



- 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.")*

Application for Disability Insurance Option Exercises Instructions / Checklist

THIS APPLICATION PACKAGE INCLUDES:

- | | | |
|--|--|--|
| Notice of Insurance Information Practices | Give the notice of Insurance Information Practices to the applicant. | <input type="checkbox"/> |
| Application for Option Exercises – pages 1-7

<i>Reference the annotated application for assistance with completing the Option Exercise.</i> | Complete Sections 1-5 with the applicant. | <input type="checkbox"/> |
| | Complete Section 6 only if the applicant is applying for additional benefits. | <input type="checkbox"/> |
| | Do you have the correct state form (where the applicant lives/ works or where the original application was taken)? | <input type="checkbox"/> |
| Representations of Proposed Insured

<i>Signature of the proposed insured on this form confirms their agreement that the application is complete, correctly recorded and true to the best of their knowledge.</i> | Obtain all appropriate signatures and submit with the application.

<i>Must be included with every case submitted.</i> | <input type="checkbox"/> |
| Supplements to the Option Exercise

<i>At least one supplemental form must be included with every case submitted.</i> | Submit correct state form (to correspond with application submitted).

Do you have the correct supplement(s) <u>fully completed</u> for the type(s) of option(s) the applicant is exercising?
– Individual Disability Insurance (IDI) – 2 pages
– Retirement Protection Plus (RPP) Program – 1 page
– Overhead Expense (OE) – 2 pages
– Disability Buy-Out (DBO) – 2 pages | <input type="checkbox"/> |
| Producer's Certification | Complete page 1 and 2 in all cases and submit with the application.

Producer must be licensed and appointed where application was signed.

If part of an association, include the endorsing agent. | <input type="checkbox"/>
<input type="checkbox"/>
<input type="checkbox"/> |
| Financial Requirements | Include the most current financial documentation (i.e., 1040, Schedules, W-2, Paystubs, Employment Contract or YTD Profit and Loss). | <input type="checkbox"/> |
| Authorization to Obtain/Release Information

<i>Form C-AUTH-2003 authorizes the Company to obtain medical and other information about the proposed insured.</i>

<i>Form NON-MED-AUTH-7-2009 can be used for option exercises where no additional benefits are requested.</i> | Obtain all appropriate signatures and submit with the application.

Submit this form on applications requiring medical underwriting (i.e., adding a benefit, CAT).

Submit this form on applications not requiring medical underwriting (i.e., FIOs with no additional benefits requested). | <input type="checkbox"/>
<input type="checkbox"/> |
| Option Exercise Transmittal | Complete the transmittal in full and submit with the application. | <input type="checkbox"/> |



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Application for Disability Insurance Option Exercises

Please indicate all insurance applied for with this application and include the appropriate application supplement for each product selected.

- Individual Disability Insurance
- Overhead Expense Insurance
- Disability Buy-Out Insurance
- Future Increase Option / Future Purchase Option
- Retirement Protection Plus Program
- Group Disability Replacement Option

Original Policy Number(s) _____

I. Proposed Insured Information

a. Proposed Insured

First	Middle Initial	Last Name

Suffix	Previous Last Name	

b. Social Security Number

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

d. Current Billing Address

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

City	State	ZIP

e. Telephone Number

Home Phone Number	Cell Phone Number

f. e-Mail Address

2. Occupational Information

a. Occupation(s)

b. Give exact duties

c. Name of Current Employer

Business Address

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

City	State	ZIP

Business Phone

Business Website

Application for Disability Insurance Option Exercises | *Continued*

d. Nature of Business(es) _____

What percentage of the business do you own?

_____ %

e. Are you actively at work on a full-time basis in the occupation(s) listed above?

Yes No

f. Are you currently disabled and/or collecting disability benefits?

Yes No

3. 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

IND = Individual

G = Group

A = Association

Status

I = In Force

AP = Applied For, or Date of Eligibility

Company Name:			
Type of Insurance:			
Category:			
Status:			
Date insurance applied for, issued, or eligible for (if known):			
Policy Number (if known):			
Benefit Amount:	\$	\$	\$
Benefit Period:			
Social Insurance Benefit:	\$	\$	\$
Automatic Increase Option:		%	%
Future Increase Option (amount remaining):	\$	\$	\$
Catastrophic Benefit:	\$	\$	\$
Retirement Benefit:	\$	\$	\$
Does employer pay premium and not include it as taxable income to you?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
If group coverage, is it convertible?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Application for Disability Insurance Option Exercises | *Continued*

b. Replacement

Is the insurance being applied for replacing this coverage?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, amount to be replaced?	\$	\$	\$
Anticipated Date:			

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 or new coverage that is issued and will not at any time reinstate this coverage. If the coverage is not terminated, the Company reserves all rights outlined in any policy or new coverage that is issued. Further, if the coverage is not terminated, benefits under any policy or new coverage that is issued based upon this application may be reduced by the amount payable under such existing policies.

- c. Is additional group disability coverage available through your employer? Yes No
 If yes, do you have the option to participate in the future? Yes No
 (If yes, give details in Remarks and Special Requests.)

4. 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 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.

	Annualized Year-To-Date	Actual Filed Last Calendar Year	Actual Filed Two Calendar Years Ago
1. Non-owner employee salary, wages and bonus from Form W-2	\$	\$	\$
2. Business owner salary, wages, and bonus from Form W-2	\$	\$	\$
3. Sole Proprietor net income (after business expenses) from Form 1040, Schedule C	\$	\$	\$
4. Share of Partnership or Sub-Chapter "S" corporation income (after business expenses) shown on Form 1040 or 1120 "S", Schedule K-1	\$	\$	\$
5. 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, 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

If yes, indicate the unearned income amounts.	\$	\$	\$
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Sources: _____

Application for Disability Insurance Option Exercises | Continued**c. Retirement Contributions**

1. Do you participate in a qualified retirement plan? Yes No
2. If yes, what type? 401(k)/403(b) SIMPLE Defined Benefit IRA Profit Sharing
 Other: _____

3. i. Your Annual Contribution	\$	\$	\$
ii. Your Employer's Match, if any	\$	\$	\$
iii. Additional Employer Contributions	\$	\$	\$
iv. Total Contributions (add lines i – iii)	\$	\$	\$

4. 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, describe the net worth in detail below. Net worth is asset value less any outstanding debt or mortgage on the asset.

Cash, Savings, Stocks, Bonds

\$

Fair Market Value of your business
(excluding goodwill)

\$

Personal Property

\$

Real Estate

\$

Other

\$

Explain:

e. Bankruptcy

Have you ever filed bankruptcy?

Yes No Personal Business

If yes, answer the following questions:

(a) Date bankruptcy filed?

(b) Date bankruptcy discharged?

5. 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. Premium to Be Paid By:

Proposed Insured Employer/Corporation

If both, list percentage of split:

%

%

Proposed Insured

Employer/Corporation

Other:

Application for Disability Insurance Option Exercises | Continued

- 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 by Pre-tax 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 Conditions of Coverage shall apply if conditions are met.*
- g. Is the policy being applied for through an association of which you are a member? Yes No
- Association Name _____

6. Complete This Section When Requesting an Additional Benefit

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

- a. Do you intend to reside or travel outside of the U.S.? Yes No
(If yes, indicate location, frequency, for work or pleasure, date of departure, length of stay.)
- b. Other than as described in Section 2, do you have any other part- or full-time jobs, occupations or employment? Yes No
- c. Do you intend to change any occupation or employment within the next six months? Yes No
- d. Within the last three years, have you participated in any of the following, or do you intend 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
- e. 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
- f. 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
- g. 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
- h. 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
- i. 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

Application for Disability Insurance Option Exercises | Continued

j. 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

k. Within the last three years, have you received, sought or had any medical advice, counseling or treatment for any medical, surgical or psychiatric condition? Yes No

l. Name of your personal physician _____

If none, check here

Address of personal physician _____

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

*Personal physician's
telephone number* _____

City _____

State _____

ZIP _____

m. Date and reason last consulted? _____

If questions 6j or 6k are left blank or are answered "Yes," no prepayment should be taken and no Conditions of Coverage issued.

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

n. 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

o. 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

p. 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

q. 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 6n through 6q is answered "Yes," no prepayment should be taken and no Conditions of Coverage issued.

7. 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, 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.

8. Amendments or Corrections (For Home Office or Customer Service Office Use Only)



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Representations of the Proposed Insured and Owner

Those parties who sign below, agree that:

1. This application, any required Representations to the Medical Examiner, and any other supplements or amendments to the application will form the basis for, and become part of and attached to, any policy or new coverage issued.
2. All of the statements that are part of the application and any other supplements to the application are correctly recorded, and are complete and true to the best of the knowledge and belief of those persons who made them.
3. No agent, broker or medical examiner has any right to accept risks, make or change contracts, or to waive or modify any of the Company's rights or requirements.
4. Any misrepresentation or omission, if found to be material, may adversely affect acceptance of the risk, claims payment or may lead to rescission of any policy or new coverage that is issued based on this application.
5. All coverage shown to be discontinued in answer to Question 3b 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 or new coverage issued. Further, benefits under any policy or new coverage issued based on this application may be reduced by the amount payable under such existing policies.
6. Insurance in the amount of the Option resulting from the exercise of the Future Increase Option, Future Purchase Option, or Group Disability Replacement Option shall take effect in accordance with the agreement or provision providing the Option, as long as the policy or new coverage is delivered, the required premium is paid, and there has been no change in the income level, status of employment, or occupation of the Proposed Insured.

Insurance in excess of the Option, if any, and additional benefits desired, if any, shall not take effect until (1) insurance in the amount of the Option takes effect, and (2) a policy including (in addition to insurance in the amount of Option) such excess insurance and/or additional benefits is delivered to the Owner while the health and other conditions affecting insurability of the Proposed Insured remains as described in the application or in any evidence of insurability furnished with this application, and (3) the required premium has been paid.

The word "Option" refers to the Options to Purchase Additional Insurance provided in an agreement or provision attached to the policy indicated. By exercising the Option, the owner hereby elects, pursuant to said agreement or provision, to purchase such additional insurance for the Option amount indicated and on the Option date indicated.
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. In those states where written consent is required by statute or State Insurance Department regulation for amendments as to plan, amount, classification, age at issue, or benefits, such changes 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. I, the proposed insured, acknowledge receipt of the Notice of Insurance Information Practices, the Fair Credit Reporting Act Pre-Notice, the Medical Information Bureau Pre-Notice and Medical Records.

Any person who knowingly, and with intent to defraud any insurance company or other person, files an application of insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and may also be subject to civil penalties.

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



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
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Insurance Information Practices

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

Notice to _____

Proposed Insured

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

Fair Credit Reporting Act Pre-Notice

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

Medical Information Bureau Pre-Notice

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

If you so request of the Bureau, it will arrange to disclose the information it may have in your file. If you question the accuracy of the information in the Bureau's file, you may contact the Bureau and seek to correct the information according to procedures set forth in the Federal Fair Credit Reporting Act. The Bureau's address is 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734, and its telephone number is 866-692-6901 (TTY 866-346-3642 for hearing impaired). Information for consumers about MIB may be obtained on its website at www.mib.com.

Medical Records

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

Personal Information Telephone Interview

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



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Pittsfield, MA 01201

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- 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 could contain reference to or results of HIV Antibody (AIDS) testing, and may relate to the symptoms, evaluation, diagnosis, examination, treatment or prognosis of any mental or physical condition, including psychiatric conditions (but excluding psychotherapy notes), and drug or alcohol abuse.

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



BERKSHIRE LIFE INSURANCE COMPANY OF AMERICA
700 South Street
Pittsfield, MA 01201

GUARDIAN®

Authorization to Obtain and Release Non-Medical Information

Name of Proposed Insured _____ Date of Birth _____

Address of Proposed Insured _____

I authorize any insurance or reinsurance company, employer, or other organization, institution or person that has any records or knowledge of me to release any and all non-medical information in its possession about me, to Berkshire Life Insurance Company of America ("Company") or its legal representatives. I authorize the Company to obtain information on disability coverage in force or applied for from the Disability Income Reporting System through the Medical Information Bureau.

I understand that the Company or its legal representatives will use the information obtained by this authorization to determine eligibility for insurance. I further understand that if I refuse to sign this authorization, the Company may not be able to process my application. 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, or other persons or organizations performing business or legal services in connection with an application, or as may be lawfully required, or as I may further authorize.

I know that I may revoke this authorization in writing, at any time, by sending a written request for revocation to 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 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.

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

Signature of 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
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1. How well do you know the proposed insured?

Known well for _____ years Known slightly for _____ years
 Met very recently Relative? _____

2. **Complete if applying for an Employer-Sponsored Plan (QSPP, VIP):** If this application is submitted through an Employer-Sponsored Plan, please complete the following:

New Existing Plan # _____

3. **Complete if applying through an Association Program:** If this application is submitted through an active Association Program, please complete the following:

New Existing Plan # _____

4. 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

5. 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

6. Remarks (and additional instructions)

Producer's Certification | Continued

7. Commissions

Producer's Name	Producer's Code	Servicing Producer (Check Only One)	Percentage	Manager/ GA Code
		<input type="checkbox"/>	%	
		<input type="checkbox"/>	%	
		<input type="checkbox"/>	%	
		<input type="checkbox"/>	%	
		<input type="checkbox"/>	%	
		<input type="checkbox"/>	%	

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 may also be subject to civil penalties.

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

Type or Print Producer's Name

Signature of Soliciting Producer

Social Security Number 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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Conditions of Coverage

I, _____, the Proposed Insured, have applied for disability insurance coverage with the Company and have submitted \$_____ to the Company. The minimum amount of premium which may accompany an application is a monthly premium amount. It is understood and agreed that no liability is created or assumed by the Company, except for the refund of any premium amount submitted, unless and until a disability insurance policy or new coverage becomes effective.

The insurance applied for will become effective and in force only if:

1. This application is approved by the Company; and
2. A modified policy or new coverage is delivered; and
3. Any amendment of the application or Special Exceptions Agreement to adjust the provisions of a policy is signed by the Proposed Insured and the Owner, where applicable; and
4. A policy or new coverage is issued during the lifetime of the Proposed Insured; and
5. The initial premium payment has been paid; and
6. The income level, status of employment, and occupation of the Proposed Insured remains insurable under the Company's underwriting standards; and
7. If applying for insurance in excess of the Option, if new coverage is applied for, and/or if applying to reinstate coverage, the health status of the Proposed Insured remains the same as described in the Application and any Representations to the Medical Examiner.

Requests for a specific effective date are honored at the Company's discretion in accordance with its published guidelines on policy dating upon the conclusion of the underwriting review.

Should the Proposed Insured be determined uninsurable based on the Company's underwriting standards, or if the Company is unable to obtain required underwriting information within 60 days, the amount submitted will be returned to the Proposed Insured. Should the amount submitted not be honored by the Proposed Insured's bank, the Company will discontinue consideration of the application.

No agent or broker has the authority to waive or alter any of the terms or conditions of the application for insurance or these Conditions of Coverage.

The premium check must be made payable to the Company (do not make check payable to the producer or leave payee blank).

I have read and understand the Conditions of Coverage.

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

Applicant's Signature

Licensed Producer's Signature

Date

One Copy to Applicant

One Copy to Company



- 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 and an administrator for 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.")

Conditions of Coverage

I, _____, the Proposed Insured, have applied for disability insurance coverage with the Company and have submitted \$_____ to the Company. The minimum amount of premium which may accompany an application is a monthly premium amount. It is understood and agreed that no liability is created or assumed by the Company, except for the refund of any premium amount submitted, unless and until a disability insurance policy or new coverage becomes effective.

The insurance applied for will become effective and in force only if:

1. This application is approved by the Company; and
2. A modified policy or new coverage is delivered; and
3. Any amendment of the application or Special Exceptions Agreement to adjust the provisions of a policy is signed by the Proposed Insured and the Owner, where applicable; and
4. A policy or new coverage is issued during the lifetime of the Proposed Insured; and
5. The initial premium payment has been paid; and
6. The income level, status of employment, and occupation of the Proposed Insured remains insurable under the Company's underwriting standards; and
7. If applying for insurance in excess of the Option, if new coverage is applied for, and/or if applying to reinstate coverage, the health status of the Proposed Insured remains the same as described in the Application and any Representations to the Medical Examiner.

Requests for a specific effective date are honored at the Company's discretion in accordance with its published guidelines on policy dating upon the conclusion of the underwriting review.

Should the Proposed Insured be determined uninsurable based on the Company's underwriting standards, or if the Company is unable to obtain required underwriting information within 60 days, the amount submitted will be returned to the Proposed Insured. Should the amount submitted not be honored by the Proposed Insured's bank, the Company will discontinue consideration of the application.

No agent or broker has the authority to waive or alter any of the terms or conditions of the application for insurance or these Conditions of Coverage.

The premium check must be made payable to the Company (do not make check payable to the producer or leave payee blank).

I have read and understand the Conditions of Coverage.

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

Applicant's Signature

Licensed Producer's Signature

Date

One Copy to Applicant

One Copy to Company



- 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.")

Application for Disability Insurance Option Exercises – Individual Disability Insurance Supplement

I. 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. Special Option or Group Disability Replacement Option Details

You are no longer eligible to participate in your employer's group long term disability plan

Date

The group long term disability plan under which you were covered ends and has not been converted or replaced

Date

Company declared Special Option

Name/Description

4. Individual Disability Insurance

a. Basic Plan / Policy Form No.

b. Monthly Indemnity

\$ _____

c. Social Insurance Substitute Benefit

\$ _____

d. Total Amount to be Exercised

\$ _____

e. Supplemental Benefits

1. **Continuation of Benefits** – If your original policy has any of the following benefits, select those you want to continue on the new policy:

Name of Benefit

Four-Year Delayed Cost of Living Adjustment

Yes No _____

Cost of Living Adjustment

Yes No % _____

Two-Year Residual Disability

Yes No _____

**Application for Disability Insurance Option Exercises –
Individual Disability Insurance Supplement | Continued**

<i>Residual Disability</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
<i>Lifetime Indemnity / Benefit Period / Graded Lifetime Indemnity for Total Disability</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
<i>Partial Disability</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
<i>Unemployment Waiver of Premium</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
<i>Other:</i> _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____

2. **Addition of Benefits** – Do you want to add any of the following benefits to your new policy:
Adding a benefit to the new policy will require underwriting. Complete Section 6 and the Authorization to Obtain and Release Information.

Name of Benefit

<i>Four-Year Delayed Cost of Living Adjustment</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
<i>Cost of Living Adjustment</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____ %
<i>Catastrophic Disability</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____ \$
<i>Residual Disability</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
<i>Graded Lifetime Indemnity for Total Disability</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
<i>Retirement Protection Plus</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____ \$
<i>Elimination Period</i>	<input type="checkbox"/> 180 days <input type="checkbox"/> 360 days	_____
<i>Benefit Period</i>	To Age 65	_____
<i>Partial Disability</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
<i>Other:</i> _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____



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 and an administrator for The Guardian Life Insurance Company of America, New York, NY

Application for Disability Insurance Option Exercises – Retirement Protection Plus Program Individual Disability Insurance Supplement

I. 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. Special Option Details

You are no longer eligible to participate in your employer’s group long term disability plan

Date

The group long term disability plan under which you were covered ends and has not been converted or replaced

Date

Company declared Special Option

Name/Description

4. Retirement Protection Plus Program

a. Basic Plan / Policy Form No.

Monthly Indemnity to be Exercised \$

Elimination Period

180 days 360 days

Benefit Period

To Age 65

Application for Disability Option Exercises – Retirement Protection Plus Program
Individual Disability Insurance Supplement | *Continued*

b. Supplemental Benefits

1. **Continuation of Benefits** – If your original policy has any of the following benefits, select those you want to continue on the new policy:

Name of Benefit

3% Compound Cost of Living Adjustment

Yes No

6% Maximum Cost of Living Adjustment

Yes No

Other: _____

Yes No

2. **Addition of Benefits** – Do you want to add any of the following benefits to your new policy: Adding a benefit to the new policy will require underwriting. Complete Section 6 and the Authorization to Obtain and Release Information.

Name of Benefit

3% Compound Cost of Living Adjustment

Yes No

6% Maximum Cost of Living Adjustment

Yes No

Other: _____

Yes No



- BERKSHIRE LIFE INSURANCE COMPANY OF AMERICA**
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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.")

Application for Disability Insurance Option Exercises – Overhead Expense Insurance Supplement

I. 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. Basic Plan / Policy Form No. _____
- b. Monthly Indemnity to be Exercised \$ _____

c. Supplemental Benefits

1. **Continuation of Benefits** – If your original policy has any of the following benefits, select those you want to continue on the new policy:

Name of Benefit

Residual Disability Yes No _____

Other: _____ Yes No _____

2. **Addition of Benefits** – Do you want to add any of the following benefits to your new policy:
Adding a benefit to the new policy will require underwriting. Complete Section 6 and the Authorization to Obtain and Release Information.

Name of Benefit

Residual Disability Yes No _____

Other: _____ Yes No _____

- d. Your share of covered expenses? \$ _____ and _____ % of total.

**Application for Disability Insurance Option Exercises –
Overhead Expense Insurance Supplement | Continued**

e. 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		_____
Wages*		_____
Other Expenses (itemized):		

TOTAL	\$	_____

*Exclude compensation for members
of insured's profession.



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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.")

Application for Disability Insurance Option Exercises – Disability Buy-Out Insurance Supplement

I. 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 Step Rate

3. Disability Buy-Out Insurance

- a. Basic Plan / Policy Form No. _____
- b. Monthly Indemnity to be Exercised \$ _____
- c. Amount of Lump Sum to be Exercised \$ _____

d. Supplemental Benefits

1. **Continuation of Benefits** – If your original policy has any of the following benefits, select those you want to continue on the new policy:

Name of Benefit

*Presumptive Permanent Disability
(for monthly or down payment
funding only)*

- Yes No

Other: _____

- Yes No

2. **Addition of Benefits** – Do you want to add any of the following benefits to your new policy:
Adding a benefit to the new policy will require underwriting. Complete Section 6 and the Authorization to Obtain and Release Information.

Name of Benefit

*Presumptive Permanent Disability
(for monthly or down payment
funding only)*

- Yes No

Other: _____

- Yes No

**Application for Disability Insurance Option Exercises –
 Disability Buy-Out Insurance Supplement | *Continued***

- 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 *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. What is the current Fair Market Value of the business organization?

\$

- h. Indicate type of business organization:

Professional Corporation/Personal Service Partnership
 Commercial Business

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

- j. Business Financial

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



- 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	<input type="checkbox"/>
Bank Change	<input type="checkbox"/>
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:

- 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. If dividends are currently being used to reduce premiums, then once this authorization is approved, dividends for life insurance policies will be used to purchase paid-up additional insurance, and dividends for term insurance policies and annuities will be left with us to accumulate at interest.
- 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.
- If the Loan Payment Arrangement is cancelled, any outstanding loans will remain unpaid.
- 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.

_____ and (1) _____ (2) _____	
Signature of Policyowner	Signature of Bank Depositor (if other than policyowner)
Type of account: Checking <input type="checkbox"/> Savings <input type="checkbox"/>	Begin deductions effective _____ (Month) _____ (Year)
Financial Institution: _____	Street Address: _____
City: _____ State: _____ Zip: _____	Transit/ABA Number: _____
Account Number: _____	Name of Bank Depositor: _____
Guard-O-Matic Premium Arrangement (Deductions to occur on or about the 15th of each month.)	Guard-O-Matic Loan Payment Arrangement (Deductions to occur on the 1st business day or 15th of each month as described above.) (available for Individual Life Products only)
List Policy Number(s)	List Policy Number(s) Amount to be Deducted
_____	_____
_____	_____
_____	_____

For Home Office Use Only, Control No.:

Authorization to Honor Checks or Account Debits Drawn by:

The Guardian Life Insurance Company of America (Guardian) and/or The Guardian Insurance & Annuity Company, Inc. (GIAC) and/or Berkshire Life Insurance Company of America (Berkshire)

Name of Bank Depositor _____ Account Number _____

Financial Institution _____ Bank Address _____

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 Depositor _____ Additional Signature (if Joint Account)



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 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.

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.

The Guardian Life Insurance Company of America
 Berkshire Life Insurance Company of America
 700 South Street
 Pittsfield, Massachusetts 01201
*Berkshire Life Insurance Company of America
 is a subsidiary of and an administrator for
 The Guardian Life Insurance Company of America, New York, NY*

SUSPENSE TICKET

Agency No.	Insured Name	Date
Policy No.	Social Security No.	
List Bill No.	List Bill Name	# Apps Submitted

All prepayments must be submitted with a Conditional Receipt

Dollar Amount	Special Instructions
\$	

Billing Frequency:

- Annual
- Semiannual
- Quarterly
- Automatic Payment Plan (APP)
- List Bill (Monthly)

Prepared By



- 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.")

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? | <input type="checkbox"/> | <input type="checkbox"/> |
| 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)?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Do you use any special medical equipment or appliances such as a wheelchair, pacemaker, oxygen tank, cane, catheter, or artificial limb? | <input type="checkbox"/> | <input type="checkbox"/> |
| 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? | <input type="checkbox"/> | <input type="checkbox"/> |

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 may also be subject to civil penalties.

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 _____



- THE GUARDIAN LIFE INSURANCE COMPANY OF AMERICA
- 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

Retirement Protection Plus Program Authorization and Irrevocable Assignment

I, _____, have submitted to Berkshire Life Insurance Company of America (the Company) an application dated _____ for a disability income insurance policy ("Policy"). This Policy, if issued by the Company, will be issued pursuant to the Retirement Protection Plus program.

In the event the Company notifies me that it has approved my claim for disability benefit payments under the Policy, I agree to establish an irrevocable trust ("Trust") promptly thereafter for the purpose of receiving payment of the benefits. I agree to execute a Declaration of Trust Form and/or any other additional documents the Company may provide to me in order to create the Trust. Under the terms of the trust documents, Berkshire Bank, or such other entity as the Company may designate at that time, shall be appointed to act as Trustee of the Trust ("Trustee").

I hereby authorize and direct the Company or its authorized representative to furnish such information to the Trustee as it may require, in its sole discretion, for the administration of the Trust and to carry out the purposes of the Trust.

I hereby irrevocably assign to the Trust all of my rights to receive any disability benefit payments that may become due or payable under the Policy, reserving to myself all other rights under the Policy.

The following terms and conditions apply to these authorizations and this assignment (hereinafter "Authorization"):

1. This Authorization is contingent upon the issuance of the Policy applied for.
2. This Authorization is irrevocable, and I shall have no power to alter, amend, revoke or terminate any provision of this Authorization, whether under this document or any other document, statute or other rule of law.

I certify that I have received and carefully read the Retirement Protection Plus Disclosure Statement.

Dated at _____ this _____ day of _____, _____.

Witness

Assignor/Applicant

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

Retirement Protection Plus Disability Benefit Rider Irrevocable Assignment And Authorization

I, _____, have submitted to Berkshire Life Insurance Company of America (the Company) an application dated _____ for a disability income insurance policy ("Policy") that includes a Retirement Protection Plus Disability Benefit Rider ("Rider"). This Rider, if issued by the Company, will be issued pursuant to the Retirement Protection Plus program.

In the event the Company notifies me that it has approved my claim for disability benefit payments under the terms of the Rider, I agree to establish an irrevocable trust ("Trust") promptly thereafter for the purpose of receiving payment of the benefits under the Rider. I agree to execute a Declaration of Trust Form and/or any other additional documents the Company may provide to me in order to create the Trust. Under the terms of the trust documents, Berkshire Bank, or such other entity as the Company may designate at that time, shall be appointed to act as Trustee of the Trust ("Trustee").

I hereby authorize and direct the Company or its authorized representative to furnish such information to the Trustee as it may require, in its sole discretion, for the administration of the Trust and to carry out the purposes of the Trust.

I hereby irrevocably assign to the Trust all of my rights to receive any disability benefit payments that may become due or payable under the Rider, reserving to myself all other rights under the Policy.

The following terms and conditions apply to these authorizations and this assignment (hereinafter "Authorization"):

1. This Authorization is contingent upon the issuance of the Policy applied for with the Rider.
2. This Authorization is irrevocable, and I shall have no power to alter, amend, revoke or terminate any provision of this Authorization, whether under this document or any other document, statute or other rule of law.

I certify that I have received and carefully read the Retirement Protection Plus Disability Benefit Rider Disclosure Statement.

Dated at _____ this _____ day of _____, _____.

Witness

Assignor/Applicant