Clear Form | Print Form

GUARDIAN®

Customer Service Office
3900 Burgess Place
Bethlehem, PA 18017

☐ **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.)

LIFE INSURANCE CHANGE REQUEST FORM

Please print

1. General Information (Complete in ALL cases)

Name of Insured: _____ Insured's Date of Birth _____

Policy Owner's Name _____

Agency Name/Code: _____

Please complete Agent's Certification to provide Agent information and other information.

2. Conversions & Exchanges

***Instructions**:*

- *Most simple term conversions and LifeSpan exchanges can be requested on the "**Term Conversion/ Exchange Express Request Form**", form **L-AP-CONV-2001**. Please refer to the Instructions printed on form L-AP-CONV-2001 for further information. This Change form should only be used for those situations that do not meet the criteria for express handling.*
- *If this Change form must be used for the requested transaction, please complete Sections 1, 2, 4, and 12 of this form. If the conversion involves underwriting (e.g., conversion to a higher face amount, or the addition of a rider or benefit), please also complete Section 7 of this form, the Authorization and any required medical Part II. If the new policy is to be variable life, please also complete a Variable Life Supplement and any other forms required for a new variable life product (e.g., the Non-Brokerage Account Application and Explanation of Investment forms).*

a) Is the Insured currently totally disabled as defined in the Waiver of Premium Rider included in the policy? ☐ Yes ☐ No *(If yes, give details in Remarks Section)*

b) Policies/Riders to be converted/exchanged:

Description of Original Coverage	Policy Number	Full/Partial *	Amount remaining in force (for partial conversion only)
_____	_____	☐ Full ☐ Partial	_____
_____	_____	☐ Full ☐ Partial	_____
_____	_____	☐ Full ☐ Partial	_____
_____	_____	☐ Full ☐ Partial	_____

** If a partial exchange of a VUL or PAL policy is being requested, the Owner agrees that the Company may split the policy into 2 policies. One of the new policies will be exchanged in accordance with the Owner's request and the other policy will remain in force as a new VUL or PAL policy (depending on whether the original policy was VUL or PAL.)*

c) Effective date of Conversion or Exchange: _____

3. Guaranteed Purchase Option/Guaranteed Insurability Option

***Instructions**:*

- *If the original policy is other than a UL or VUL policy, complete Sections 1, 3, 4, 8 and 12 of this form.*
- *If the original policy is a UL or VUL policy, then complete Sections 1, 3, and 12 of this form. Since the amount exercised under the rider will be treated as a face amount increase under the base policy, please indicate in Section 5d if any change is being made to the Planned Premium as a result of the GIO exercise.*
- *If the new policy is to include riders, then please also complete Section 7, the Authorization and any required medical Part II.*

Policy Number(s)	Type of Option Date	Amount Exercised
_____	☐ Regular ☐ Alternate *	$ _____
_____	☐ Regular ☐ Alternate *	$ _____
_____	☐ Regular ☐ Alternate *	$ _____

* For Alternate Option Date, please indicate: date of applicable event: _____ and reason

☐ Marriage ☐ Birth of Child(ren) ☐ Adoption of Child(ren) ☐ Other (please identify) _____

IMNB320010010101

4. New Policy Information (for conversions, exchanges, GIO, etc)

Instructions:
When making a conversion, exchange, exercising a GIO option, or any other situation where a new policy is to be issued, use this Section to provide details about the new policy.

New Policy Plan_____ **Face Amount** _____

Riders (give type and, if applicable, amount) _____ _____
_____ _____
_____ _____

Dividend Option _____ **Premium Mode *** _____ **APL?** ☐ Yes ☐ No *(Default is Yes)*

Death Benefit Option _____ **Planned Premium** *(UL/VUL)* _____ **7702 Test** _____

Owner _____

Beneficiary _____

Other Information _____

_____

_____

_____

_____

** If adding this policy to an existing G-O-M arrangement, please provide existing policy number in "Other information".*

5. Universal Life/Variable Universal Life Changes

Instructions:

- *For face amount increases (not due to exercise of GIO), please complete Sections 1, 5, 7, 12, the Authorization, and any required Part II. If the product allows face increases to be specifically allocated to Basic Sum Insured and Additional Sum Insured, please indicate how the face increase is to be issued in Section 10, Remarks.*
- *For face amount decreases, complete Sections 1, 5 and 12 of this form.*
- *For changes in Death Benefit Option, please complete Sections 1,5 and 12 of this form. However, for changes from Option 1 to Option 2, underwriting may be required (depending on the product). If so, you must also complete Section 7, the Authorization and any required medical Part II.*

(a) Face Amount Changes

Policy Number	Type of Change	Amount of Face Change *(do not enter resulting face amount)*
_____	☐ Increase ☐ Decrease	$ _____
_____	☐ Increase ☐ Decrease	$ _____
_____	☐ Increase ☐ Decrease	$ _____

(b) Is the Insured currently totally disabled as defined in a disability Waiver benefit included in the policy? ☐ Yes ☐ No
If Yes, please give details in Remarks section, and also indicate which type of Waiver rider (e.g., Waiver of Monthly Deductions, Disability Benefit Rider, or both).

(c) If increasing the face amount, are you also requesting an increase in the Specified Amount under a Disability Benefit Rider?
☐ Yes Amount of Increase $_____ ☐ No

(d) Change in Planned Premium *(can be done in conjunction with a face amount change, or separately)*

New Planned Premium: _____ New Premium Mode, if applicable _____

(e) Change in Death Benefit Option

Change From:		To:	
☐	Option 1	☐	Option 1
☐	Option 2	☐	Option 2
☐	Option 3		

6. Other Policy Changes

Change applies to Policy Number(s) _____

- ☐ Plan changes* to: _____
- ☐ Redate* to:_____
- ☐ Add rider/benefit* _____
- ☐ Cancel rider/benefit _____
- ☐ Rating improvement request*_____
- ☐ Exercise Simplified Insurability Option* _____
- ☐ Increase Coverage* to:_____
- ☐ Reduce Coverage ** to:_____
- ☐ Correction of Age _____ (provide birth certificate)
- ☐ Change Premium Mode _____
- ☐ Change Dividend Option * to _____ (effective on next anniversary)
- ☐ Place Policy on Nonforfeiture Option _____
- ☐ Other* (explain below)

_____

_____

_____

_____

_____

Instructions:

** Some policy changes involve additional underwriting. For these changes, please complete Sections 1, 6, 7 and 12 of this form, the Authorization and any required medical Part II. If the change being made does not require additional underwriting, then please complete Sections 1, 6 and 12 of this form only.*

*** (Note: for reductions in face amount, include instruction on how any release of cash value is to be handled. If not specific, release of cash value will be used to Purchase Paid-Up Additions.)*

7. Personal History of the Insured

		Yes	No
a.	Since the coverage was originally issued:		
	(i) have you changed your occupation or do you intend to do so?……	☐	☐
	(ii) has there been any illness, injury, or surgical operation?……	☐	☐
	(iii) have you consulted a physician or other practitioner, or have you had any lab, x-ray or other diagnostic test?….	☐	☐
	(iv) have you flown, or do you contemplate flying, as a pilot or crew member?……..	☐	☐
	(v) have you had disability, accident, medical or life insurance declined, postponed, modified, rated, cancelled or withdrawn a pending application, or had a renewal or reinstatement refused?……..	☐	☐
b.	Within the past 12 months, have you experienced or are you experiencing any symptoms for which you are considering seeking medical attention or advice?……	☐	☐
c.	Have you smoked cigarettes in the past 24 months?…….. (If you have quit, date last used: _____)	☐	☐
d.	Have you used tobacco in any form in the last 12 months?……	☐	☐
	If "No", have you used tobacco in any form in the last 24 months?……	☐	☐
	If "No", have you used tobacco in any form in the last 48 months?…… (If you have quit, date last used: _____)	☐	☐
e.	Do you currently use a nicotine patch or nicotine gum?……..	☐	☐

f. Please indicate the name(s) and address(es) of your physician(s).

Name _____

Address _____

g. Please provide information regarding the last time you consulted with each of the listed physicians.

Date _____

Reason _____

Results _____

8. Replacement/Existing Coverage

Does the owner/applicant have any existing individual life insurance policies or annuity contracts (including those in the process of being lapsed or surrendered)? ☐ Yes ☐ No *(If "Yes", please complete appropriate state replacement forms.)*

9. Reinstatement

Reinstatement of policy number _____ which lapsed for non-payment of premium due on _____ .
The following amount is enclosed in payment of the costs to reinstate the policy $_____ .

Instructions: *Question **a** is asked of the policyowner. The remainder of the questions are asked of the person to be insured under the reinstated policy. If there are other persons to be insured under the reinstated policy (e.g., a Survivorship policy or a Beneficiary Insurance Option rider), a separate Change form for each such person is required. Please provide full details in Remarks section (Section 10) for any "yes" answers to the following questions.) In addition to this Section, please also complete Sections 1 and 12, the Authorization, and any required medical Part II.*

		Yes	No
a.	Has any person died who was ever insured under this policy or any rider attached to this policy?.....	☐	☐
b.	Within the past 5 years, have you:		
(i)	Had any medical or surgical treatment, observation or consultation?.....	☐	☐
(ii)	Had disability, accident, medical or life insurance declined, postponed, modified, rated, cancelled or withdrawn a pending application, or had a renewal or reinstatement refused?.....	☐	☐
(iii)	Made claims for or received benefits under any life or health insurance policy or prepayment plan, workmen's compensation or state or federal disability law, any pension or other allowance governmental or otherwise?.....	☐	☐
(iv)	Made any aerial flights, except as a fare-paying passenger?.....	☐	☐
c.	Within the past 12 months, have you experienced or are you experiencing any symptoms for which you are considering seeking medical attention or advice?.....	☐	☐

d. What is your current occupation? _____

e. How much life insurance is in force or applied for on your life (not including this policy)?_____

10. Remarks

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

12. Representations (Complete in ALL cases)

Those parties who sign below, agree that:

1. Approval by the Company of the changes requested shall be based upon this Life Insurance Change Request form, and on the statements and representations made herein and in any required Part II or other supplement forms, all of which shall be attached to the policy.
2. All of the statements and answers 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.
3. For any new insurance: any misrepresentation or omission, if found to be material, may adversely affect acceptance of the risk, claims payment or may lead to rescission of any policy or new coverage that is issued based on this application.
4. No agent, broker or medical examiner has any right to accept risks, make or change contracts, or to waive or modify any of the Company's rights or requirements. 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.
5. Changes or corrections made by the Company and noted in Section 11 of this form are ratified by the undersigned upon acceptance of the new policy or policy change. Amendments made other than for administrative purposes will only be made with the Owner's written consent.
6. When a new policy is to be issued as a result of the requested policy change and no underwriting is required for the transaction, the new policy will take effect on the later of the policy date of the new policy or the date the first premium is paid. If the transaction does involve underwriting, then the portion of the new policy that was subject to underwriting will not take effect until the later of the policy date or the date the first premium is paid during the lifetime and prior to any change in health of the Proposed Insured. The policy date is the date from which premiums are calculated and become due.
7. For any new policy issued as a result of the requested change, 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.
8. In the case of reinstatement: (a) that the reinstatement, if approved by the Company, shall be contestable to the same extent and for the same period of time as was the original policy, beginning from the effective date of this reinstatement; (b) that no reinstatement shall take effect unless and until this application is approved by the Company and payment of any overdue premiums have been made during the lifetime of any insureds covered under the reinstated policy; (c) that any payment taken in connection with this application shall be collected at the risk of and for the account of the payor. Any payment made shall remain the payor's property until the Company approves this application. If it is not approved, any payment made shall be returned to and accepted by the payor, without interest; and (d) upon reinstatement, no benefit shall be paid if the death of any insured occurs between the end of the grace period and the effective date of reinstatement.

Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

Signed at: _____ on _____
City and State mm/dd/yyyy

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

_____ _____
Signature of Additional Owner Witness (for applications taken by mail)

☐ Check here if this form was taken by mail. If application is taken by mail, the signature of the agent does not attest to the signature of the Proposed Insured or Owner if Other than the Proposed Insured.

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

_____ _____
Signature of Licensed Agent License Number(s)

_____ _____
Agent's Name State(s) where licensed

Life Customer Service Office
3900 Burgess Place
Bethlehem, PA 18017

Disability Customer Service Office
700 South Street
Pittsfield, MA 01201

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

Insurance Information Practices

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

Notice to _____
Proposed Insured

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

Fair Credit Reporting Act Pre-Notice

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

Medical Information Bureau Pre-Notice

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

If you so request of the Bureau, it will arrange to disclose the information it may have in your file. If you question the accuracy of the information in the Bureau's file, you may contact the Bureau and seek to correct the information according to procedures set forth in the Federal Fair Credit Reporting Act. The Bureau's address is Post Office Box 105, Essex Station, Boston, MA 02112, and its telephone number is 866-692-6901 (TTY 866-346-3642 for the hearing impaired).

Medical Records

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

Personal Information Telephone Interview

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

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Pittsfield, MA 01201

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

Authorization to Obtain and Release Information

Name of Proposed Insured _____ Date of Birth _____

Address of Proposed Insured _____

_____

This Authorization complies with the HIPAA Privacy Rule

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

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

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

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

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

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

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

_____
Signature of Proposed Insured or Personal Representative

_____
Personal Representative's Authority or Relationship to Proposed Insured

_____
Witness Signature

C-AUTH-2003

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AGENT'S CERTIFICATION

(Please Print)

This Agent's Certification is to be used with the application for life insurance on the life of _____ (Proposed Insured) for the application dated _____. Proposed Insured's Date of Birth: _____.

1. How long have you known the Proposed Insured? _____ Years; Proposed Owner? _____ Years
2. If Proposed Insured is not gainfully employed, indicate amount of insurance on premium payor's life and relationship to Proposed Insured. _____
3. If beneficiary is estate, explain in Remarks why, and who will ultimately receive the proceeds of the policy?
4. 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
5. Do you have knowledge of any existing life insurance policy or annuity contract in force on the Proposed Insured? ☐ Yes ☐ No
6. a. Did every person signing this application communicate in English well enough to understand and answer each question in English? ☐ Yes ☐ No (If no, please answer questions 6b, 6c, and 6d)
   b. Who acted as interpreter? _____
   c. If English was not used as the primary language, which language and/or dialect(s) was the sales interview conducted in? _____
   d. For the purpose of completing any Personal Information Telephone Interview, the proposed insured can converse comfortably in: _____
7. **Complete if Medical Examination necessary.** Medical Requirements being submitted:
   ☐ Chest X-ray ☐ EKG ☐ Stress EKG ☐ Full Blood ☐ Saliva ☐ Urine
   ☐ Paramedical Exam ☐ Medical Exam ☐ Other _____
8. Remarks (and additional instructions):

_____

_____

_____

9. Commissions

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

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 agent or broker is duly appointed and licensed in the state in which this application was signed and for the product(s) proposed.

Dated at _____, _____ this _____ day of _____, _____.
City and State (month) (year)

_____ _____
Type or print Agent's/Dealer's name Signature of Soliciting Agent

_____ _____
Signature of Approved Registered Principal (For Variable Life Only) Signature of General Agent

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