, _____ (month, year).

_____
(Applicant Signature)

GUARDIAN®

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

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

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

## Representations of the Proposed Insured and Owner

Those parties who sign below, agree that:

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

**Any person who knowingly, and with intent to defraud any insurance company or other person, files an application of insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each violation.**

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

_____ _____
Signature of Proposed Insured | Signature of Applicant/Owner if Other than Proposed Insured

_____
Witness

GUARDIAN℠

**Life Customer Service Office**
3900 Burgess Place
Bethlehem, PA 18017

**Disability Customer Service Office**
700 South Street
Pittsfield, MA 01201

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

# Authorization to Obtain and Release Information

Name of Proposed Insured _____ Date of Birth _____

Address of Proposed Insured _____

_____

**This Authorization complies with the HIPAA Privacy Rule**

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

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

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

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

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

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

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

_____
Signature of Proposed Insured or Personal Representative

_____
Personal Representative's Authority or Relationship to Proposed Insured

_____
Witness Signature

## Producer's Certification (Complete in all cases.)

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

First Middle Initial Last Name

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

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

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

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

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

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

6. Remarks (and additional instructions)

7. Commissions

| Producer's Name | Producer's Code | Servicing Producer (Check Only One) | Percentage | Manager/ GA Code |
|---|---|---|---|---|
| | | ☐ | % | |
| | | ☐ | % | |
| | | ☐ | % | |
| | | ☐ | % | |
| | | ☐ | % | |
| | | ☐ | % | |

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

**Any person who knowingly, and with intent to defraud any insurance company or other person, files an application of insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.**

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

_____ Type or Print Producer's Name

_____ Signature of Soliciting Producer

_____ State(s) Where Licensed

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

_____ Date Submitted

Signed _____ (Agency Personnel)

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

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

# Conditional Receipt for Disability Insurance

**This receipt does not create any temporary or interim insurance. This receipt sets the date and conditions under which the insurance being applied for will go into effect. Unless all of the conditions in paragraph 2 below are met in full, no insurance will become effective. No agent of the Company and no broker is authorized to alter or waive any of the Company's requirements. If questions 4m or 4n on the accompanying Application for Insurance are left blank or are answered "Yes," no prepayment should be taken and no Conditional Receipt should be issued.**

1. **Effective Date** – As used herein, "Effective Date" means the latest of (i) the date of the Application for Insurance, (ii) the date of the Representations to the Medical Examiner (or the date of the latest if more than one is required), (iii) the date of this receipt, (iv) the date of the latest completion of any medical examinations, tests, x-rays and electrocardiograms that the Company requires, or (v) the Policy Date, if any, requested in the Application.
2. **Conditions Under Which Insurance May Become Effective** – The insurance in the amount and for the policy applied for will, subject to the limitations in paragraph 4, become effective as of the Effective Date only if all of the following conditions are met:
   (a) an initial premium payment has been made as acknowledged below and honored on first presentation for payment. The check must be made payable to the Company (do not make check payable to the producer or leave payee blank);
   (b) on the Effective Date the proposed insured is, in the opinion of the Company authorized officers, insurable and an acceptable risk under the Company rules, limits and standards for the proposed insurance amount, policy, and benefits exactly as applied for without restriction or modification;
   (c) on the date of this receipt, all answers and statements in any part of the application(s) having an earlier date are complete and true as though given on the date of this receipt;
   (d) information required by the Company to determine insurability must be received at the Company's Home Office within 60 days of the date of this receipt.

**If any one of these conditions is not met, this receipt is void and there shall be no liability on the part of the Company. The Company will return the payment accompanying this receipt in the form of a Company check.**

3. **Amendment of Application** – If the Company does not approve the application as applied for or if I request a modification as to the amount of insurance, policy, or benefits subsequent to the date of this receipt, then I understand that this receipt is void and there shall be no liability on the part of the Company. Should the Company offer insurance other than as applied for or in response to my request for a modification, such insurance shall not be effective unless and until:
   (a) the modified policy is delivered; and
   (b) an amendment of the application to adjust the provisions of the contract is signed by the proposed insured and the owner; and
   (c) the health and other conditions affecting the insurability of the proposed insured continues to remain the same as described in the Application for Insurance and the Representations to the Medical Examiner.

**One Copy to Applicant** **One Copy to Company**

## Conditional Receipt for Disability Insurance | *Continued*

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

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

*Age means age of proposed insured at birthday nearest date of Conditional Receipt.
**Products not available.

5. **Acknowledgement of Payment** – We have received from _____(applicant):
   (a) the sum of $_____ to pay all or part of the first premium for the proposed disability income insurance policy;
   (b) the sum of $_____ to pay all or part of the first premium for the proposed disability buy-out insurance policy;
   (c) the sum of $_____ to pay all or part of the first premium for the proposed overhead expense insurance policy;
   on _____(proposed insured) in accordance with the Application(s) for insurance.
6. **Period of Coverage** – If less than the first full premium has been paid according to the mode of payment selected for the policy type and the amount of insurance applied for, any insurance effective under paragraphs 2 and 3 above shall be in force only for the pro rata portion of the policy year for which the premium has been paid. This portion of the policy year begins on the Effective Date and does not include any grace period.

**I have read this receipt and have received a copy signed by the producer. I understand that insurance becomes effective only if all the conditions of paragraph 2 are met and then only from the Effective Date, and for not more than the limitations in paragraph 4. I understand that if a policy date is requested in the application that is later than the date of either the Application for Insurance or the Representations to the Medical Examiner, I am waiving some rights under this receipt. I further understand that this receipt is void if there is any incorrect, untrue, incomplete or omitted statement of material fact in the Application for Insurance, Representations to the Medical Examiner, or any supplemental form that becomes part of any policy issued.**

Signed_____Applicant(s) Date_____(mm/dd/yyyy)

Signed_____Producer Date_____(mm/dd/yyyy)

**One Copy to Applicant One Copy to Company**

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

# Conditional Receipt for Disability Insurance

**This receipt does not create any temporary or interim insurance. This receipt sets the date and conditions under which the insurance being applied for will go into effect. Unless all of the conditions in paragraph 2 below are met in full, no insurance will become effective. No agent of the Company and no broker is authorized to alter or waive any of the Company's requirements. If questions 4m or 4n on the accompanying Application for Insurance are left blank or are answered "Yes," no prepayment should be taken and no Conditional Receipt should be issued.**

1. **Effective Date** – As used herein, "Effective Date" means the latest of (i) the date of the Application for Insurance, (ii) the date of the Representations to the Medical Examiner (or the date of the latest if more than one is required), (iii) the date of this receipt, (iv) the date of the latest completion of any medical examinations, tests, x-rays and electrocardiograms that the Company requires, or (v) the Policy Date, if any, requested in the Application.
2. **Conditions Under Which Insurance May Become Effective** – The insurance in the amount and for the policy applied for will, subject to the limitations in paragraph 4, become effective as of the Effective Date only if all of the following conditions are met:
   (a) an initial premium payment has been made as acknowledged below and honored on first presentation for payment. The check must be made payable to the Company (do not make check payable to the producer or leave payee blank);
   (b) on the Effective Date the proposed insured is, in the opinion of the Company authorized officers, insurable and an acceptable risk under the Company rules, limits and standards for the proposed insurance amount, policy, and benefits exactly as applied for without restriction or modification;
   (c) on the date of this receipt, all answers and statements in any part of the application(s) having an earlier date are complete and true as though given on the date of this receipt;
   (d) information required by the Company to determine insurability must be received at the Company's Home Office within 60 days of the date of this receipt.

**If any one of these conditions is not met, this receipt is void and there shall be no liability on the part of the Company. The Company will return the payment accompanying this receipt in the form of a Company check.**

3. **Amendment of Application** – If the Company does not approve the application as applied for or if I request a modification as to the amount of insurance, policy, or benefits subsequent to the date of this receipt, then I understand that this receipt is void and there shall be no liability on the part of the Company. Should the Company offer insurance other than as applied for or in response to my request for a modification, such insurance shall not be effective unless and until:
   (a) the modified policy is delivered; and
   (b) an amendment of the application to adjust the provisions of the contract is signed by the proposed insured and the owner; and
   (c) the health and other conditions affecting the insurability of the proposed insured continues to remain the same as described in the Application for Insurance and the Representations to the Medical Examiner.

**One Copy to Applicant** **One Copy to Company**

## Conditional Receipt for Disability Insurance | *Continued*

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

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

*Age means age of proposed insured at birthday nearest date of Conditional Receipt.
**Products not available.

5. **Acknowledgement of Payment** – We have received from _____(applicant):
   (a) the sum of $_____ to pay all or part of the first premium for the proposed disability income insurance policy;
   (b) the sum of $_____ to pay all or part of the first premium for the proposed disability buy-out insurance policy;
   (c) the sum of $_____ to pay all or part of the first premium for the proposed overhead expense insurance policy;
   on _____(proposed insured) in accordance with the Application(s) for insurance.
6. **Period of Coverage** – If less than the first full premium has been paid according to the mode of payment selected for the policy type and the amount of insurance applied for, any insurance effective under paragraphs 2 and 3 above shall be in force only for the pro rata portion of the policy year for which the premium has been paid. This portion of the policy year begins on the Effective Date and does not include any grace period.

**I have read this receipt and have received a copy signed by the producer. I understand that insurance becomes effective only if all the conditions of paragraph 2 are met and then only from the Effective Date, and for not more than the limitations in paragraph 4. I understand that if a policy date is requested in the application that is later than the date of either the Application for Insurance or the Representations to the Medical Examiner, I am waiving some rights under this receipt. I further understand that this receipt is void if there is any incorrect, untrue, incomplete or omitted statement of material fact in the Application for Insurance, Representations to the Medical Examiner, or any supplemental form that becomes part of any policy issued.**

Signed_____Applicant(s) Date_____(mm/dd/yyyy)

Signed_____Producer Date_____(mm/dd/yyyy)

**One Copy to Applicant One Copy to Company**

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

# Application for Insurance | Part 2 Non-Medical

## 1. Proposed Insured Information

a. Proposed Insured

First Middle Initial Last Name

b. Social Security Number

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

d. Name of your primary care physician

**If none, check here** ☐

*Address of primary care physician*

(If mailing address is PO Box, include street address as well.)

City State ZIP

*Primary care physician's telephone number*

e. Date and reason last consulted?

f. What treatment or medication was given or recommended?

g. Height feet inches

Weight lbs.

h. Weight change past year: ☐ Gain ☐ Loss _____ lbs. ☐ None

*Reason for change*:

**(Please provide details in Remarks and Special Requests for any "Yes" answers.)**

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

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

i. high blood pressure, chest pain or disorder of the heart or circulatory system? ☐ Yes ☐ No

ii. diabetes or disorder of the glands, bone, blood or skin? ☐ Yes ☐ No

iii. complications of pregnancy, infertility, or any disorder of the breasts, reproductive or genital organs, prostate, kidneys, or urinary systems? ☐ Yes ☐ No

iv. hernia, hepatitis, or disorder of the liver, gall bladder, esophagus, stomach, pancreas, spleen, intestines, colon or rectum? ☐ Yes ☐ No

v. arthritis, rheumatism, or disorder of the joints, limbs or muscles? ☐ Yes ☐ No

| | |
|---|---|
| vi. disorder or condition of the back, neck or spine? | ☐ Yes ☐ No |
| vii. allergy, asthma, sinusitis, emphysema, disorder of the lungs or respiratory system, or sleep apnea? | ☐ Yes ☐ No |
| viii. epilepsy, stroke, dizziness, headache, muscle weakness, or disorder of the brain or spinal cord? | ☐ Yes ☐ No |
| ix. disorder of the eyes, ears, nose or throat? | ☐ Yes ☐ No |
| x. anxiety, depression, nervousness, stress, mental or nervous disorder, or other emotional disorder? | ☐ Yes ☐ No |
| xi. Chronic Fatigue Syndrome, Fibromyalgia, Epstein Barr Virus or Lyme Disease? | ☐ Yes ☐ No |
| k. Do you have any loss of hearing or sight, an amputation of any kind, or any physical deformity, impairment or handicap? | ☐ Yes ☐ No |
| l. Within the past 10 years, have you been diagnosed by or received treatment from a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC? | ☐ Yes ☐ No |
| m. i. Are you currently taking prescribed medication? | ☐ Yes ☐ No |
| ii. Are you currently taking non-prescription medication? | ☐ Yes ☐ No |
| n. i. Have you ever used stimulants, hallucinogens, narcotics or any other controlled substance? (If yes, complete the Alcohol and Drug Usage Supplement.) | ☐ Yes ☐ No |
| ii. Have you ever had or been advised to have counseling or treatment for alcohol or drug use? (If yes, complete the Alcohol and Drug Usage Supplement.) | ☐ Yes ☐ No |
| o. Are you now pregnant? If yes, expected delivery date: _____ | ☐ Yes ☐ No |
| p. Within the past five years, have you had a sickness or injury for which you have made a benefits claim or for which you will make a benefits claim? | ☐ Yes ☐ No |
| q. Within the past five years, have you had a physical exam or check-up of any kind? | ☐ Yes ☐ No |
| r. Within the past five years, have you been advised to have surgery or any diagnostic tests that were not performed, except for HIV tests? | ☐ Yes ☐ No |
| s. To the best of your knowledge and belief, within the past 12 months, have you had symptoms of any condition listed in this Section 1, except those conditions listed in question 1.l., for which you have not sought medical attention or advice? | ☐ Yes ☐ No |
| t. Other than as previously stated on this application, in the last five years have you received medical advice or counseling from physicians, medical or mental health professionals, counselors, psychotherapists, chiropractors, or other practitioners, or have you been a patient in a hospital, clinic, sanatorium, or other medical facility? | ☐ Yes ☐ No |
| u. To the best of your knowledge and belief, do you have a family history of: diabetes, cancer, high blood pressure, heart disease, Huntington's Disease, mental illness or suicide? | ☐ Yes ☐ No |

| | Age if Living | Cause of Death | Age at Death |
|---|---|---|---|
| FATHER | | | |
| MOTHER | | | |
| BROTHERS and SISTERS | | | |
| No. Living _____ | | | |
| No. Dead _____ | | | |

## 2. Remarks and Special Requests

**DETAILS OF "YES" ANSWERS. IDENTIFY QUESTION & NUMBER.**
Give diagnosis or symptoms, tests performed, dates, types and amounts of medication, length of disability, degree of recovery, and names and addresses of all physicians, medical or mental health professionals, counselors, psychotherapists, practitioners or hospitals. Additional paper may be attached if necessary to explain details.

I understand and agree that the statements and answers in this Application for Insurance (Part 2 Non-Medical) are written as made by me; to the best of my knowledge and belief are full, complete and true; and that they shall be a part of the contract of insurance, if issued.

**Any person who knowingly, and with intent to defraud any insurance company or other person, files an application of insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.**

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

_____ _____
Witness Signature of Proposed Insured

GUARDIAN®

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

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

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

In this Request for G-O-M Arrangement form, the "Company" is the insurer checked above
**See next page for VUL instructions.**

**IMPORTANT: A voided blank check or photocopy (starter checks are not acceptable) is required for checking accounts or a deposit slip for a savings account.** See next page for general Guard-O-Matic information.

Guardian and/or GIAC and/or Berkshire is requested and authorized to debit your financial institution or to initiate electronic funds transfer on or about the 15th of each month to pay premiums due and/or on the 1st business day of each month to pay the policy loan on the policy(ies) identified below (on or about the 15th of each month to pay the policy loan on Guardian policy(ies) administered by Berkshire).

**I understand that:**

1. Completion of this form shall not constitute a premium payment and/or loan payment. Authorization for premium payments is not effective until the initial premium(s) has been received and paid at the home office or you have requested initial premiums be paid under this Arrangement. Multiple months' premiums may be required to bring the policy to a current due date. If dividends are currently being used to purchase paid-up additional insurance, and dividends for term insurance policies and annuities will be left with us to accumulate at interest.
2. The Guard-O-Matic Premium Arrangement or Loan Payment Arrangement may be terminated by the Policyowner or by the Company upon written notice. If the Bank Depositor is other than the policyowner, the Company will terminate the arrangement upon written request of such Bank Depositor. The policyowner or depositor may cancel this authorization by giving our home office 30 days' written notice
3. If the Loan Payment Arrangement is cancelled, any outstanding loans will remain unpaid.
4. Any withdrawal returned due to insufficient funds may be deposited for collection a second time. We may terminate the Guard-O-Matic plan immediately by written notice in the event any withdrawal or electronic fund transfer is dishonored.

**PLEASE PRINT**

Type of account: Checking ☐ Savings ☐ Begin deductions effective _____ (Month) _____(Year)
Financial Institution: _____
Street Address: _____City: _____
State: _____ Zip: _____ Transit/ABA Number: _____
Account Number: _____ Name of Account Holder: _____

**Guard-O-Matic Premium Arrangement**.

| List Policy Numbers | Insured's Name | Last 4 Digits of Policyowners's SS# |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

**Guard-O-Matic Loan Payment Arrangement**.

| Life Policy Numbers | Amount to be Deducted | Life Policy Number | Amount to be Deducted |
|---|---|---|---|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

*As a convenience to me, I authorize you to pay and charge to my account checks, electronic funds transfer debits or other account debits made upon my account by and payable to the order of Guardian/GIAC/Berkshire indicated above. I agree that your treatment of each check or debit, and your rights with respect to it, will be the same as if it were signed or initialed personally by me. I further agree that if any check or debit is dishonored for any reason you will not be under any liability even though dishonor results in the forfeiture of insurance.*

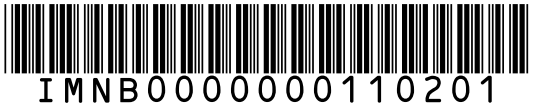
I further agree that this authorization is to remain in effect until you receive written notice from me of its revocation unless you end it earlier.

_____ _____
Date Signature of Bank Account Owner

_____ _____
Signature of Policy Owner, if other than Bank Account Owner For Home Office Use Only, Control No.:



R223 (Rev. 4/10)



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

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

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

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

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

## GUARD-O-MATIC General Information

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

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

## INDEMNIFICATION AGREEMENT

**TO: The Bank named on the previous page.**

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

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

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

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



R223 (Rev. 4/10)

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

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

**NOTICE AND CONSENT FOR BLOOD TESTING**
Which May Include AIDS Virus (HIV) Antibody/Antigen Testing

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

*Berkshire Life Insurance Company of America is a wholly owned stock subsidiary of and an administrator for The Guardian Life Insurance Company of America, New York, NY*

## Special Instructions for the Soliciting Agent and the Medical Professional When Drawing Blood for Company's Proposed Insured

### Soliciting Agent

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

### Medical Professional

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

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

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

# NOTICE AND CONSENT FOR BLOOD TESTING
Which May Include AIDS Virus (HIV) Antibody/Antigen Testing

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

*Berkshire Life Insurance Company of America is a wholly owned stock subsidiary of and an administrator for The Guardian Life Insurance Company of America, New York, NY*

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

To determine your insurability, the Insurer named above (the Insurer) has requested that you provide a sample of your blood for testing and analysis. All tests will be performed by a licensed laboratory.

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

Unless precluded by law, tests may be performed to determine the presence of antibodies or antigens to the Human Immunodeficiency Virus (HIV), also known as the AIDS virus. The HIV antibody test that we perform is actually a series of tests done by a medically accepted procedure. The HIV antigen test directly identifies AIDS viral particles. These tests are extremely reliable. Other tests which may be performed include determinations of blood cholesterol and related lipids (fats) and screening for liver or kidney disorders, diabetes, and immune disorders.

All tests results will be treated confidentially. They will be reported by the laboratory to the Insurer. When necessary for business reasons in connection with insurance you have or have applied for with the Insurer, the Insurer may disclose test results to others involved solely in the underwriting process such as its affiliates, reinsurers, employees, or contractors. If the Insurer is a member of the Medical Information Bureau (MIB, Inc.), and if the test results for HIV antibodies/antigens are other than normal, the Insurer will report to the MIB, Inc. a generic code which signifies only a nonspecific blood test abnormality. If your HIV test is normal, no report will be made about it to the MIB, Inc. Other test results may be reported to the MIB, Inc. in a more specific manner. The organizations described in this paragraph may maintain the test results in a file or data bank. There will be no other disclosure of test results or even that the tests have been done except as may be required or permitted by law or as authorized by you.

If your HIV test results are normal, no routine notification will be sent to you. If the HIV test results are other than normal, the Insurer will contact you. The Insurer may also contact you if there are other abnormal test results which, in the Insurer's opinion are significant. The Insurer will ask you for the name of a physician or other health care provider to whom you may authorize disclosure and with whom you may wish to discuss the results.

Positive HIV antibody/antigen test results do not mean that you have AIDS, but that you are at significantly increased risk of developing AIDS or AIDS-related conditions. Federal authorities say that persons who are HIV antibody/antigen positive should be considered infected with the AIDS virus and capable of infecting others. If your test is positive, you might consider further independent testing at your own expense.

Positive HIV antibody or antigen test results or other significant blood abnormalities will adversely affect your application for insurance. This means that your application may be declined, that an increased premium may be charged, or that other policy changes may be necessary. You may designate below the person(s) to whom test results can be disclosed in the event of an adverse underwriting decision.

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

I have read and I understand this Notice of Consent For Blood Testing Which May Include AIDS Virus (HIV) Antibody/Antigen Testing. I voluntarily consent to the withdrawal of blood from me by needle, the testing of that blood, and the disclosure of the test results as described above.

I understand that I have the right to request and receive a copy of this authorization. A photocopy of this form will be as valid as the original.

_____ _____
Proposed Insured Date of Birth

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

_____

_____

_____

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

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

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

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

# AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

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

*Berkshire Life Insurance Company of America is a wholly owned stock subsidiary of and an administrator for The Guardian Life Insurance Company of America, New York, NY*

***"I," "me," "my" means the Applicant signing this Authorization.***

This authorization is at the request of the individual whose name appears below.

In the event my application for insurance is not approved or if my policy is issued at a rate or with benefits other than as applied for, I authorize the Company to disclose the specific reasons for the underwriting decision to my agent or broker and/or to his or her marketing organization. I understand that the Company will not condition eligibility for coverage, underwriting or risk rating determination, or payment of benefits on any provision of this authorization. **I understand that this disclosure may involve specific, protected health information regarding me. I also understand that authorizing this disclosure is optional and I am not required to sign this authorization.**

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

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

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

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

_____
**Applicant's Name (Please Print)**

_____ _____
**Applicant's Signature** **Date**

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

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

## DISABILITY BUY-OUT POLICY
## REQUIRED OUTLINE OF COVERAGE

### Policy Form 3200

1. READ THE POLICY CAREFULLY – This outline of coverage briefly describes some of the important features of the Policy. This is not the insurance contract and only the actual policy provisions will control. The Policy itself sets forth, in detail, the rights and obligations of the Policyowner, You, and Berkshire Life Insurance Company of America. It is important that the Policyowner and You READ THE POLICY CAREFULLY!

2. DISABILITY INCOME PROTECTION COVERAGE – This type of coverage is designed to provide benefits for a Disability resulting from Injury or Sickness, subject to any limitations set forth in the Policy. Benefits are not provided for basic hospital, basic medical-surgical, or major medical expenses.

3. BENEFITS OF THE POLICY – The purpose of the Policy is to provide a benefit to an individual, entity or a business to buy out the business interest of another individual (the Insured) who becomes Totally Disabled. Coverage is contingent on the Insured being Gainfully Employed Full Time by the Business at the start of the Total Disability, and the Policyowner being obligated to buy the business interest of the Insured because of the Total Disability, and the Policyowner actually making payments to purchase that interest.

   If You are Totally Disabled according to the terms of the Policy, and the Elimination Period of _____ days has been satisfied, benefits of up to $_____ (Maximum Aggregate Benefit) will be paid to the Policyowner. The Policyowner has chosen the funding method indicated below:

   ☐ 1. Monthly Installment. If the Monthly Installment Funding Method is elected, the benefits will become payable to the Policyowner after the end of the Elimination Period, or the Closing Date, if later. The monthly benefit payable will be the least of:

   - the Monthly Purchase Amount;
   - the Maximum Monthly Installment Benefit; or
   - an amount equal to (A ÷ B), where:

     A is the Business Valuation Amount less the Prior Buy-Out Coverage, and
     B is the number of months in the Monthly Installment Period.

   ☐ 2. Lump Sum. If the Lump Sum Funding Method is elected, the benefit will become payable to the Policyowner after the end of the Elimination Period, or the Closing Date, if later. The benefit payable will be the least of:

   - the Purchase Amount;
   - the Maximum Aggregate Benefit; or
   - the Business Valuation Amount less the Prior Buy-Out Coverage

   ☐ 3. Down Payment. If the Down Payment Funding Method is elected, the benefits will become payable to the Policyowner after the end of the Elimination Period, or the Closing Date, if later. We will first pay the Policyowner the least of:

   - the actual down payment amount paid to You by the Policyowner;
   - the Maximum Lump Sum Benefit; or
   - the Business Valuation Amount less the Prior Buy-Out Coverage.

Thereafter, the monthly benefit payable will be the least of:

- the Monthly Purchase Amount;
- the Maximum Monthly Installment Benefit; or
- an amount equal to (A – B) ÷ C, where:

  A is the Business Valuation Amount less the Prior Buy-Out Coverage
  B is the total amount of benefit already paid by Us, and
  C is the number of months in the Monthly Installment Period.

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

Your Occupation means the occupation (or occupations if more than one) in which You are Gainfully Employed during the 12 months prior to the time You become Totally Disabled.

Waiver of Premium Benefit – If You are Totally Disabled for the length of the Elimination Period due to Injury or Sickness not excluded from Coverage, We will refund the portion of any premium paid which applies to the period of Total Disability beyond the date that You were first Totally Disabled in the same claim. We will then waive any later premiums that are due while You are receiving benefits for the Total Disability.

Occupational Rehabilitation Benefit – If You are Totally Disabled and the Elimination Period has not been satisfied, You may be eligible for an Occupational Rehabilitation Benefit. If We agree in advance on a program of occupational rehabilitation, We will pay for the program as set forth in a signed written agreement. The program of occupational rehabilitation must be a formal plan that will help You to return to Gainful Employment in Your Occupation. The program must be directed by an organization or individual licensed or accredited to provide occupational rehabilitation or education to persons who are disabled.

OPTIONAL BENEFITS – Coverage will be provided for the following benefits only if an additional premium for the benefit is shown in the Schedule Page.

Future Increase Option Rider – This rider provides for the purchase of additional amounts of Disability Buy-Out insurance without evidence of medical insurability. Subject to the Conditions and Limitations provision of the rider, the Policyowner may exercise an Increase Option up to the Option Amount during an Option Period. The Option Amount means the additional Maximum Aggregate Benefit that may be applied for on each Option Date. The Option Amount is shown in the Schedule Page.

If the Policyowner does not exercise an Increase Option on an Option Date, the Policyowner may apply for up to twice the Option Amount on the next Option Date.

Each Option Amount applied for during an Option Period will be underwritten based on Our underwriting rules, including issue limits, then in use, or those in effect on the Effective Date of the Policy, whichever are more favorable to the Policyowner, to determine the total amount of allowable Maximum Aggregate Benefit, if any, available to the Policyowner.

An Increase Option may not be exercised when You are disabled, receiving disability benefits or eligible to receive disability benefits from any source.

These benefits are subject to a maximum option amount and certain other limitations listed in the rider.

4. EXCLUSIONS AND LIMITATIONS OF THE POLICY – There will be no benefits for any Total Disability:

- caused by, contributed to, or which results from armed forces training, or act of war, whether declared or undeclared, while You are serving in the armed forces or units auxiliary thereto;

- caused by, contributed to, or which results from Your commission of, or attempt to commit, a felony or Your participation in a riot or insurrection;
- caused by, contributed to, or which results from Your being engaged in an illegal occupation;
- caused by, contributed to, or which results from the suspension, revocation or surrender of Your professional or occupational license or certification;
- caused by, contributed to, or which results from an intentionally self-inflicted Injury; or
- due to any loss We have excluded by name or specific description and is attached to and made a part of the Policy.

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

5. RENEWABILITY OF THE POLICY – The Policy is renewable by timely payment of premiums until the earliest of the following events or occurrences at which time the Policy will terminate:

    1. The Policyowner, if an individual, no longer has an Ownership Interest in the Business;

    2. You no longer have an Ownership Interest in the Business;

    3. You are no longer Gainfully Employed Full Time by the Business for any reason other than Total Disability;

    4. You have actual and/or Constructive Ownership of more than 90% of the Business;

    5. You have an actual Ownership Interest of less than 5% of the Business;

    6. The Maximum Aggregate Benefit has been paid; or

    7. The first Policy Anniversary after Your 65th birthday.

This is a non-participating policy.

THIS OUTLINE OF COVERAGE IS ONLY A SUMMARY OF THE COVERAGE PROVIDED. THE POLICY ITSELF SHOULD BE CONSULTED TO DETERMINE GOVERNING CONTRACTUAL PROVISIONS AND AMOUNTS.

GUARDIAN®

☐ **BERKSHIRE LIFE INSURANCE COMPANY OF AMERICA**
Home Office: 700 South Street, Pittsfield, MA 01201
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Administrative Office: 700 South Street, Pittsfield, MA 01201
(Please check appropriate company(ies). Any insurer checked above is herein referred to as the "Company.")

# Catastrophic Disability Benefit Rider Supplement to Application

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

Name of Proposed Insured: _____ Date of Birth: _____

| | Yes | No |
|---|---|---|
| 1. Have you ever had an injury or sickness which caused a loss of: sight in both eyes, hearing in both ears, speech, or the use of two arms or two legs? | ☐ | ☐ |
| 2. Do you need human assistance of any kind to perform every day activities such as bathing, continence, dressing, eating, using the toilet or transferring (for example, from the chair to your bed)? | ☐ | ☐ |
| 3. Do you use any special medical equipment or appliances such as a wheelchair, pacemaker, oxygen tank, cane, catheter, or artificial limb? | ☐ | ☐ |
| 4. Have you ever received treatment, attention or advice for memory loss or confusion, Alzheimer's disease, stroke, senility, dementia, loss of speech or comprehension of spoken language? | ☐ | ☐ |

Please provide details below for any "Yes" answers to Questions 1 – 4:

Remarks: _____

_____

_____

**Any person who knowingly, and with intent to defraud any insurance company or other person, files an application of insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.**

I declare that my statements and answers are correctly recorded, complete and true to the best of my knowledge and belief. I am aware that these statements and answers will become part of my application to the Company.

_____ _____
Date Signed Signature of Proposed Insured

_____
Witness