



THE GUARDIAN LIFE INSURANCE COMPANY OF AMERICA (Guardian)
THE GUARDIAN INSURANCE & ANNUITY COMPANY, INC. (GIAC)
BERKSHIRE LIFE INSURANCE COMPANY OF AMERICA (Berkshire)

Customer Service Office
3900 Burgess Place Bethlehem, PA 18017

INSTRUCTIONS FOR COMPLETING THE LIFE INSURANCE APPLICATION

(Please detach before mailing)

*All questions must be answered completely. **Any changes to these answers must be initialed by the Proposed Insured, Owner, if Other than Proposed Insured, and Agent.** An agent has no authority to waive, change or limit any question on the application.*

For all new Individual Traditional Life complete the following:

- Insurance Information Practices (the form should be left with the Proposed Insured);
- All pages of the Part 1 application;
- Authorization;
- Part 2 Non-Medical Supplement if a paramedical or medical examination will not be required;
- Conditional Receipt for Life Insurance if cash is being paid with the application. This form should be left with the applicant. Note that there are specific conditions under which cash may be paid with the application. In addition to the conditions listed in the Conditional Receipt form itself please note that cash cannot be accepted with the application (and the Receipt therefore should not be used) if the total amount of coverage being applied for is over \$5,000,000 for a Guardian or GIAC application, or over \$2,500,000 for a Berkshire application;
- Agent's Certification.

In addition to the forms listed above and contained in this package, other forms may be required such as:

- Aviation Supplement, Avocation Supplement, Alcohol/Drug Use Supplement
- HIV Notice and Consent Forms
- Replacement forms
- Illustration Certification, if used in lieu of illustration
- Medical/Paramedical Part 2 Supplement
- "Elite" Underwriting Class Supplement
- Guard-O-Matic Forms
- Other miscellaneous disclosure forms, depending on the product and state

All of the above forms are not contained in this application package, but are available in Guardian Online, through either the Forms on Demand function or the New Business Resource Center function.

For all new Individual Variable Life products:

- Complete all of the applicable items listed above for Traditional Life;
- Complete a Variable Life Supplement (form L-AP-VLI-2004 or appropriate state variation);
- Provide applicant with Patriot Act Notice (Notice to Applicants for Variable Life Insurance, form USAPA-VLI);
- Complete any other forms needed for variable life such as the Non-Brokerage Account Application and Explanation of Investment forms



Life Customer Service Office
3900 Burgess Place
Bethlehem, PA 18017

Disability Customer Service Office
700 South Street
Pittsfield, MA 01201

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

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

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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Bethlehem, PA 18017

- THE GUARDIAN LIFE INSURANCE COMPANY OF AMERICA
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 - BERKSHIRE LIFE INSURANCE COMPANY OF AMERICA
- (Please check appropriate company. In this application, "the Company" is the insurer checked above.)

APPLICATION FOR LIFE INSURANCE

Part 1

Please print

(Page 1 of 7)

I. Proposed Insured Information

- a. First Name _____ MI _____ Last Name _____
- b. Social Security # _____
- c. Sex Male Female
- d. Date of Birth (mm/dd/yyyy) _____
- e. Place of Birth _____
- f. Are you a U.S. citizen? Yes No
- g. Marital Status
- If no, give: Visa Type _____ Married Single Separated
- Visa Duration _____ Widowed Divorced
- Other _____
- h. Address _____
- City _____ State _____ Zip _____
- i. How long at this address? _____
- j. Home phone _____
- k. e-mail address _____
- l. *If less than 2 years at current address, please furnish previous address:*
- Address _____
- City _____ State _____ Zip _____
- m. Telephone Interview – if more information is needed, a representative may call you. Show the most convenient place and range of times for such a call weekdays between the hours of 9:00 a.m. and 9:00 p.m.
- Home Business Other – Phone _____ Times _____ a.m. p.m.

2. Employment Information

- a. Name of Employer _____
- b. Address _____
- City _____ State _____ Zip _____
- Business Phone _____ Business Web Site _____
- c. If address is P.O. Box, include street address as well:
- Address _____
- City _____ State _____ Zip _____
- d. Occupation _____
- e. Job Title _____
- f. Nature of Business _____
- g. How many years employed? _____ *(If less than 2 years please furnish previous employer below)*
- h. Former Employer _____
- Address _____
- City _____ State _____ Zip _____
- i. Occupation _____
- j. Job Title _____
- k. Nature of Business _____



3. Owner Information

(Complete only if the proposed insured is NOT to be the policyowner)

- a. Owner name (First, MI, Last) or name of trust, company or other owner:
b. Social Security No./Tax ID No. c. Relationship to proposed insured
d. Street Address
e. Telephone Number
f. Tax Qualified Plan? Yes No
g. Complete if Policy is Trust Owned:
Date of Trust
Complete Names of Authorized Trustees

4. Beneficiary Information

Print full name and relationship to Proposed Insured. (Unless otherwise indicated, all Primary Beneficiaries who survive the Insured shall share equally. If no Primary Beneficiary survives the Insured, benefits will be paid in equal shares to the Contingent Beneficiaries, etc., if surviving the Insured, unless otherwise specified).

- a. Primary Beneficiary
b. Contingent Beneficiary
c. Tertiary Beneficiary

5. Purpose of Insurance

Please describe the purpose of the proposed insurance (check one or more of the following, or describe in "Other"):

- Buy-Sell, Deferred Compensation, Charitable Planning, Family Income, Mortgage, Key Person, Split Dollar, Estate Planning, Retirement, Spouse/Child Insurance, Executive Bonus, Collateral for Debt, Wealth Accumulation, Education, Other

6. Financial Information

Personal Finances (This section applies to the proposed insured. If this policy is business owned, please also complete the Business Finances section below.)

- a. Total Assets \$ b. Total Liabilities \$ c. Net Worth \$
d. Earned Income \$ e. Unearned Income (if in excess of \$10,000) \$

Business Finances (Complete if policy is business owned)

- f. Type of Business (Check One): Limited Liability Co. Sole Proprietor Partnership S Corp C Corp Other
g. Total Assets \$ h. Total Liabilities \$ i. Net Worth \$
j. Net Profit After Taxes for past Two Years: Last Year \$ Previous Year \$
k. How long has the business been established?
l. What is the nature of the business?
m. What percentage of the business is owned by the proposed insured?
n. Is there business insurance applied for or in force on other key members of this firm? Yes No
If "yes", please provide details:

7. Proposed Insurance

a. Plan of Insurance _____ Base Policy Face Amount \$ _____

b. Riders

Traditional Life/Term Riders (Note: Option Q and R riders are elected in the Dividends Section)

- Accidental Death Benefit (ADB) ADB Face Amount: \$ _____
- Waiver of Premium (WP) Initial Period Waiver of Premium (For LifeSpan only)
- Scheduled/Unscheduled Paid-Up Additions (EPUA) Rider Unscheduled Only Paid-Up Additions (EPUA) Rider
 - If a Scheduled PUA Payment is desired, indicate annual amount \$ _____
 - If an Initial PUA Payment is to be made, indicate amount (not including first Scheduled payment) \$ _____
 - If Waiver of Specified Amount benefit is requested, indicate annual Specified Amount \$ _____
- Guaranteed Purchase Option (GIO)/Whole Life Purchase Option Option Amount: \$ _____
- Accelerated Benefit Rider (EABR/ABR) (please complete required disclosure form)
- 10 Year Annually Renewable Term (RTR-10) Term Amount: \$ _____
- Paid-Up Insurance Rider (for EMP, GIWL, SUPP only) Equivalent Annual Deposit, excluding Waiver \$ _____
- Paid-Up Additions Rider (for EMP, GIWL, SUPP only) First Year Purchase Payment \$ _____
- DuoGuard (List names & amounts for Designated Lives. Complete a separate application for each Designated Life.)

Name of Designated Life	Amount	Name of Designated Life	Amount
_____	\$ _____	_____	\$ _____
_____	\$ _____	_____	\$ _____
_____	\$ _____	_____	\$ _____
- Exchange to Term Insurance Select Security Rider
- Other _____ \$ _____ Other _____ \$ _____

Universal Life and Variable Life Riders

- Additional Sum Insured (Do NOT include this amount in Base Face Amount shown above) \$ _____
- Secondary Guarantee Coverage Rider/Guaranteed Coverage Rider (for VUL GCR, elect coverage to age _____)
- Accidental Death Benefit (ADB) ADB Face Amount: \$ _____
- Waiver of Monthly Deductions
- Disability Benefit Rider Monthly Specified Amount: \$ _____
- Guaranteed Insurability Option Option Amount \$ _____
- Adjustable Annual Renewable Term Term Amount: \$ _____ Select Security Rider
- Other _____ \$ _____ Other _____ \$ _____

Riders for Survivorship Products (EstateGuard, SVUL, etc.)

- Survivorship Waiver of Premium (Death Waiver) (available on one or both of the base policy insureds) 10 Year 15 Year
 - (1st Insured) _____ (2nd Insured) _____
- Policy Split Option
- Adjustable Annual Renewable Term (on both insureds) Term Amount: \$ _____
- Single Life Term/RTR 85 (available on one or both of the base policy insureds)
 - (1st Insured) _____ \$ _____
 - (2nd Insured) _____ \$ _____
- Second to Die DuoGuard (List names & amounts for Designated Lives. Complete a separate application for each Designated Life.)

Name of Designated Life	Amount	Name of Designated Life	Amount
_____	\$ _____	_____	\$ _____
_____	\$ _____	_____	\$ _____
- First To Die DuoGuard (available on one or both of the base policy insureds)
 - (1st Insured) _____ \$ _____
 - (2nd Insured) _____ \$ _____
- Split Dollar Protector (available on one or both of the base policy insureds)
 - (1st Insured) _____ (2nd Insured) _____
- Other _____ \$ _____ Other _____ \$ _____

8. Premiums

- a. Mode
 - Annual Semiannual Quarterly Monthly *(list bill only – this may not be available for all products)*
 - Guard-O-Matic *(complete the appropriate Request Form)*
 - New Service Add to my existing service Existing Policy Number _____
 - Other _____
- b. Who is to pay premiums? _____
- c. Send premium notices to:
 - Residence Business Owner's address Other _____
 - List Bill
 - New – Billing Name _____ Common billing date _____
 - Existing account # _____
- d. Automatic Premium Loan (if available) Yes No *(if left blank, default will be Yes)*
- e. Complete for VUL/UL policies:
 - Initial Premium \$ _____ Planned Premium (at the mode indicated above) \$ _____
- f. Complete for Variable Whole Life (PAL) policies:
 - Initial Premium \$ _____ Planned Modal Unscheduled Payment \$ _____
- g. Prepayment of Premium
 - No money is being submitted with this application.
 - Money is being submitted with this application, in the amount of \$ _____ for proposed life insurance in the amount of \$ _____ in exchange for the Conditional Receipt providing proposed conditional coverage for this amount of insurance only. Please see the Conditional Receipt for the circumstances under which money can be paid with this application, and Item (3) under "Conditions" in the Receipt for rules pertaining to the amount of life insurance that can be entered above.

9. Dividends (for participating policies only)

- A-Paid in cash
- B-Reduce premiums
- C-Left at interest *(Complete W-9 form if elected)*
- D-Paid-Up Additional Insurance *(Option D will be the default option if no other is elected)*
- F- Term Insurance face amount not in excess of cash value/Balance to purchase paid-up additional insurance
- G-Term Insurance face amount not in excess of cash value/Balance to reduce premium
- K-Deferred Additional Insurance (EMP plans only)
- L- Term Insurance face amount not in excess of twice face amount of basic policy/Balance to purchase paid-up additional insurance
- P- Term Insurance face amount not in excess of twice face amount of basic policy/Balance to reduce premium
- Q- One Year Term Insurance not to exceed Target Face Amount* of \$ _____
- R- One Year Term Insurance with Increasing Target Face Amount* Initial Target \$ _____
 - Level Increases % _____ Compound Increases % _____
- S- Premium Offset – *(available only if a PUA rider is requested. Premiums to be offset at the end of the first policy year by use of PUA rider additions and future dividends)* with Target Face Amount* not to exceed \$ _____
- U-Loan Repayment/Balance to Paid-up Additions
- Other _____

* Do not include the base policy face amount in the Target Face Amount.

10. Additional Information for VUL/UL Policies

- a. **Death Benefit Option** *(Note, not all options may be available with all policies)*
 - Option 1 Option 2 Option 3 Other _____
- 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 are 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

11. Replacement/Existing Insurance

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.)

12. Existing Insurance on Proposed Insured

Are there any existing life insurance policies or annuity contracts in force on the proposed insured? Yes (please list below) No

A. Life insurance policies

<u>Name of Company</u>	<u>Year Issued</u>	<u>Amount</u>	<u>Personal or Business</u>	<u>Accidental Death Amt</u>	<u>Waiver of Premium</u>	<u>GIO Amt</u>
_____	_____	_____	<input type="checkbox"/> Per. <input type="checkbox"/> Bus	_____	_____	_____
_____	_____	_____	<input type="checkbox"/> Per. <input type="checkbox"/> Bus	_____	_____	_____
_____	_____	_____	<input type="checkbox"/> Per. <input type="checkbox"/> Bus	_____	_____	_____

B. Annuity contracts

<u>Name of Company</u>	<u>Year Issued</u>	<u>Waiver of Premium</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

13. Personal History of the Proposed Insured

(These questions apply to the Proposed Insured. Please provide details in Remarks section for any "yes" answers to the following questions, except for 13c.)

- | | Yes | No |
|--|--------------------------|--------------------------|
| a. Do you intend to change your occupation?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Do you intend to reside or travel outside of the U.S.?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Do you drive a motor vehicle? | <input type="checkbox"/> | <input type="checkbox"/> |
| Driver's License State _____ Driver's License # _____ | | |
| d. Within the past five years, have you been charged with and/or convicted of any motor vehicle moving violations or had your driver's license suspended or revoked? (If yes, details must include date of violation, description of violation and penalty.)..... | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Within the last ten years, have you been convicted of a felony, or is such a charge pending against you?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Within the last three years have you participated in, or do you intend to participate in, any of the following: piloting any type of aircraft; mountain climbing or rock climbing; scuba diving; hang gliding; parachuting or skydiving; or motor vehicle racing? (If yes to any, complete Aviation and/or Avocation Supplement.) | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Have you ever filed for personal or business bankruptcy? (If yes, give full details and date of discharge in Remarks section.) | <input type="checkbox"/> | <input type="checkbox"/> |
| h. Within the past five years, 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? | <input type="checkbox"/> | <input type="checkbox"/> |
| i. Have you smoked cigarettes in the past 24 months?..... (If you have quit, date last used: _____) | <input type="checkbox"/> | <input type="checkbox"/> |
| j. 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: _____) | <input type="checkbox"/> | <input type="checkbox"/> |
| k. Do you currently use a nicotine patch or nicotine gum?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| l. Do you plan to apply for or are you currently applying for any other life, disability or accident insurance? (In details, include amount and company applied with, and whether this other insurance will be in addition to or in lieu of insurance with Guardian/GIAC/Berkshire.) | <input type="checkbox"/> | <input type="checkbox"/> |

Application For Life Insurance – Part I (continued)

Representations of the Proposed Insured and Owner

(Page 7 of 7)

Those parties who sign below, agree that:

1. This application, (Part 1, Part 2, the Authorization, the Variable Life Supplement, if applicable, and any other supplements to the application) will form the basis for, and become part of and attached to, any policy issued.
2. That 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.
3. No agent, broker or medical examiner has any right to accept risks, make or change contracts, or to waive or modify any of the Company's rights or requirements. 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.
4. Any misrepresentation or omission, if found to be material, may adversely affect acceptance of the risk, claims payment or may lead to rescission of any policy that is issued based on this application.
5. The policy date is the date from which premiums are calculated and become due. The effective date is the date the policy is delivered and the first premium is paid. Except as provided in the Conditional Receipt (if an advance payment has been made and acknowledged and such Receipt issued) coverage does not begin until the effective date assuming the first premium is paid during the lifetime and prior to any change in the health of the Proposed Insured.
6. Changes or corrections made by the Company and noted in the "Amendments or Corrections" section are ratified by the Owner upon acceptance of a policy containing this application with the noted changes or corrections. In those states where written consent is required by statute or State Insurance Department regulation for amendments as to plan, amount, classification, age at issue, or benefits, such changes will be made only with the Owner's written consent.
7. 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. Check here if backdating to save age is being requested. Note that a request to backdate to save age can only be honored if permitted by state law. If not backdating to save age, but a specific policy date is being requested, please enter date here: _____

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

Signed at: _____ 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 application 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 application 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



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Disability Customer Service Office
700 South Street
Pittsfield, MA 01201

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BERKSHIRE LIFE INSURANCE COMPANY OF AMERICA

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

Authorization to Obtain and Release Information

Name of Proposed Insured Date of Birth

Address of Proposed Insured

This Authorization complies with the HIPAA Privacy Rule

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

Medical Records and other information. I authorize any physician, medical or mental health professional, practitioner, hospital, clinic, other health facility, pharmacy, pharmacy benefit manager, consumer reporting agency, the Social Security Administration, the Medical Information Bureau, insurance or reinsurance company, or employer, laboratory or 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. Non-medical information shall include data about my driving record; any criminal activity or association; civil action or bankruptcy court records; hazardous sport or aviation activity; use of alcohol or drugs, employment information, business pursuits, documentation of earned and unearned income; any claim of eligibility for disability income benefits; and other applications for insurance. 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. Except for disclosure of HIV related information, I agree that this authorization shall be valid for two years from the date shown below. With regard to disclosure of HIV related information, I agree that this authorization shall be valid for 180 days from the date shown below. I agree 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



IMNB0400000040201



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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 receipt, "the Company" is the insurer checked above.)

APPLICATION FOR LIFE INSURANCE
Part 2 - Health and Personal History of Proposed Insured

Complete this section ONLY if no Medical or Paramedical Exam is required

(Page 1 of 2)

PROPOSED INSURED INFORMATION

Please print:

- 1a. First Name MI Last Name
b. Date of Birth (mm/dd/yyyy)
c. Name and Address of your personal physician. If none, so state.
d. Date and reason last consulted
e. What treatment or medication was given or recommended?
f. Height: ft. in. Weight: lbs.
g. Weight change past year: Gain Loss lbs. Reason for change:

(If you answer "Yes" to questions 2-14, provide details in item #15 on the next page.)

- 2. Have you ever had or been treated for cancer or tumor?
3. In the last ten years, have you had, been treated for or received a consultation or counseling for:
i. high blood pressure, chest pain or disorder of the heart or circulatory system?
ii. diabetes or disorder of the glands, bone, blood or skin?
iii. complications of pregnancy, infertility, or any disorder of the breasts, reproductive or genital organs, prostate, kidneys, or urinary systems?
iv. hernia, hepatitis, or disorder of the liver, gall bladder, stomach, pancreas, spleen, intestines or rectum?
v. arthritis, rheumatism, or disorder of the joints, limbs or muscles?
vi. disorder or condition of the back, neck or spine?
vii. allergy, asthma, sinusitis, emphysema, disorder of the lungs or respiratory system, or sleep apnea?
viii. epilepsy, stroke, dizziness, headache, or disorder of the brain, or spinal cord?
ix. disorder of the eyes, ears, nose or throat?
x. anxiety, depression, nervousness, stress, mental or nervous disorder, or other emotional disorder?
xi. Chronic Fatigue Syndrome, Fibromyalgia, Epstein Barr virus or Lyme Disease?
4. Do you have any loss of hearing or sight, an amputation of any kind, or any physical deformity, impairment or handicap?
5. Within the past ten years, have you been diagnosed by or received treatment from a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or any deficiency of the immune system such as Human Immunodeficiency Virus?
6. i. Are you currently taking prescribed medication?
ii. Are you currently taking non-prescription medication?



IMNB0000000060201



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(Please check appropriate company. In this receipt, "the Company" is the insurer checked above.)

CONDITIONAL RECEIPT FOR LIFE INSURANCE

This Conditional Receipt is to be used with the application for insurance on (Proposed Insured) for the application dated. The Proposed Insured's Date of Birth is

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, AS CHECKED ABOVE. DO NOT MAKE CHECK PAYABLE TO THE AGENT/DEALER OR LEAVE PAYEE BLANK. CASH PAYMENTS AND MONEY ORDERS CANNOT BE ACCEPTED.

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

(a) The Insured answers "no" to all 4 medical questions asked below; (b) The insured's age on his or her nearest birthday is age 65 or less; (c) Payment is made concurrent with the signing of the application and such payment is at least equal to one-sixth of the annual premium for the amount of insurance entered below (or one month's premium in the case of a policy on Guard-O-Matic). Note: depending on the contractual provisions of the policy being applied for, the minimum payment referred to above may not be sufficient to put the policy in force). (d) The application is not taken by mail.

- 1) Has the Proposed Insured, within the last 12 months, been treated for or had any known heart attack, stroke or cancer?
2) Has the Proposed Insured, within the last 12 months, had an electrocardiogram because of chest pain or any other physical problem?
3) Has the Proposed Insured, within the last 12 months, taken medication for elevated blood pressure?
4) Within the past 10 years, has the Proposed Insured been diagnosed by or received treatment from a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or any deficiency of the immune system, such as Human Immunodeficiency Virus (HIV)?

IF ANY OF THESE QUESTIONS IS ANSWERED "YES" OR LEFT BLANK, THIS CONDITIONAL RECEIPT SHALL BE VOID.

Received from \$ for life insurance in the amount of \$

SEE CONDITION (3) BELOW FOR RULES ABOUT THE MAXIMUM INSURANCE AMOUNT. THIS RECEIPT WILL NOT BE VALID IF AN AMOUNT MORE THAN \$1,000,000 IS ENTERED ABOVE, OR IF A PREMIUM AMOUNT IS COLLECTED WHICH EXCEEDS THAT WHICH IS NECESSARY TO PROVIDE THE CONDITIONAL COVERAGE FOR THE AMOUNT OF COVERAGE ENTERED ABOVE. IN THIS CASE, THE ENTIRE PREMIUM PAID WILL BE REFUNDED.

Conditions:

- (1) Insurance shall be effective on the date of the Part I or the last dated Part II, whichever is later. Such insurance shall be in force only for such proportional part of a year as the above payment bears to the full annual premium for the above insurance amount.
(2) The Proposed Insured must be insurable as a standard risk under our 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.
If these conditions are not met, the Company shall have no liability under this receipt except to return the payment made.
If the Proposed Insured should die within 60 days of the date of this receipt and:
- After the required Parts I and II have been received at the Home Office; and
- After the last of any required medical examinations have been completed; then the Company shall not deny liability because of failure to submit any additional evidence of insurability it may have required. Instead, it shall determine insurability as of the effective date of insurance as indicated in Conditions of Insurance item (1) above.
(3) The total amount of life insurance available under this receipt cannot exceed the amount shown in Part I, Question 7 of the application, including the amount of any Accidental Death Benefit rider, 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). This amount, together with any insurance applied for or pending issue with the Company, shall not exceed \$1,000,000.
(4) No person, except the President, a Vice President or a Secretary of the Company has authority to alter or modify the printed provisions of this receipt.
(5) If any check or draft given in exchange for this receipt is dishonored when first presented for payment, this receipt shall be null and void.

Dated at City and State on month day year Signature of Agent/ Dealer

I have read the terms of this receipt and have had them explained to me by the agent/dealer. I 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.

Signature of Proposed Insured

Signature of Owner, if other than Proposed Insured



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
_____	<input type="text"/>	<input type="checkbox"/>	_____	<input type="text"/> % <input type="text"/>
_____	<input type="text"/>	<input type="checkbox"/>	_____	<input type="text"/> % <input type="text"/>
_____	<input type="text"/>	<input type="checkbox"/>	_____	<input type="text"/> % <input type="text"/>
_____	<input type="text"/>	<input type="checkbox"/>	_____	<input type="text"/> % <input type="text"/>
_____	<input type="text"/>	<input type="checkbox"/>	_____	<input type="text"/> % <input type="text"/>
_____	<input type="text"/>	<input type="checkbox"/>	_____	<input type="text"/> % <input type="text"/>

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

