



**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.")

## Underwriting Inquiry

This is a preliminary inquiry, not an application for insurance.

This form should be completed and submitted whenever company rules require, in accordance with the instructions in the Life and Disability Manuals. It must be signed by the Proposed Applicant.

<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 33%; text-align: center;">First</td> <td style="width: 33%; text-align: center;">MI</td> <td style="width: 33%; text-align: center;">Last</td> </tr> <tr> <td colspan="3">Name:</td> </tr> <tr> <td>Date of Birth:</td> <td colspan="2"> <input type="checkbox"/> Married   <input type="checkbox"/> Single         </td> </tr> <tr> <td colspan="3">Place of Birth:</td> </tr> <tr> <td colspan="3">Social Security #:</td> </tr> <tr> <td colspan="3">Address:</td> </tr> <tr> <td colspan="3">Name of Employer:</td> </tr> <tr> <td colspan="3">Occupation:</td> </tr> <tr> <td>Height:</td> <td colspan="2">Weight Change Past Year</td> </tr> <tr> <td>Weight:      lbs.</td> <td colspan="2"> <input type="checkbox"/> Gain   <input type="checkbox"/> Loss             lbs.         </td> </tr> <tr> <td colspan="3">Approximate Net Worth \$</td> </tr> <tr> <td colspan="3">Annual Income \$</td> </tr> </table>	First	MI	Last	Name:			Date of Birth:	<input type="checkbox"/> Married <input type="checkbox"/> Single		Place of Birth:			Social Security #:			Address:			Name of Employer:			Occupation:			Height:	Weight Change Past Year		Weight:      lbs.	<input type="checkbox"/> Gain <input type="checkbox"/> Loss lbs.		Approximate Net Worth \$			Annual Income \$			<p>Amount and Plan of Life/Disability Insurance proposed?</p> <p> <input type="checkbox"/> Waiver of Premium      <input type="checkbox"/> Accidental Death         </p> <p>Name and relationship of proposed beneficiary</p> <p>Life/Disability insurance now carried: (Include Group)</p> <table border="1" style="width: 100%; border-collapse: collapse; text-align: center;"> <thead> <tr> <th style="width: 10%;">Year</th> <th style="width: 20%;">Company</th> <th style="width: 15%;">Amount</th> <th style="width: 15%;">Plan</th> <th style="width: 10%;">Mo. Disability Income</th> </tr> </thead> <tbody> <tr><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td></tr> </tbody> </table>	Year	Company	Amount	Plan	Mo. Disability Income																																			
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**IN THE PAST FIVE YEARS WHAT ILLNESSES, DISEASES, OPERATIONS OR ACCIDENTS HAS PROPOSED APPLICANT HAD OR DOES PROPOSED APPLICANT NOW HAVE?**

Nature of illnesses including dates, number of attacks and duration of symptoms.

Attending physicians and practitioners (names and addresses) and dates of consultation.

**WHO IS PROPOSED APPLICANT'S REGULAR PHYSICIAN OR PRACTITIONER?**

Name \_\_\_\_\_

Date of Last Consultation \_\_\_\_\_

Address \_\_\_\_\_

Reason \_\_\_\_\_

Last application for insurance:

Date: \_\_\_\_\_ Company: \_\_\_\_\_ Amount: \_\_\_\_\_ Kind of Policy: \_\_\_\_\_  
Standard? \_\_\_\_\_ Ridered? \_\_\_\_\_ Rated? \_\_\_\_\_ Rating Class? \_\_\_\_\_ Extra Premium? \_\_\_\_\_

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Is there any formal or informal application pending or contemplated? (Give details and Company)

\_\_\_\_\_  
Soliciting Agent's Name

\_\_\_\_\_  
Agent No.

**I 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.

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

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

\_\_\_\_\_  
Signature of Proposed Applicant

\_\_\_\_\_  
Witness



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## Insurance Information Practices

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

**Notice to** \_\_\_\_\_

Proposed Insured

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

### Fair Credit Reporting Act Pre-Notice

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

### Medical Information Bureau Pre-Notice

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

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

Signature of Proposed Insured or Personal Representative

Personal Representative's Authority or Relationship to Proposed Insured

Witness Signature