Guardian

Application for Individual Life Insurance – Part 1

(For Producer Use Only)

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

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

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

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

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

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

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Application for Individual Life Insurance – Part 1

- Conditional Receipt if accepting cash with application; there are specific conditions that appear on the Receipt form under which the receipt cannot be used. In addition to the conditions on the Receipt form, note that we do not allow cash with application for variable life policies, survivorship type policies, or any policy where the face amount is over $5,000,000. **NOTE:** There is no Conditional Receipt in Kansas and cash cannot be accepted with the application;
- Other miscellaneous disclosure forms, depending on the product and state

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

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

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

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

- Aviation Supplement, Avocation Supplement, Alcohol/Drug Use Supplement, Foreign Travel Supplement, Personal and or Business Financial Supplement;
- Replacement Forms (state specific);
- Illustration Certification, if used in lieu of Illustration;
- Based on amount requested M172 or medical records may be required;
- Guard-O-Matic Form, if requesting GOM mode;

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Application for Individual Life Insurance – Part 1

- Conditional Receipt if accepting cash with application; there are specific conditions that appear on the Receipt form under which the receipt cannot be used. In addition to the conditions on the Receipt form, note that we do not allow cash with application for variable life policies, survivorship type policies, or any policy where the face amount is over $5,000,000. **NOTE:** There is no Conditional Receipt in Kansas and cash cannot be accepted with the application;
- Other miscellaneous disclosure forms, depending on the product and state.

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

Guardian®

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

Application for Individual Life Insurance - Part 1

The insurer identified below will be herein referred to as the "Company."
THE GUARDIAN LIFE INSURANCE COMPANY OF AMERICA
Unless subsidiary checked below:
☐ THE GUARDIAN INSURANCE & ANNUITY COMPANY, INC.

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

SECTION A: Proposed Insured Information

1. First Name _____ MI _____ Last Name _____ Suffix _____

2. Previous Name (**ONLY** if changed in the last 5 years)
First Name _____ MI _____ Last Name _____

3. Date of Birth (mm/dd/yyyy) _____ **4.** Place of Birth _____

5. Social Security Number _____ **6.** Gender: ☐ Male ☐ Female

7. Are you a U.S. Citizen? ☐ Yes ☐ No If "No," are you a permanent resident (green card holder)? ☐ Yes ☐ No
If you are not a U.S. Citizen or permanent resident, please complete the Foreign Travel and Residence Supplement.
If you are a permanent resident (green card holder), please provide a copy of your green card.

8. Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

9. Driver's License Number _____ Driver's License State _____
If none, please provide a government photo ID number, issuer, and expiration date in the Remarks section.

10. Street Address (Primary Residence) _____
City _____ State _____ Zip _____

11. How long have you lived at this address? _____ years

12. If mailing address is same as street address, check here ☐. If different, please provide mailing address below.
Mailing Address _____
City _____ State _____ Zip _____

13. Preferred Phone _____ ☐ Cell ☐ Home ☐ Work
Alternate Phone (optional) _____ ☐ Cell ☐ Home ☐ Work

14. E-mail Address _____

Note: If there are multiple Proposed Insureds, you may need to complete the Additional Insured Supplement.

SECTION B: Proposed Insured Employment Information

1. ☐ Employed (Complete rest of section) ☐ Retired ☐ Homemaker ☐ Unemployed ☐ Disabled ☐ Student
☐ Other _____

2. Name of Employer _____

3. Street Address _____
City _____ State _____ Zip _____

4. Business Phone _____ **5.** Business Website _____

6. Occupation _____ **7.** Job Title _____

8. Nature of the Business _____ **9.** Years Employed _____
If employed for less than 1 year, please provide the below information for your previous employer.

10. Name of Previous Employer _____

11. Occupation _____ **12.** Years Employed _____

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

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

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

 # 1 - Other Individual(s)

a. First Name _____ MI _____ Last Name _____

b. Date of Birth (mm/dd/yyyy) _____ **c.** Social Security Number _____

d. Driver's License # and State _____

If none, please provide a government photo ID number, issuer, and expiration date in the Remarks section.

e. Relationship to Proposed Insured _____

f. Is the Owner a U.S. Citizen? ☐ Yes ☐ No *If "No," please provide details in the Remarks section.*

g. Preferred Phone _____ ☐ Cell ☐ Home ☐ Work

Alternate Phone (optional) _____ ☐ Cell ☐ Home ☐ Work

h. E-mail Address _____

i. Street Address _____

City _____ State _____ Zip _____

j. If mailing address is same as street address, check here ☐ . If different, please provide mailing address below.

Mailing Address _____

City _____ State _____ Zip _____

 # 2 - Trust, Charity or Business Entity

a. Full Name _____

b. Is entity established or organized under the laws of a state of the U.S.? ☐ Yes ☐ No

c. Tax ID Number _____

d. Phone _____ **e.** E-mail Address _____

f. Street Address _____

City _____ State _____ Zip _____

g. If mailing address is same as street address, check here ☐. If different, please provide mailing address below.

Mailing Address _____

City _____ State _____ Zip _____

If the Owner is a Trust, you must complete the Trust Certification form.

 # 3 - Uniform Transfer to a Minor

a. Custodian: First Name _____ MI _____ Last Name _____

b. Minor: First Name _____ MI _____ Last Name _____

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

d. Minor's Social Security Number _____

If the Owner is a minor child, you must complete the Uniform Gifts to Minors Act (UGMA)/ Uniform Transfers to Minors Act (UTMA) Certification form.

SECTION D: Change of Ownership

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

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

SECTION E: Beneficiary Information

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

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

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

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

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

Individual Beneficiary 1

a. Full Name _____ **b.** Date of birth (mm/dd/yyyy) _____

c. Beneficiary Type (see above): ☐ Primary ☐ Contingent ☐ Tertiary **d.** ☐ Per Stirpes*

e. Relationship to Proposed Insured _____ **f.** Percentage _____ %

g. Social Security Number _____ **h.** Phone _____

i. If address is same as Owner, check here ☐. If different, please provide mailing address below.

Mailing Address _____

City _____ State _____ Zip _____

Individual Beneficiary 2

a. Full Name _____ **b.** Date of birth (mm/dd/yyyy) _____

c. Beneficiary Type (see above): ☐ Primary ☐ Contingent ☐ Tertiary **d.** ☐ Per Stirpes*

e. Relationship to Proposed Insured _____ **f.** Percentage _____ %

g. Social Security Number _____ **h.** Phone _____

i. If address is same as Owner, check here ☐. If different, please provide mailing address below.

Mailing Address _____

City _____ State _____ Zip _____

SECTION E: Beneficiary Information (continued)

Individual Beneficiary 3

a. Full Name _____ **b.** Date of birth (mm/dd/yyyy) _____

c. Beneficiary Type (see above): ☐ Primary ☐ Contingent ☐ Tertiary **d.** ☐ Per Stirpes*

e. Relationship to Proposed Insured _____ **f.** Percentage _____ %

g. Social Security Number _____ **h.** Phone _____

i. If address is same as Owner, check here ☐. If different, please provide mailing address below.

Mailing Address _____

City _____ State _____ Zip _____

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

Trust, Charity or Business Entity

a. Full Name _____

b. Beneficiary Type (see above): ☐ Primary ☐ Contingent ☐ Tertiary **c.** Percentage _____ %

d. Is entity established or organized under the laws of a state in the U.S.? ☐ Yes ☐ No

e. Phone _____ **f.** E-mail Address _____

g. Tax ID Number _____ **h.** Contact Person _____

i. Mailing Address _____

City _____ State _____ Zip _____

4. Class Designations

☐ Children of the Proposed Insured (including adopted children) Percentage _____ %

Beneficiary Type: ☐ Primary ☐ Contingent ☐ Tertiary ☐ Per Stirpes*

☐ Children (including adopted children) of the Proposed Insured's Marriage With _____

_____ (spouse) Percentage _____ %

Beneficiary Type: ☐ Primary ☐ Contingent ☐ Tertiary ☐ Per Stirpes*

☐ Grandchildren of the Proposed Insured Percentage _____ %

Beneficiary Type: ☐ Primary ☐ Contingent ☐ Tertiary ☐ Per Stirpes*

5. Other Designations

☐ Proposed Insured's Estate

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

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

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

☐ Other _____

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

SECTION F: Purpose of Insurance

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

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

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

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

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

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

4. Riders

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

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

b. ☐ Accelerated Benefit Rider (EABR/TABR) *If elected, please refer to the Representations section.*

c. ☐ Index Participation Rider (IPR) *If elected, please complete the IPR supplement.*

d. ☐ Paid-Up Additions Rider (PUA)
Scheduled PUA Amount: ☐ Minimum ☐ Other amount $ _____
Unscheduled PUA Amount $ _____

e. ☐ Waiver of Specified Amount (WSA)
☐ Scheduled PUA Amount ☐ Other $ _____

f. Guaranteed Insurability Options (GIO): ☐ GIO Plus ☐ GIO
GIO Option Amount $ _____

g. ☐ Whole Life Purchase Option (WLPO) – **Term Only**
Option Amount: ☐ Maximum ☐ Other $ _____

h. ☐ Extended Conversion Rider – **Term Only**

i. ☐ 10 Year Renewable Term (RTR10) Term Face Amount $ _____

j. ☐ Lifetime Protection Builder Term Face Amount $ _____

k. ☐ Long Term Care (LTC) Rider $ _____ *If elected, please complete the LTC Supplement.*

l. ☐ Select Security *If elected, please complete the Select Security supplement.*

m. ☐ Exchange of Insureds

n. ☐ Accidental Death Benefit (ADB) ADB Face Amount $ _____

o. ☐ DuoGuard *If elected, please list the names and amounts for the Designated Lives. Please also complete a separate Additional Insured Supplement for each Designated Life.*

_____

_____

p. ☐ Other _____

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

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

Basic:
- ☐ A - Paid in Cash*
- ☐ B - Reduce Premiums*
- ☐ C - Left at Interest*
- ☐ D - Paid-Up Additional Insurance
- ☐ U - Loan Repayment/Balance to Paid-Up Additions

Term:
- ☐ Q - One Year Term Insurance *If elected, please enter the Target Face Amount in Plans section above.*
- ☐ R - One Year Term Insurance *If elected, please enter the Target Face Amount in Plans section above.*
  - ☐ Level Increases _____ % ☐ Compound Increases _____ %
- ☐ Other _____

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

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

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

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

☐ Level ☐ Increasing ☐ Return of Premium

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

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

☐ Guideline Premium Test ☐ Cash Value Accumulation Test

5. Initial Premium $ _____ Planned Modal Premium $ _____

6. Riders

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

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

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

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

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

4. Universal Life Only

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

☐ Level ☐ Increasing ☐ Return of Premium

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

☐ Guideline Premium Test ☐ Cash Value Accumulation Test

c. Initial Premium $ _____ Planned Modal Premium $ _____

5. Riders

a. ☐ Survivorship Waiver of Premium (Death Waiver) (available on one or both of the base policy Insureds)

☐ 1st Insured _____

☐ 2nd Insured _____

b. ☐ Policy Split Option

c. ☐ Paid-Up Additions Rider (PUA)

Scheduled PUA Amount: ☐ Minimum ☐ Other amount $ _____

Unscheduled PUA Amount $ _____

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

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

☐ 1st Insured _____

☐ 2nd Insured _____

f. ☐ Second to Die DuoGuard (List names & amounts for Designated Lives. Complete a separate Additional Insured Supplement for each Designated Life.)

_____

_____

g. ☐ First to Die DuoGuard (Available on one or both of the base policy Insureds.) Face Amount $ _____

☐ 1st Insured _____

☐ 2nd Insured _____

h. ☐ Other _____ ☐ Other _____

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

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

Basic:
- ☐ A - Paid in Cash*
- ☐ B - Reduce Premiums*
- ☐ C - Left at Interest*
- ☐ D - Paid-Up Additional Insurance
- ☐ U - Loan Repayment/Balance to Paid-Up Additions

Term:
- ☐ Q - One Year Term Insurance *If elected, please enter the Target Face Amount in Plans section above.*
- ☐ R - One Year Term Insurance *If elected, please enter the Target Face Amount in Plans section above.*
  - ☐ Level Increases _____ % ☐ Compound Increases _____ %
- ☐ Other _____

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

SECTION H: Alternate/Additional Life Policy

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

☐ Alternate Policy: Plan of Insurance _____ Face Amount $ _____

Details (Riders, Benefits, Dividend Options, etc.): _____

_____

_____

☐ Additional Policy: Plan of Insurance _____ Face Amount $ _____

Details (Riders, Benefits, Dividend Options, etc.): _____

_____

_____

SECTION I: Premiums

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

a. Name _____

b. Reason for Paying Premiums _____

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

e. Street Address _____

City _____ State _____ Zip _____

2. Mode: ☐ Annual

☐ Monthly Automatic Bank Draft (GOM)

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

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

☐ Semi-Annual

☐ Quarterly

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

☐ New – Billing Name _____

☐ Existing – Account Number _____

☐ Common Billing Date _____

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

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

5. Will money be submitted with this application?

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

☐ No

6. Secondary Addressee Designation

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

Name _____

Mailing Address _____

City _____ State _____ Zip _____

7. Policy Date

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

☐ Backdate to save age

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

☐ Specific policy date is requested. *If elected, please provide requested policy date (mm/dd/yyyy):* _____

SECTION J: Financial Information of Owner

1. Is the applied for policy in accordance with your insurance objectives and your anticipated financial needs? ☐ Yes ☐ No

2. Do you believe you have the financial ability to continue making premium payments on this policy? ☐ Yes ☐ No

3. Have you ever filed for personal or business bankruptcy? ☐ Yes ☐ No

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

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

4. Personal Finances:

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

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

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

6.

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

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

8. What is the nature of the business? _____

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

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

If "Yes," please provide details: _____

SECTION K: Insurance History

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

1. Guardian Policy(ies):

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

2. Non-Guardian Policy(ies):

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

3. Has the Proposed Insured ever had life, disability, accident or medical insurance declined, postponed, modified, rated or cancelled, have withdrawn a pending application, or had a renewal or reinstatement refused? *If "Yes," please provide full details in the Remarks section.* ☐ Yes ☐ No

4. Are any other life, disability or accident insurance products currently being applied for on the life of the Proposed Insured, or is there any plan to do so in the near future? *If "Yes," please include amount and company applied with, and whether this other insurance will be in addition to or in lieu of insurance with the Company.* ☐ Yes ☐ No

SECTION L: Existing Insurance/Replacement

IMPORTANT: If "Yes" to either of the below questions, please refer to the Instruction Sheet for Life Insurance Application regarding additional state required replacement forms.

1. Does the Applicant/Owner have any existing individual life insurance policies or annuity contracts (including those that may have recently been lapsed or surrendered)? ☐ Yes ☐ No

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

IMPORTANT: If "Yes" to question 2, please refer to the Instruction Sheet for Life Insurance Application regarding when it is required to complete the below chart.

Policy Number	Issuing Company	Name of Insured	Face Amount of Policy

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

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

1. Are you a member of the Armed Forces, including the Reserves, or have you entered into a written agreement to enter the military services or are you on alert? *If "Yes," please complete the Military Status Supplement.* ☐ Yes ☐ No

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

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

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

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

Country _____ Duration _____ Purpose of Travel _____

Country _____ Duration _____ Purpose of Travel _____

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

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

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

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

☐ Mountain Climbing ☐ Rock Climbing ☐ Scuba Diving ☐ Hang Gliding

☐ Parachuting ☐ Skydiving ☐ Motor Vehicle Racing

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

9. Describe your complete use of tobacco or tobacco products below. This includes, but is not limited to: cigarettes, cigars, pipes, chewing tobacco, snuff, hookah, nicotine gum, nicotine patch, and electronic delivery devices.

Type of Product	Quantity	Frequency	Date Last Used (mm/dd/yyyy)
Cigarettes		☐Daily ☐Weekly ☐Monthly ☐Yearly	
Cigars		☐Daily ☐Weekly ☐Monthly ☐Yearly	
Pipes		☐Daily ☐Weekly ☐Monthly ☐Yearly	
Chewing Tobacco		☐Daily ☐Weekly ☐Monthly ☐Yearly	
Other _____		☐Daily ☐Weekly ☐Monthly ☐Yearly	
☐ I have never used tobacco products.			

SECTION N: Illustration (ONLY complete for products and/or states where an illustration is required)

This section <u>does not</u> need to be completed if (a) the policy applied for is variable life insurance; (b) a signed illustration is not required by law for the policy applied for; or (c) the Applicant has signed an illustration that matches the policy as applied for.

Primary	Add	Alt	
☐	☐	☐	No illustration was used in the sale of this life insurance Policy.
☐	☐	☐	The sales illustration used for the Proposed Insured does not conform to the Policy as applied for.
☐	☐	☐	The sales illustration for the Proposed Insured was shown on a computer screen. The illustration conforms to the Policy as applied for, however, no hard copy was furnished.

SECTION O: Tax Certification

Under penalties of perjury I certify that:

(1) The number shown on this form is my correct social security number or taxpayer identification number, and

(2) I am not subject to backup withholding because:

(a) I am exempt from backup withholding, or;

(b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or;

(c) the IRS has notified me that I am no longer subject to backup withholding, and;

(3) I am a U.S. citizen (including a U.S. Resident Alien) or domestic business entity, and;

(4) I am exempt from FATCA reporting*

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

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

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

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

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

_____ _____

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

SECTION P: Remarks

Question #	Details

SECTION Q: Amendments or Corrections (For Home Office or Customer Service Office Use Only)

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

Those parties who sign below, agree that:

1. This application, (Part I, Medical Supplement Part II, the Authorization, any amendments to the application, and any required supplements or questionnaires) will form the basis for, and will be attached to and become a part of, any policy issued. All of the statements that are part of the application are correctly recorded, and are complete and true to the best of the knowledge and belief of those persons who made them. Any misrepresentation or omission, if found to be material, may adversely affect acceptance of the risk, or a claims payment and/or may cause the Company to seek rescission of any policy or coverage that is issued based on this application.
2. No producer, broker or medical examiner has any right to accept risks, make, void or change contracts, change the terms of this application, waive or modify any of the Company's rights or requirements or extend the time for any payment. No information acquired by any Representative of the Company shall bind the Company unless it shall have been set out in writing in this application.
3. For any policy that will be issued, the policy date is the date from which premiums are calculated and become due. Except as provided in the Conditional Temporary Coverage and Receipt (if an advance payment has been made and such Receipt has been issued and its terms complied with), no insurance coverage shall take effect unless and until the policy is delivered to and accepted by the Owner and all delivery requirements have been completed and the first premium is paid, and this delivery, acceptance and premium payment occurs (a) during the lifetime of the Proposed Insured, and (b) while all answers in this application are still true and complete, and (c) prior to any change in the health or insurability, of the Proposed Insured.
4. Backdating is the process whereby a policy is given a policy date that is earlier than the date a policy is issued. If your backdating request involves saving age, your insurance age will be one year younger than your actual age and may result in a lower premium. However, by electing to backdate the policy (Section I, #7 of this application), regardless of saving age, the premium will be billed from a date that will result in you paying premium for a period of time during which the policy did not provide insurance coverage. You are not required to pay such premium, but by selecting to backdate the policy you will be doing so. You can avoid paying such premium by not requesting the policy be backdated. The amount of time you will be paying premium for which the policy did not provide coverage depends on the time it takes to underwrite, issue and deliver the policy, if a policy is issued. You can reduce the amount of time by promptly completing any requirements or paying a premium and obtaining a Conditional Temporary Coverage and Receipt.
5. By paying premiums on a basis more frequently than annually, the total premium payable during one year's time will be greater than if the premium were paid annually. That is, the cost of paying annualized periodic premiums will be more than the cost of paying one annual premium.
6. If no illustration was given at the time of application, the producer has explained why in Section N of this application. The Owner understands that an illustration will be provided no later than at time of policy delivery.
7. If applying for a rider form that provides for the ability to accelerate the policy's death benefit for terminal illness and/or chronic illness, I (we) certify that I (we) have received a disclosure describing the benefits and conditions of such rider.
8. Changes or corrections made by the Company and noted in the Amendments or Corrections section of this application are ratified by the Owner upon acceptance of a policy containing this application with the noted changes or corrections. Amendments as to plan, amount, classification, age at issue or benefits will be made only with the Owner's written consent.

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.

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

Signed at _____ _____

City and State | Month/Day/Year

_____ _____

Signature of Proposed Insured (*or parent or guardian if insured is under 18*) | Signature of Applicant/Owner (*if other than Proposed Insured*)

_____ _____

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

SECTION S: Representations and Signatures of the Producer

☐ Check here if this application was sent to the Proposed Insured for signature by mail or e-mail. If so, the signature of the producer does not attest to the signature of the Proposed Insured.

☐ Check here if this application was taken in the presence of the Proposed Insured. I certify that I have taken this application in the presence of the Proposed Insured, and that I have truly and accurately recorded on this application the information supplied by the Proposed Insured.

Signature of Licensed Producer	License Number(s)
Producer's Name	State(s) where licensed

Guardian®

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

Producer Certification

The insurer identified below will be herein referred to as the "Company."
THE GUARDIAN LIFE INSURANCE COMPANY OF AMERICA
Unless subsidiary checked below:
☐ THE GUARDIAN INSURANCE & ANNUITY COMPANY, INC.

Please print.

SECTION A: Proposed Insured Information

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

First Name _____ MI _____ Last Name _____

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

SECTION B: Producer's Certification

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

☐ No Marketing Initiative ☐ Wealth Steps ☐ Business Resource Center ☐ CPA Referral
☐ Living Balance Sheet ☐ DI to Life Program ☐ Take Advantage/Rapid App ☐ Other _____

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

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

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

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

3b. Have you been in the presence of, or seen the Proposed Insured in person within the last 30 days? ☐ Yes ☐ No

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

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

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

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

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

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

9b. Who acted as interpreter? _____

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

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

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

IMNB521800012010 3

SECTION B: Producer's Certification (continued)

11. Is the premium for this policy to be paid by a person or entity other than the Owner? ☐Yes ☐No

If "Yes," please provide a letter of authorization (with all required signatures) and also provide payor's Tax ID number.

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

12a. How much do you think the Applicant is worth? $ _____

12b. What do you believe the Applicant's annual income to be? $ _____

12c. What is the total amount of life insurance in force on the life of the Applicant? $ _____

13. Did you see the Proposed Insured at the time this application was completed? ☐Yes ☐No

a. Did he/she appear to be in good health at the time? ☐Yes ☐No

b. Did he/she appear to have any kind of physical disability? ☐Yes ☐No

14. Give names of brothers and sisters of Proposed Insured who are under the age of 18, and date of birth and insurance in force and applied for on each.

Name	Date of Birth	Insurance Inforce/Applied For

15. Was this application signed and dated in a state other than the state in which the Owner lives or works? *If "Yes," please provide details in the Remarks and Additional Instructions section.* ☐Yes ☐No

16. What underwriting requirements are being submitted?

Medical Supplement (Choose One): ☐eMed and Physical Measurements ☐Paramedical Examination

Other Medical Requirements: ☐EKG ☐Stress EKG ☐Blood ☐Urine ☐APS

SECTION C: Remarks and Additional Instructions

SECTION D: Commissions

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

SECTION E: Signatures

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

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

Signed at _____ _____

City and State | Month/Day/Year

_____ _____

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

_____ _____

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

Guardian®

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

HIV ANTIBODY TESTING CONSENT FORM

The insurer identified below will be herein referred to as the "Company."
THE GUARDIAN LIFE INSURANCE COMPANY OF AMERICA
Unless subsidiary checked below:
☐ THE GUARDIAN INSURANCE & ANNUITY COMPANY, INC.
☐ BERKSHIRE LIFE INSURANCE COMPANY OF AMERICA

Type of Policy Applied For: _____

Insurer (Company) Address
6255 Sterner's Way
Bethlehem, PA 18017-9464

Examiner: _____

The Tests
To evaluate your eligibility for insurance or insurance benefits, it is requested that you provide a sample of your blood for testing and analysis. One of the tests to be performed on this sample may be a test to determine the presence of antibodies to the Human Immunodeficiency Virus (HIV), also known as the AIDS virus. The HIV antibody test is actually a series of tests done by a medically accepted procedure which is extremely reliable. The testing will be performed by a licensed laboratory.

Disclosure of Test Results
All test results will be treated confidentially. The results of the test will be reported to the Insurer named above (Company). The results also may be reported to its affiliates, reinsurers or contractors in connection with insurance you have or have applied for. Along with the insurer these organizations may also have access to your insurance file. In addition, if your HIV antibody test is abnormal (positive), a generic code signifying a non-specific blood abnormality may be made known to the Medical Information Bureau (MIB, Inc.) as described in the notice given you at the time of application. The fact that the test has been done and the results of the test will not be otherwise disclosed except as may be required by law or as authorized by you.

In addition, New Jersey law requires that laboratories must report in writing to the New Jersey Department of Health any results of infection with HIV. The laboratory must report any identifying information it may have with regard to you if your HIV antibody test is abnormal.

Meaning of Test Results
While positive HIV antibody test results do not mean that you have AIDS, they do mean that you are at seriously increased risk of developing AIDS or AIDS-related conditions. Federal authorities say that persons who are HIV antibody positive should be considered infected with the AIDS virus and capable of infecting others. If your blood is tested for HIV antibodies and if your test results are positive, the Insurer will contact you for the name of a physician or other health care provider to whom you may authorize disclosure and with whom you may want to discuss the results. Positive HIV antibody test results will adversely affect your insurance application.

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

_____ _____
NAME OF PROPOSED INSURED (PLEASE PRINT) DATE OF BIRTH

_____ _____
SIGNATURE OF PROPOSED INSURED DATE

_____
STATE OF RESIDENCE

Guardian®

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

Accelerated Benefit Rider Summary and Disclosure Statement

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

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

EFFECTS OF AN ACCELERATED BENEFIT PAYMENT ON A LIFE INSURANCE POLICY

WHEN AN ACCELERATED BENEFIT IS PAID, A LIEN IS CREATED AGAINST THE POLICY EQUAL TO THE AMOUNT OF THE ACCELERATED BENEFIT WE PAY, PLUS LIEN CARRYING CHARGES TO THE NEXT POLICY ANNIVERSARY. ANY LIEN CREATED WILL BEAR CARRYING CHARGES, WHICH ARE PAYABLE IN ADVANCE ON THE DATE THE LIEN WAS CREATED AND ON EACH SUBSEQUENT POLICY ANNIVERSARY. THE INTEREST RATE VARIES DEPENDING ON THE AMOUNT OF THE OUTSTANDING LIEN. IF THE OUTSTANDING LIEN IS LESS THAN OR EQUAL TO THE CASH VALUE OF THE POLICY PLUS THE CASH VALUE OF ANY ADDITIONS DISCOUNTED TO THE DATE THE LIEN CARRYING CHARGES ARE DETERMINED, THE LIEN CARRYING CHARGE RATE IS EQUAL TO THE LESSER OF THE FIXED LOAN INTEREST RATE THEN IN EFFECT UNDER THE POLICY OR AN ADJUSTABLE LOAN INTEREST RATE AS ALLOWED BY LAW. THE RATE FOR ANY AMOUNT OF AN OUTSTANDING LIEN WHICH EXCEEDS THE CASH VALUE OF THE POLICY PLUS THE CASH VALUE OF ADDITIONS DISCOUNTED TO THE DATE THE LIEN CARRYING CHARGES ARE DETERMINED IS EQUAL TO AN ADJUSTABLE LOAN INTEREST RATE AS ALLOWED BY LAW. THE ADJUSTABLE LOAN INTEREST RATE IS BASED ON THE MOODY'S CORPORATE BOND YIELD AVERAGE PUBLISHED BY MOODY'S INVESTORS SERVICE, INC., OR ANY SUCCESSOR THERETO, AS OF THE CALENDAR MONTH ENDING TWO MONTHS BEFORE THE FIRST DAY OF THE MONTH OF THE POLICY ANNIVERSARY.

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

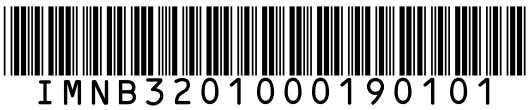
UPON RECEIPT OF A REQUEST FOR AN ACCELERATED BENEFIT PAYMENT, GUARDIAN WILL NOTIFY THE OWNER AND ANY IRREVOCABLE BENEFICIARY OF THE EFFECT THAT SUCH PAYMENT WILL HAVE ON POLICY BENEFITS AND VALUES.

TAX CONSEQUENCES

ALTHOUGH THE PAYMENTS MADE UNDER THIS RIDER ARE INTENDED TO QUALIFY FOR FAVORABLE TAX TREATMENT UNDER SECTION 101(g) OF THE FEDERAL INTERNAL REVENUE CODE, PAYMENTS UNDER THIS RIDER MAY BE TAXABLE. THE OWNER SHOULD CONSULT A COMPETENT TAX ADVISOR TO DETERMINE THE CURRENT TAX CONSEQUENCES BEFORE REQUESTING ANY ACCELERATED PROCEEDS.

GOVERNMENT ENTITLEMENTS

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



LIMITS OF AN ACCELERATED BENEFIT RIDER

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

OTHER OPTIONS

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

DEFINITIONS

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

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

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

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

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

THE ACCELERATED BENEFIT PAYMENT

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

The accelerated benefit payment will be paid to the owner in a lump sum.

LIMITATIONS OR CONDITIONS ON ELIGIBILITY OF BENEFITS

Accelerated Benefit payments are limited by both the Annual Lien Limit and the Total Lien Limit. The owner may take a maximum of 4 liens per policy year. If the policy was issued as part of a pension plan, in order for an Accelerated Benefit to be paid, the policy must be out of the pension plan and individually owned. The policy must be in force other than as extended term insurance on the date the accelerated benefit is requested. If the policy is in force as paid-up insurance on the date the first accelerated benefit is requested, the amount of paid-up insurance must be at least $100,000. Guardian must receive at its home office the written consent of any assignee and any irrevocable beneficiary to the payment of the accelerated benefit. And, when a lien is outstanding under the policy, no changes may be made to the plan or amount of the policy.

ANNUAL LIEN LIMIT

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

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

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

TOTAL LIEN LIMIT

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

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

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

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

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

COST

There is no additional premium charged to add an Accelerated Benefit Rider to a life insurance policy.

TERMINATION

This Accelerated Benefit Rider will terminate on the earliest of:

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

Guardian®

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

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

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)

Witness Signature

Insurance Information Practices

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

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

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.

Guardian®

Customer Service Office
Mailing Address
6255 Sterner's Way
Bethlehem, PA 18017-9464
1-888- GUARDIAN

The insurer identified below will be herein referred to as the "Company."
THE GUARDIAN LIFE INSURANCE COMPANY OF AMERICA
Unless subsidiary checked below:
☐ THE GUARDIAN INSURANCE & ANNUITY COMPANY, INC.
☐ BERKSHIRE LIFE INSURANCE COMPANY OF AMERICA

IMPORTANT NOTICE: REGARDING REPLACEMENT OF LIFE INSURANCE OR ANNUITIES

This document must be signed by the applicant and the producer, if there is one, and a copy left with the applicant

You are contemplating the purchase of a life insurance policy or annuity contract. In some cases this purchase may involve discontinuing or changing an existing policy or contract. If so, a replacement is occurring. Financed purchases are also considered replacements.

A replacement occurs when a new policy or contract is purchased and, in connection with the sale you discontinue making premium payments on the existing policy or contract, or an existing policy or contract is surrendered, forfeited, assigned to the replacing insurer, or otherwise terminated or used in a financed purchase.

A financed purchase occurs when the purchase of a new life insurance policy involves the use of funds obtained by the withdrawal or surrender of an existing policy or by borrowing some or all of the policy values, including accumulated dividends, of an existing policy, to pay all or part of any premium or payment due on the new policy. A financed purchase is a replacement.

You should carefully consider whether a replacement is in your best interests. You will pay acquisition costs and there may be surrender costs deducted from your existing policy or contract. You may be able to make changes to your existing policy or contract to meet your insurance needs at less cost. A financed purchase will reduce the value of your existing policy and may reduce the amount paid upon the death of the insured.

We want you to understand the effects of replacements before you make your purchase decision and ask that you answer the following questions and consider the questions on the next page of this form.

1. Are you considering discontinuing making premium payments, surrendering, forfeiting, assigning to the insurer, or otherwise terminating your existing policy or contract?
   ☐ YES ☐ NO

2. Are you considering using funds from your existing policies or contracts to pay premiums due on the new policy?
   ☐ YES ☐ NO

Please list each existing policy or contract you are contemplating replacing (include the name of the insurer, the insured or annuitant, and the policy or contract number if available) and whether each policy or contract will be replaced or used as a source of financing.

	INSURER NAME	CONTRACT OR POLICY #	INSURED OR ANNUITANT	REPLACED (R) OR FINANCING (F)
1.				
2.				
3.				

1st signed copy – Applicant • 2nd signed copy – Replacing Insurer • 3rd signed copy – Agency

IMNB320200018010 1

Make sure you know the facts. Contact your existing company or its producer for information about the old policy or contract. (You may request that an in-force illustration, policy summary or available disclosure documents be sent to you by the existing insurer.) Ask for and retain all sales material used by the producer in the sales presentation. Be sure that you are making an informed decision.

The existing policy or contract is being replaced because _____

I certify that the responses herein are, to the best of my knowledge, accurate:

_____	_____	_____
Applicant's Signature	Printed Name	Date
_____	_____	_____
Producer's Signature	Printed Name	Date

I do not want this notice read aloud to me._____(Applicants must initial only if they do not want the notice read aloud.)

A replacement may not be in your best interest, or your decision could be a good one. You should make a careful comparison of the costs and benefits or your existing policy or contract and the proposed policy or contract. One way to do this is to ask the company or producer that sold you your existing policy or contract to provide you with information concerning your existing policy or contract. This may include an illustration of how your existing policy or contract is working now and how it would perform in the future based on certain assumptions. Illustrations should not, however, be used as a sole basis to compare policies or contracts. You should discuss the following with your producer to determine whether replacement or financing your purchase makes sense:

PREMIUMS:

- Are they affordable?
- Could they change?
- You're older -- are premiums higher for the proposed new policy?
- How long will you have to pay premiums on the new policy? On the old policy?

POLICY VALUES:

- New policies usually take longer to build cash values and to pay dividends.
- Acquisition costs for the old policy may have been paid; you will incur acquisition costs for the new one.
- What surrender charges do the policies have?
- What expense and sales charges will you pay on the new policy?
- Does the new policy provide more insurance coverage?

INSURABILITY:

- If your health has changed since you bought your old policy, the new one could cost you more, or you could be turned down.
- You may need a medical exam for a new policy.
- Claims on most new policies for up to the first two years can be denied based on inaccurate statements.
- Suicide limitations may begin anew on the new coverage.

IF YOU ARE KEEPING THE OLD POLICY AS WELL AS THE NEW POLICY:

- How are premiums for both policies being paid?
- How will the premiums on your existing policy be affected?
- Will a loan be deducted from death benefits?
- What values from the old policy are being used to pay premiums?

IF YOU ARE SURRENDERING AN ANNUITY OR INTEREST SENSITIVE LIFE PRODUCT:

- Will you pay surrender charges on your old contract?
- What are the interest rate guarantees for the new contract?
- Have you compared the contract charges or other policy expenses?

OTHER ISSUES TO CONSIDER FOR ALL TRANSACTIONS:

- What are the tax consequences of buying the new policy?
- Is this a tax-free exchange? (See your tax advisor.)
- Is there a benefit from favorable "grandfathered" treatment of old policy under the Federal tax code?
- Will the existing insurer be willing to modify the old policy?
- How does the quality and financial stability of the new company compare with your existing company?

Guardian®

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

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

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

Guardian®

Life Customer Service Office
P.O. Box 26100
Lehigh Valley, PA 18002-6100

Conditional Temporary Coverage Agreement and Receipt

The insurer identified below will be herein referred to as the "Company."
THE GUARDIAN LIFE INSURANCE COMPANY OF AMERICA
Unless subsidiary checked below:
☐ THE GUARDIAN INSURANCE & ANNUITY COMPANY, INC.

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

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

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

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

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

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

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

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

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

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

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Conditions:

The temporary insurance shall be effective on the later of:

(a) the date of the application for insurance which includes the Application for Life Insurance Part I, the Authorization, any amendments to the application, and any required supplements or questionnaires ("Part I");

(b) the date of any Medical Supplement for Individual Life and/or Disability Insurance Part II ("Part II");

(c) the date of any reports from medical examiners, or any other medical examinations that are required by the Company's published underwriting rules; and

(d) the date of any lab work that is required by the Company's published underwriting rules.

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

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

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

- After the required Parts I and II have been received at the Company's Customer Service Office; and
- After the last of any required reports from medical examiners, other medical examinations, and/or medical records and/or information including any required lab work, have been completed and received by the Company.

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

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

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

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

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

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

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

_____ _____
Signature of Proposed Insured (*or parent or guardian if insured is under 18*) Signature of Owner *(if other than Proposed Insured)*

_____
Signature of Producer

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

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

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

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

This Authorization is at the request of the Applicant 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.

_____
Applicant's Name (Please print)

_____ _____
Applicant's Signature Date

Guardian®

☐ **THE GUARDIAN LIFE INSURANCE COMPANY OF AMERICA**
☐ **THE GUARDIAN INSURANCE & ANNUITY COMPANY, INC.**
☐ **BERKSHIRE LIFE INSURANCE COMPANY OF AMERICA**
(Please check appropriate company. In this form, "the Company" is the insurer checked above.)

Mail to:
P.O. Box 981590
El Paso TX, 79998-1590

TRUST CERTIFICATION

1. Policy Information – Proposed Insured(s)/Insured(s)

Policy Number(s) _____

LIFE ONE

1. Name _____
First Middle Last

LIFE TWO

2. Name _____
First Middle Last

2. Trust Information

1. Name of Trust _____

2. **a)** Name(s) of Trustee(s) _____

b) Nature of the relationship between the Grantor(s) and the Trustee(s) _____

c) Duration of the relationship _____

3. Tax Identification Number of Trust _____

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

4. Is this a Grantor Trust? ☐ Yes ☐ No

Please consult with a tax advisor to determine whether your Trust is a Grantor Trust (as described in Sections 671–679 of the Internal Revenue Code).

If 'Yes', please provide: Grantor's TIN or SSN: _____ Grantor's Date of Birth: _____
Month Day Year

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

☐ Any one Trustee ☐ All Trustees ☐ A majority of Trustees

6. Who are the current Beneficiaries of the Trust? _____

7. **a)** Effective Date of Trust _____ **b)** Date Trust was signed/executed _____
Month Day Year Month Day Year

c) Situs of Trust: The Trust is subject to the laws of the State of _____

8. Address of Trust _____
Street No. & Name Suite No. City State Zip code

9. Did you retain an attorney to prepare the Trust document? ☐ Yes ☐ No (We will not contact the attorney without your written approval.)

If 'Yes', provide name and address of attorney. If 'No' provide name and address of person who provided Trust document.

Name of Attorney/Provider _____

Address of Attorney/Provider _____
Street No. & Name Suite No. City State Zip code

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3. Certification

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

a) the Trust is: ☐ **Irrevocable and is in full force and in effect;**
☐ **Revocable and is in full force and in effect;**

b) the Trustee(s) is/are allowed by the terms of the Trust to purchase Life Insurance and Securities (if applicable);

c) the Trust permits the Trustee(s) to exercise all ownership rights provided by the Policy issued by the Company to the Trust, including but not limited to, the right to surrender, pledge or encumber the Policy or make withdrawals,

d) and the Trustee(s) is/are permitted to distribute the Policy to any beneficiary of the Trust or to sell and transfer ownership of the Policy pursuant to the sale;

e) neither the Company nor anyone acting as an agent of the Company is responsible to determine the authority of the Trustee(s) or inquire into, or review the provisions of the Trust, and shall not be charged with knowledge of the terms of the Trust;

f) the Company may rely on the evidence submitted with respect to any change of the Trustee(s) and/or the appointment of a successor Trustee, and is not responsible to determine that the change or the appointment of any additional or successor Trustee(s) conforms with the Trust provisions;

g) beneficial interests under the Trust can and will only be established for persons who (1) are related to the Proposed Life Insured(s) by blood or by law, (2) have a substantial interest in the Proposed Life Insured(s) engendered by love and affection, or (3) hold a lawful and substantial economic interest in the continued life of the Proposed Life Insured(s); and

h) neither the Company nor its affiliates, employees, representatives, or agents have provided tax or legal advice and the Trustee(s) have had the opportunity to consult with their own tax and/or legal advisors regarding the preparation of the Trust Certification.

4. Tax Certification and Signatures

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

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

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

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

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

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

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

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

X _____
Signature of Trustee Date

By signing below, you jointly and severally indemnify and hold the Company harmless from any liability for acting according to your instructions under the referenced Trust.

Guardian will rely on this certification and will not be liable for action taken including any tax reporting performed pursuant to and in reliance on the representations made on this form.

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

Signed at _____
City & State

X _____ **X** _____
Signature of Trustee Date Signature of Trustee Date

Guardian®

The Guardian Life Insurance Company of America ("Guardian")
The Guardian Insurance & Annuity Company, Inc. ("GIAC")
Berkshire Life Insurance Company of America ("Berkshire")
(Any insurer above, individually or collectively, is herein referred to as the "Company.")

BANK DRAFT AUTHORIZATION

(REQUEST FOR GUARD-O-MATIC ARRANGEMENT)

Please Print

1. Type of Request *(Check all the apply)*

- ☐ Establish a new Bank Draft Authorization for monthly payments
- ☐ Update Financial Institution Information on an existing Bank Draft Authorization
- ☐ Change draft date option and/or draft amount on an existing Bank Draft Authorization
- ☐ Add policy(ies) to existing Bank Draft Authorization:
  List one policy from existing arrangement: _____
- ☐ Revoke Bank Draft Authorization for Policy Number(s): _____

2. Financial Institution Information

Financial Institution Name: _____

Type of Account *(Check one):* ☐ Checking ☐ Savings ☐ Business _____
Type of Business

Transit/ABA Number *(Always 9 digits.)*

Account Number

Account Holder Information *(All fields required. Please print.):*

Full Title of Account (e.g. John Smith or The John Smith Irrevocable Trust dtd 01/02/2016): _____

☐ Individual ☐ Joint ☐ Trust ☐ Custodial ☐ Business ☐ Other: _____

Authorized Signer of Account: _____

Address: _____
Address City State Zip

Phone: _____ Email: _____

3. Premium Arrangement Information

Please note the "Monthly Amount to Be Deducted" will be the monthly modal premium described in your policy. The "Effective Date of Change" will be the date your next premium payment is due.

Policy Number	Draft Date*	Insured Name	Monthly Amount to Be Deducted**	Effective Date of Change *(mm/yy)*	Control Number *(For Home Office Use Only.)*
	☐ 1st ☐ 15th		$		
	☐ 1st ☐ 15th		$		
	☐ 1st ☐ 15th		$		
	☐ 1st ☐ 15th		$		
	☐ 1st ☐ 15th		$		
	☐ 1st ☐ 15th		$		

* *Variable Life and Universal Life Policies allow for premium payments on the 15th only; Premium payments for Traditional Life and Disability Policies can be made on the 1st or the 15th of each month; If no selection is made, the draft date will default to the 15th of each month.*

** *For UL/VL policies only. Indicate an amount for UL/VL policies if the amount to be deducted will be different from the planned premium.*

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4. Loan Payment Information

Policy Number	Monthly Amount to Be Deducted*	Policy Number	Monthly Amount to Be Deducted*
	$		$
	$		$
	$		$

** Loan payments for policies administered by Berkshire will be made on or about the 15th of each month; For all other policies, loan payments will be made on the 1st business day of each month.*

5. Terms and Conditions

By the signature(s) below, I or we agree and consent to all of the terms and conditions stated herein.

1. The Company is authorized to debit the account or to initiate electronic funds transfer from the financial institution identified above on or about the 15th or 1st of each month to pay premiums due and/or to pay the policy loan on the policy(ies) identified above. If neither, or both the 1st or 15th is selected, the 15th will be the default date for drafting. Due to timing of the authorization, the initial transfer processed may result in more than one premium payment being withdrawn.
2. The Company is authorized to make monthly withdrawals from the specified account. The Company's treatment of each check or debit, and its' rights with respect to it, will be the same as if it were signed or initialed personally by the Authorized Signer of Account. If any check or debit is dishonored by the bank or financial institution for any reason, the premium payment will be reversed and the premium will not be considered paid. This may cause the policy to lapse in accordance with the provisions of the policy and result in the forfeiture of insurance.
3. Completion of this form shall not constitute a premium payment and/or loan payment. Multiple months' premiums may be required to bring the policy to a current due date.
4. This Bank Draft Authorization (Request for Guard-O-Matic Arrangement) may be terminated by the Policy Owner, the Company, or the Authorized Signer of Account (if different from Policy Owner) upon written notice. The Policy Owner or Authorized Signer of Account may cancel this Authorization by giving the Company 30 days' written notice. This Authorization is to remain in effect until the Company receives written notice of its revocation unless the Company ends it earlier.
5. If the Loan Payment Authorization is cancelled, any outstanding loans will remain unpaid.
6. The Company may try a second time for any withdrawal returned due to insufficient funds. The Company may terminate this Authorization immediately by written notice in the event any withdrawal or electronic fund transfer is dishonored for any reason.
7. A confirmation statement for premium payments paid for non-variable products through this Bank Draft Authorization will not be sent. Information provided by the bank or financial institution may be helpful to reconcile the deductions.
8. For details on the bank draft monthly payments, please refer to the Policy Owner's annual benefits statement, policy, or product prospectus, as applicable. For any questions about the policy or about the amounts to be drafted to pay premiums or loan principal, please contact the servicing agent on the policy or the Customer Call Center at the number provided below.
9. For Universal or Variable Universal Life Insurance, the policy is designed to have flexible premiums. Policy Owners should consider paying the necessary amount each month to keep the policy in force. The Policy Owner will receive notification if additional payments are required to keep the policy from lapsing.
10. The Company should be provided with 30 days' advance notification of any change in the banking information provided above. If advance notification cannot be provided, sufficient funds should be left in the account identified above in this form to honor charges until the Company's records are changed.
11. Any change in name or address of the Authorized Signer of Account or Policy Owner must be communicated immediately to the Company.
12. If this service is no longer in effect, premiums will be due according to the most frequent payment mode offered for the policy. Loan repayments scheduled under the Loan Payment Arrangement will no longer be automatically deducted. Any future loan repayment will be the Policy Owner's responsibility.
13. Any bank fees are the responsibility of the Authorized Signer of Account.

5. Terms and Conditions (Continued)

14. I/we authorize Guardian and its officers, directors, agents, employees and representatives to make any inquiries that Guardian considers necessary to validate the account identified above and/or investigate any dispute involving your premium payment, which may include verifying the information I/we provide and/or that Guardian acquired against third party databases.

15. I/we authorize Guardian (or its agent or representative) to initiate one or more debits by electronic fund transfers (withdrawals), and I/we authorize the financial institution that holds my/our account to deduct such payments, in the amounts and frequency designated in your then-current premium payment mode.

_____ _____

Signature of Bank Account Owner Date

_____ _____

Signature of Policy Owner, if other than Bank Account Owner Date

Life Insurance

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

Email: ILSolutions@glic.com
Customer Call Center: 1-888-GUARDIAN (482-7342)
Fax: 610-807-2720

The Guardian Insurance & Annuity Company
Park Avenue Variable Life
P.O. Box 981588
El Paso TX 79998-1588

Email: VULSolutions@glic.com
Customer Call Center: 1-888-GUARDIAN (482-7342)
Fax: 610-807-2940

Disability Income Insurance

Berkshire Life Insurance Company of America
Policy Services
P.O. Box 981594
El Paso TX 79998-1594

Email: Diprocessing@glic.com
Customer Call Center: 1-888-GUARDIAN (482-7342)
Fax: 413-395-5992