



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

APPLICATION FOR INDIVIDUAL DISABILITY INSURANCE: PART I

SECTION 1: PROPOSED INSURED INFORMATION

A. First Name Middle Initial Last Name Suffix

Previous Last Name (if applicable)

B. Gender: ☐ Male ☐ Female

C. Social Security Number:

D. 1. Residence Address:

Street

City

State

Zip Code

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

Street

City

State

Zip Code

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

F. State, Country of Birth:

G. Phone:

H. Email Address:



SECTION 1: PROPOSED INSURED INFORMATION (CONTINUED)

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

If No, please answer the following:

2. Visa Type:

3. Visa Duration:

4. Do you plan to reside in another country besides the U.S. in the next 2 years? ☐ Yes ☐ No

If Yes, include details:

5. When do you expect to obtain U.S. citizenship or permanent residency (green card)?

SECTION 2: BUSINESS INFORMATION

A. 1. Current Employer:

2. Number of years with current employer:

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

B. Business Address:

Street

City

State

Zip Code

C. Business Website:

D. Nature of Business or Industry:

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

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

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

SECTION 3: OCCUPATIONAL INFORMATION

A. Occupation:

B. Number of years working in this occupation:

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

D. 1. Job Title:

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

2. Medical Board Specialty Certification:

3. Medical Board Subspecialty Certification:

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

F. 1. Are you any of the following?

☐ Student ☐ Resident ☐ Fellow ☐ None

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

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

Description of Specific Duties	% of Time Devoted to Each Duty

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

If yes, please provide details:

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

If yes, please provide details:

SECTION 3: OCCUPATIONAL INFORMATION (CONTINUED)

I. Are you presently employed, and have you been continuously at work full-time (at least 30 hours per week) performing the usual duties of your occupation for the past 180 days?..... ☐ Yes ☐ No

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

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

If yes, how many?

K. Employment Status? ☐ Employee (no ownership)

☐ Sole Proprietor or 1099 Employee

☐ Partner % of ownership

☐ S-Corp Shareholder % of ownership

☐ C-Corp Shareholder % of ownership

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

If yes, provide details:

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

If yes, provide details:

SECTION 4: OTHER INSURANCE COVERAGE

- A. Within the past five years, have you had any application for insurance declined, postponed, modified, rated, cancelled, rescinded, or have you withdrawn a pending application, or had a renewal or reinstatement request refused?..... ☐ Yes ☐ No

If yes, provide details in Remarks & Special Requests Section 9

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

2. If yes, what company?

- C. Do you have any disability insurance in force or applied for, or for which you are eligible within the next 12 months with any company, including Guardian or Berkshire Life Insurance Company of America ("Berkshire")?.... ☐ Yes ☐ No
If yes, list all coverages in the chart below.

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

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

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

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

SECTION 5: PERSONAL FINANCIAL INFORMATION

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

A. Earned Income

1. Year-to-Date This Calendar Year: \$
2. Actually Filed with the IRS Last Calendar Year: \$
3. Actually Filed with the IRS Two Calendar Years Ago: \$

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

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

☐ Yes ☐ No ☐ Not Applicable

If yes, complete question (D).

D. Total Annual Retirement Contributions:

Personal Contributions

1. Year-To-Date This Calendar Year: \$
2. Last Calendar Year: \$
3. Two Calendar Years Ago: \$

Employer Contributions

4. Year-To-Date This Calendar Year: \$
5. Last Calendar Year: \$
6. Two Calendar Years Ago: \$

SECTION 6: ADDITIONAL INFORMATION

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

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

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

B. Within the next 2 years, do you plan to reside or travel outside of the U.S.? ☐ Yes ☐ No

C. Within the past 5 years, have you ever: pled guilty to, pled no contest to, or been convicted of reckless driving, driving while impaired or intoxicated, or any other moving violation; had your license suspended or revoked; or been involved in any accident in which you were found to be at fault? ☐ Yes ☐ No

D. In the past 10 years, have you ever pled guilty to, pled no contest to, or been convicted of any felony or misdemeanor? ☐ Yes ☐ No

E. Do any of the following apply? 1) Your professional or occupational license or certification has ever been suspended, revoked, restricted, inactivated, surrendered, or the like; 2) There is a pending investigation or complaint concerning you with a regulatory, governmental, or other entity that oversees your profession; 3) You have ever been disbarred; or 4) You have ever been fined or sanctioned by an entity that oversees your profession. ☐ Yes ☐ No

F. Have you participated within the last 3 years, or do you intend within the next 2 years to engage in any of the following activities: contact martial arts; mountain or rock climbing; motor sports events or racing (auto, truck, cycle, boat, etc.); scuba diving; skydiving; hang gliding; parachuting; and/or paragliding? ☐ Yes ☐ No
(If yes, complete the Avocation Supplement.)

SECTION 6: ADDITIONAL INFORMATION (CONTINUED)

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

G. Have you used any tobacco or nicotine products and/or nicotine delivery systems in the last 12 months? ☐ Yes ☐ No

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

H. Are you currently a member of the US armed forces or National Guard, have you received military orders to appear for service, been placed on alert, or have you entered into a written agreement to become a member of the military? ☐ Yes ☐ No

SECTION 7: PREMIUM INFORMATION

A. What percentage of the premium for the coverage you are applying for will be paid by your employer?

☐ None ☐ 100% ☐ Other %

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

C. If any part of the premium is paid by you, is it paid with: ☐ Pre-Tax dollars ☐ After-Tax dollars

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

E. Billing Type: ☐ Paper Bill

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

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

☐ Group Bill: ☐ Existing Group #

☐ New – Billing Name: Common Billing Day

F. Send premium notices to:

☐ Residence

☐ Owner's Address

☐ Business

☐ Other

G. Prepayment of Premium – *A prepayment must be accompanied by a signed Conditional Receipt.*

☐ No money has been submitted with this application.

☐ \$ has been submitted with this application.

SECTION 8: COVERAGE APPLIED FOR

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

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

SECTION 9: REMARKS & SPECIAL REQUESTS

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

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

SECTION 11: REPRESENTATIONS OF THE PROPOSED INSURED AND OWNER

Those parties who sign below, agree that:

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

Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

Signed at City, State

Today’s Date (mm/dd/yyyy)

Signature of Proposed Insured

Signature of Applicant/Owner if Other than Proposed Insured

Witness Signature

not required



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

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, 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 or 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
7. Within the past 10 years, have you tested positive, been diagnosed by or received treatment from a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or Human Immunodeficiency Virus (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

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

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 illicit drug or controlled substance except as prescribed by a member of the medical profession? *If "Yes," complete the Alcohol and Drug Usage Supplement.*

☐ Yes ☐ No

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

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

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 by a member of the medical profession 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, 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.

Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

Signed at _____
City and State Month/Day/Year

Signature of Witness Signature of Proposed Insured



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

Authorization to Obtain and Release Information

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

Name of Proposed Insured _____
Date of Birth (mm/dd/yyyy) _____

**This Authorization Is Designed to Comply with The Health Insurance Portability Act of 1996
as amended (HIPAA) Privacy Rule**

This Authorization applies to the Proposed Insured named above. It can only be signed by the Proposed Insured, or the parent or legal guardian of the Proposed Insured in the case of a minor under the age of 18.

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

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

Investigative consumer 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 my entire medical record without restriction. I understand that the information released could contain reference to or results of Human Immunodeficiency Virus (HIV) or Antibody (Acquired Immune Deficiency Syndrome (AIDS)) or genetic testing, genetic information and may relate to the symptoms, evaluation, diagnosis, examination, treatment or prognosis of any mental or physical condition, including psychiatric, and psychological conditions, and drug or alcohol abuse.

I agree that this Authorization shall be valid for twenty-four (24) months from the date shown below. However, this time limit may be shorter if the time period permitted by applicable law in the state where the policy is delivered or issued for delivery is less. I agree that a copy of this Authorization shall be as valid as the original. I agree that if I sign this Authorization electronically, including via voice authorization, that it will be equally as effective and valid as if I signed the form through traditional means. I understand, however, that I am under no obligation to sign this document electronically.

I know that I may revoke this Authorization in writing, at any time, by sending a written request for revocation to the Chief Underwriter at the address above. I understand that a revocation is not effective to the extent that the Company and/or any of the entities listed above has already relied on this Authorization, or to the extent that the Company has a legal right to contest a claim under an insurance policy or to contest the policy itself.



I understand that the Company or its legal representatives will use the information obtained by this Authorization in connection with underwriting my application for insurance, to determine eligibility for insurance, to determine the premium for the insurance, to obtain reinsurance, to service any insurance issued, to administer coverage, to evaluate any claim for insurance benefits, to determine eligibility for benefits under an existing policy, and to conduct any other legally permissible activities that relate to any existing coverage, coverage that I have applied for, or may in the future apply for with the Company. In addition to the above, the Company or its legal representative may use the information to perform actuarial or research studies, analytics, review internal processes or experience, 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 release any information obtained using this Authorization to any person or organization except to reinsurance companies, MIB, Inc., Innovative Underwriters Services (a subsidiary of The Guardian Life Insurance Company of America), or other persons, agencies, companies or organizations performing business or legal services in connection with an application, claim, to perform actuarial or research studies perform analytics, or in evaluating our internal processes or experience or as may be lawfully permitted or required, or as I may further authorize. I understand that any information disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal regulations governing privacy (such as the HIPAA Privacy Rule). If I am applying for insurance and/or have existing coverage with the Company, information collected to determine eligibility for insurance and/or for benefits under an existing policy will be shared by the Company. I further understand that any policy issued will be delivered to the policy owner, which may be a party other than the Proposed Insured, and that this Authorization may become part of any policy issued.

I authorize the Company or its legal representatives to make a brief report of my personal health information to the MIB, Inc.

I acknowledge that I have been given a copy of this Authorization and also acknowledge receipt of the Notice of Insurance Information Practices, which includes the Fair Credit Reporting Act Pre-Notice, the MIB Pre-Notice, and Medical Records. I also acknowledge that I or an individual authorized to act on my behalf is entitled to receive an additional copy of this authorization. Any alteration of this Authorization will not be accepted.

Signed at _____
City and State _____ Month/Day/Year _____

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

not required

Witness Signature

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

P.O. Box 26100

Lehigh Valley, PA 18002-6100

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. The Company or its legal representative may also use the information to perform actuarial or research studies, analytics, review internal processes or experience, and/or conduct a legally permissible contestability review.

This notice is given to you at the time you apply for insurance to tell you about the kinds of information we may obtain in connection with your application. Only qualified members of our Company's staff or its legal representatives will have access to your medical file to determine your eligibility for insurance or to service your claim for benefits under a policy. Your authorization will govern our requests for information and any later disclosure of that information. However, the information collected by the Company may in certain circumstances be disclosed to third parties without your specific authorization as permitted or required by law. We will treat all personal information about you as confidential. You have a right of access and correction with respect to this information. If you wish a more detailed explanation of our Information Practices, please send your written request to the Privacy Office of the Guardian Corporate Family at 10 Hudson Yards, New York, NY 10001.

Fair Credit Reporting Act Pre-Notice

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

MIB Pre-Notice

MIB, Inc. is a not-for-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB Member company for life or disability insurance, or if a claim for benefits is submitted to such company, MIB, Inc., upon request, will supply such company with the information in its files. Our Company, its legal representatives, or its reinsurers may make a brief report of objective findings about you to MIB, Inc.

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

Personal Information Telephone Interview

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

This notification must be given to the Proposed Insured.



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

Authorization for Disclosure of Protected Health Information

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

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

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

In order to allow my insurance representative to communicate with the Company (Company referred to herein includes The Guardian Life Insurance Company of America and/or The Guardian Insurance & Annuity Company, Inc., and/or Berkshire Life Insurance Company of America) and me about any medical, psychological or psychiatric or other health care information concerning my application for insurance coverage, reinstatement, or other insurance transaction, I authorize the Company to disclose the specific reasons for the underwriting decision to my insurance representative and/or to their delegate. I understand that the Company will not condition eligibility for coverage, underwriting or risk rating determination, or payment of benefits on any provision of this authorization. **I understand that this disclosure may involve specific, protected health information regarding me. I also understand that authorizing this disclosure is optional and I am not required to sign this Authorization.**

REVOCATION OF AUTHORIZATION

I know that I may revoke this Authorization in writing, at any time, by sending a written request for revocation to the Chief Underwriter at the address above. I understand that a revocation is not effective to the extent that the Company and/or any of the entities listed above has already relied on this Authorization, or to the extent that the Company has a legal right to contest a claim under an insurance policy or to contest the policy itself.

EXPIRATION OF AUTHORIZATION

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

I agree that a copy of this Authorization shall be as valid as the original. I agree that if I sign this Authorization electronically, including via voice authorization, that it will be equally as effective and valid as if I signed the form through traditional means. I understand, however, that I am under no obligation to sign this document electronically.

Proposed Insured's Name (Please Print)

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

Date



Agreement to Conduct Business Electronically

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

1. Definitions

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

2. Consumer Consent

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

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

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

3. Withdrawal of Consent to Use Electronic Records

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

4. Procedure to Update Information Required to Contact You Electronically

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

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

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

6. Hardware and Software Requirements

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

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

Desktop Browsers, Minimum Version

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

Mobile and Tablet Browsers/Operating Systems, Minimum Version

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

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

7. Legal Effect

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

8. General

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

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

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

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

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

9. Acceptance

By agreeing, you agree and affirm:

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

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

Signature

Date

How to Submit Your Application

Unsigned applications are welcome.

Feel free to omit your SSN. Most applications need to be revised anyway.

Fax

[\(206\) 899 1356](tel:(206)8991356)

Upload

<https://disabilityunderwriters.com/upload>

DocuSign

If you are viewing this within DocuSign, just complete the session.

Email

rip@ripcurtis.com

Do not use ordinary email. Use a secure message portal or Outlook native encryption. If you don't know how, please ask.



Rip W. Curtis
Disability Underwriters
1420 5th Avenue, Suite 2200 Seattle, WA 98101
[\(206\) 652 2266](tel:(206)6522266)

State insurance license numbers

Alabama 693034
Alaska 0109096
Arkansas 670169
Arizona 1034318
California 0B73499
Colorado 351718
Connecticut 2625242
Delaware 3000471370
District of Columbia
3000085210
Florida W004391
Georgia 3009530
Hawaii 486346
Idaho 292989
Illinois 670169
Indiana 3411220
Iowa 670169
Kansas 670169

Kentucky 1026779
Louisiana 727692
Maine PRN325152
Maryland 3000002183
Massachusetts 1932470
Montana 3000276492
Michigan 0721730
Minnesota 40519161
Mississippi 10594113
Missouri 8345962
Nebraska 0670169
Nevada 3157202
New Hampshire 670169
New Jersey 1576772
New Mexico 670169
New York 1484281
North Carolina 0670169
North Dakota 670169

Ohio 769705
Oklahoma 3000471388
Oregon 670169
Pennsylvania 847459
Rhode Is. 3000471373
South Carolina 670169
South Dakota 40507150
Tennessee 2047645
Texas 1726888
Utah 483697
Vermont 3411471
Virginia 895401
Washington 118074
West Virginia 670169
Wisconsin 2635185
Wyoming 391239