

**BERKSHIRE LIFE INSURANCE COMPANY OF AMERICA**

Home Office: 700 South Street, Pittsfield, MA 01201

Berkshire Life Insurance Company of America is a wholly owned stock subsidiary of and an administrator for The Guardian Life Insurance Company of America, New York, NY

Application for Disability Insurance Option Exercises Instructions / Checklist**THIS APPLICATION PACKAGE INCLUDES:**

Application for Option Exercises – pages 1-2

Complete Sections 1-7 with the applicant.

This application should be used when applying for option exercises for Individual disability, Retirement Protection Plus, Overhead Expense, Disability Buy-Out and adding additional benefits. Only pages 1 and 2 are needed for individual disability options where elimination period, benefit period and riders remain the same. Applying for Retirement Protection Plus options would also require only pages 1 and 2.

Do you have the correct state form (where the applicant lives/works or where the original application was taken)?

Supplements to the Option Exercise

A supplemental form must be included with every Overhead Expense, Disability Buy-Out or Request for Additional Benefits application (including requests for Catastrophic Disability Benefit Rider).

Submit correct state form (to correspond with application submitted).

- Overhead Expense (OE)
 - Disability Buy-Out (DBO)
 - Request for Additional Benefits (including CAT)* – 2 pages
- *Provide your client a copy of the Insurance Information Practices (C-NIIP-2003) and complete and submit the Authorization to Obtain and Release Information (C-AUTH-2003)

Producer's CertificationProducer must be licensed and appointed where application was signed. **Authorization to Obtain/Release Information**

Form NON-MED-AUTH-7-2009 can be used for option exercises when no additional benefits are requested.

Obtain all appropriate signatures and submit with the application.

Submit this form on applications not requiring medical underwriting (i.e., FIOs with no additional benefits requested).

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

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

Option Exercise Transmittal

Complete the New Business transmittal (AA1732) in full and submit with the application.

Conditions of Coverage Forms

All prepayments must be submitted with a completed and signed Conditions of Coverage Form FIO-CC-2009.

Supplement to Application for Insurance

Use this when requesting the removal or reduction of benefits or when needing additional space for application details.

Financial Requirements

Include the most current financial documentation (i.e., 1040, Schedules, W-2, Paystubs, Employment Contract or YTD Profit and Loss).

Submit the application by either faxing it to 1-800-683-1195 or email Application_Requirements@Berkshirelife.com. Prepayment should be submitted using the Initial Premiums Reporting Requirements envelope #4129.



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Application for Disability Insurance Option Exercises

I. Proposed Insured Information

a. Name (First, Middle Initial, Last)
b. Date of Birth (mm/dd/yyyy)
c. Social Security #
d. Employer Name & Address (Street, City, State, Zip)
e. Telephone: Home, Business, Cell
f. Residence Address (Street, City, State, Zip)
g. Original Policy #

2. Options

a. Option Requested
b. Total amount to be exercised: Monthly Indemnity, Lump Sum (if DBO)
c. If requesting Retirement Protection Plus (RPP), please select elimination period: 180 days, 360 days

3. Occupational Information

Explain "Yes" answers in Details.

a. Are you actively at work on a full-time basis in the occupation(s) listed below?
b. Are you currently disabled and/or collecting disability benefits?
c. Occupation(s) and Duties
d. Details (please reference question #)

4. Personal Information of the Proposed Insured

a. Employment Status
b. Earned Income (Business owners include share of business profit/loss in addition to wages.)
c. Unearned Income (Unearned income or passive income includes, but is not limited to, income from dividends, capital gains, interest (including tax exempt interest), rentals, royalties, retirement plans, alimony, investments, and business interests as an inactive owner.)
d. Do you participate in a qualified retirement plan such as a 401(k), 403(b), SIMPLE, IRA or profit sharing?
e. Total Annual Retirement Contribution (including your contribution and employer contributions)
f. Do you wish to have this retirement contribution considered as part of your earned income?
g. Total Net Worth if 6 million dollars or more (assets minus liabilities, excluding primary residence)
h. Have you ever filed bankruptcy?

5. Other Disability Coverage of the Proposed Insured

a. Do you have disability insurance in force or applied for, or are you eligible for disability insurance within the next 12 months with any company, including Guardian or Berkshire?

b. Describe all disability income pending or in-force coverage (If none, please answer "none.")

Type of Insurance: Individual (IDI), Group (G), Overhead Expense (OE), Disability Buy-Out (DBO), Retirement Protection (RP), Association (A), Other (O – Explain)

Status: I = In Force, P = Pending, E = Eligible For

Company Name	Type	Status	Benefit Amount	Benefit Period	Social Insurance Benefit	Automatic Increase Option	Catastrophic Benefit	Employer pay?*(Y/N)	Is this being replaced (Y/N)? If 'Y,' Date for Coverage to be Replaced	Amount to be Replaced?

*Does your employer pay the premium and not include it as taxable income to you?

6. Premium Information

- a. Premium Structure: Level Graded Step Rate
- b. What percentage of the premium for the coverage you are applying for will be paid by your employer?
 None 100% Other _____%
- c. If your employer will pay any part of the premium, will it be reportable by you as taxable income?..... Yes No
- d. If paid by the proposed insured, is it paid by: Pre-tax dollars After-tax dollars
- e. Premium Mode: Annual Semiannual Quarterly
 Monthly:
 Automatic Payment Plan - New Service Add to My Existing Service
 List Bill
- f. Prepayment of Premium – *A prepayment must be accompanied by a signed Conditions of Coverage.*
 No money has been submitted with this application.
 \$ _____ has been submitted with this application for proposed insurance.

7. Representations of the Proposed Insured and Owner

Those parties, who sign below, agree that:

1. This application and any other supplements or amendments to the application will form the basis for, and become part of and attached to, any policy or new coverage issued by Berkshire Life Insurance Company of America ("Company").
2. All of the statements that are part of the application and any other supplements to the application are correctly recorded, and are complete and true to the best of the knowledge and belief of those persons who made them.
3. No agent, broker or medical examiner has any right to accept risks, make or change contracts, or to waive or modify any of the Company's rights or requirements.
4. Any misrepresentation or omission, if found to be material, may adversely affect acceptance of the risk, claims payment or may lead to rescission of any policy or new coverage that is issued based on this application.
5. All coverage shown to be discontinued or replaced in answer to Question 5b of this application will be permanently terminated on or before the date(s) indicated. If not, it is understood and agreed that the Company reserves all rights outlined in any policy or new coverage issued. Further, benefits under any policy or new coverage issued based on this application may be reduced by the amount payable under such existing policies.
6. Insurance in the amount resulting from the exercise of the Future Increase Option, Future Purchase Option, or Group Disability Replacement Option ("the Option") shall take effect in accordance with the agreement or provision providing the Option, so long as the new policy or additional coverage is delivered, the required premium is paid, and there has been no change in the income level, status of employment, or occupation of the Proposed Insured.
7. By paying premiums on a basis more frequently than annually, the total premium payable during one year's time may be greater than if the premium were paid annually. That is, the cost of paying annualized periodic premiums may be more than the cost of paying one annual premium.
8. I **acknowledge** receipt of the Insurance Information Practices.

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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

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

Signature of Proposed Insured

Signature of Applicant/Owner if Other than Proposed Insured

Witness



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

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Authorization to Obtain and Release Non-Medical Information

Name of Proposed Insured _____ Date of Birth _____

Address of Proposed Insured _____

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

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

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

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

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

Signature of Proposed Insured

Witness Signature



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 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734, and its telephone number is 866-692-6901 (TTY 866-346-3642 for hearing impaired). Information for consumers about MIB may be obtained on its website at www.mib.com.

Medical Records

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

Personal Information Telephone Interview

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



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Conditions of Coverage

I, _____, the Proposed Insured, have applied for disability insurance coverage with Berkshire Life Insurance Company of America ("Company") and have submitted \$ _____ to the Company. The minimum amount of premium which may accompany an application is a monthly premium amount. It is understood and agreed that no liability is created or assumed by the Company, except for the refund of any premium amount submitted, unless and until a disability insurance policy or new coverage becomes effective. The insurance applied for will become effective and in force only if:

1. This application is approved by the Company, and
2. A modified policy or new coverage is delivered, and
3. Any amendment of the application or Special Exceptions Agreement to adjust the provisions of a policy is signed by the Proposed Insured and the Owner, where applicable, and
4. A policy or new coverage is issued during the lifetime of the Proposed Insured, and
5. The initial premium payment has been paid, and
6. The income level, status of employment, and occupation of the Proposed Insured remains insurable under the Company's underwriting standards.

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

Should the Proposed Insured be determined uninsurable based on the Company's underwriting standards, or if the Company is unable to obtain required underwriting information within 60 days, the amount submitted will be returned to the Proposed Insured.

Should the amount submitted not be honored by the Proposed Insured's bank, the Company will discontinue consideration of the application.

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

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

I have read and understand the Conditions of Coverage.

Licensed Producer's Signature
Date
Applicant's Signature



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1. This application is approved by the Company, and
2. A modified policy or new coverage is delivered, and
3. Any amendment of the application or Special Exceptions Agreement to adjust the provisions of a policy is signed by the Proposed Insured and the Owner, where applicable, and
4. A policy or new coverage is issued during the lifetime of the Proposed Insured, and
5. The initial premium payment has been paid, and
6. The income level, status of employment, and occupation of the Proposed Insured remains insurable under the Company's underwriting standards.

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

Should the Proposed Insured be determined uninsurable based on the Company's underwriting standards, or if the Company is unable to obtain required underwriting information within 60 days, the amount submitted will be returned to the Proposed Insured.

Should the amount submitted not be honored by the Proposed Insured's bank, the Company will discontinue consideration of the application.

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

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

I have read and understand the Conditions of Coverage.

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Date
Applicant's Signature



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Application for Disability Insurance Option Exercises – Overhead Expense Insurance Supplement

I. Proposed Insured Information

a. Name (First, Middle Initial, Last) _____ b. Date of Birth (mm/dd/yyyy) _____

2. Overhead Expenses

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

b. Monthly Expenses of the Business Entity – What are the current average monthly overhead expenses incurred for the items shown? (If responsible for expenses shared jointly with others, include only the portion for which the proposed insured is responsible.)

Advertising \$ _____

Car and Truck Expenses _____

Commissions and Fees _____

Contract Labor _____

Depreciation and Section 179 Expense Deduction _____

Employee Benefit Programs _____

Insurance _____

Interest:

Mortgage (Paid to Banks, etc.) _____

Other _____

Legal and Professional Services _____

Office Expenses _____

Pension and Profit Sharing Plans _____

Rent or Lease (Other Business Property) _____

Repairs and Maintenance _____

Taxes and Licenses _____

Utilities _____

Wages (exclude compensation for members of insured's profession) _____

Other Expenses (itemized):

_____ \$ _____

TOTAL \$ _____

Proposed Insured Monthly Earned Income* \$ _____

**Earned income is considered for and in accordance with Salary Replacement guidelines of 50% of the Proposed Insured's Earned Income not to exceed one-half of the total monthly overhead expense benefit or \$10,000, whichever is less. Available only with policy form 4200 Salary Replacement.*



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

I. Proposed Insured Information

a. Name (First, Middle Initial, Last) _____ b. Date of Birth (mm/dd/yyyy) _____

2. Disability Buy-Out Insurance

a. Give names of all other stockholders or partners. (Please note if there are any on whom Disability Buy-Out (DBO) is not carried or proposed on the Supplement to Application for Insurance.)

Name and Title	Percentage Owned	Amount of DBO in Force	Amount of DBO Proposed
	%	\$	\$
	%	\$	\$
	%	\$	\$
	%	\$	\$

b. Does a familial relationship exist among any of the above stockholders or partners? Yes No
 If yes, describe:

c. Indicate type of business organization: Professional Corporation/Personal Service Partnership
 Commercial Business

d. Employer Tax ID # _____

e. What is the current Fair Market Value of the business organization? \$ _____

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

g. Business Financial

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

l. Name of your primary care physician _____

If none, check here

Address of primary care physician _____

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

City _____

State _____

ZIP _____

Primary care physician's telephone number _____

m. Date and reason last consulted? _____

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

n. Have you ever had an injury or sickness that caused a loss of: sight in both eyes; hearing in both ears; speech; or the use of two arms or two legs? Yes No

o. Do you need human assistance of any kind to perform everyday activities such as bathing, continence, dressing, eating, using the toilet or transferring (for example, from the chair to your bed)? Yes No

p. Do you use any special medical equipment or appliances, including but not limited to, a wheelchair, pacemaker, oxygen tank, cane, catheter, or artificial limb? Yes No

q. Have you ever received treatment, attention or advice for memory loss or confusion, Alzheimer's disease, stroke, senility, dementia, loss of speech or comprehension of spoken language? Yes No

If any question listed in 3n through 3q is left blank or is answered "Yes," no prepayment should be taken and no Conditions of Coverage issued.

4. Remarks and Special Requests

Provide all details to any "yes" answers, identifying each detail by question number. Include, if applicable, diagnosis or symptoms, tests performed, dates, types and amounts of medication, length of disability, degree of recovery, and names and addresses of all physicians, medical or mental health professionals, counselors, psychotherapists, practitioners or hospitals.

Any additional benefits requested shall not take effect until the policy has been delivered, the first premium has been paid while the health and other conditions affecting insurability of the Proposed Insured remain as described in the application.

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 Insured

Signature of Applicant/Owner if Other than
Proposed Insured

Witness



Life Customer Service Office
3900 Burgess Place
Bethlehem, PA 18017

Disability Customer Service Office
700 South Street
Pittsfield, MA 01201

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

(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.

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 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.

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



- The Guardian Life Insurance Company of America ("Guardian")
- The Guardian Insurance & Annuity Company, Inc. ("GIAC")
- Berkshire Life Insurance Company of America ("Berkshire")

<u>AGENCY USE ONLY</u>	
New Application	<input type="checkbox"/>
Bank Change	<input type="checkbox"/>
Agency Code:	_____

REQUEST FOR GUARD-O-MATIC ARRANGEMENT (page 1 of 2)

In this Request for G-O-M Arrangement form, the "Company" is the insurer checked above

See next page for VUL instructions.

IMPORTANT: A voided blank check or photocopy (starter checks are not acceptable) is required for checking accounts or a deposit slip for a savings account. See next page for general Guard-O-Matic information.

Guardian and/or GIAC and/or Berkshire is requested and authorized to debit your financial institution or to initiate electronic funds transfer on or about the 15th of each month to pay premiums due and/or on the 1st business day of each month to pay the policy loan on the policy(ies) identified below (on or about the 15th of each month to pay the policy loan on Guardian policy(ies) administered by Berkshire).

I understand that:

1. Completion of this form shall not constitute a premium payment and/or loan payment. Authorization for premium payments is not effective until the initial premium(s) has been received and paid at the home office or you have requested initial premiums be paid under this Arrangement. Multiple months' premiums may be required to bring the policy to a current due date. If dividends are currently being used to purchase paid-up additional insurance, and dividends for term insurance policies and annuities will be left with us to accumulate at interest.
2. The Guard-O-Matic Premium Arrangement or Loan Payment Arrangement may be terminated by the Policyowner or by the Company upon written notice. If the Bank Depositor is other than the policyowner, the Company will terminate the arrangement upon written request of such Bank Depositor. The policyowner or depositor may cancel this authorization by giving our home office 30 days' written notice
3. If the Loan Payment Arrangement is cancelled, any outstanding loans will remain unpaid.
4. Any withdrawal returned due to insufficient funds may be deposited for collection a second time. We may terminate the Guard-O-Matic plan immediately by written notice in the event any withdrawal or electronic fund transfer is dishonored.

PLEASE PRINT

Type of account: Checking Savings Begin deductions effective _____ (Month) _____ (Year)

Financial Institution: _____

Street Address: _____ City: _____

State: _____ Zip: _____ Transit/ABA Number: _____

Account Number: _____ Name of Account Holder: _____

Guard-O-Matic Premium Arrangement.

List Policy Numbers	Insured's Name	Last 4 Digits of Policyowners's SS#
_____	_____	_____
_____	_____	_____
_____	_____	_____

Guard-O-Matic Loan Payment Arrangement.

Life Policy Numbers	Amount to be Deducted	Life Policy Number	Amount to be Deducted
_____	_____	_____	_____
_____	_____	_____	_____

As a convenience to me, I authorize you to pay and charge to my account checks, electronic funds transfer debits or other account debits made upon my account by and payable to the order of Guardian/GIAC/Berkshire indicated above. I agree that your treatment of each check or debit, and your rights with respect to it, will be the same as if it were signed or initialed personally by me. I further agree that if any check or debit is dishonored for any reason you will not be under any liability even though dishonor results in the forfeiture of insurance.

I further agree that this authorization is to remain in effect until you receive written notice from me of its revocation unless you end it earlier.

Date Signature of Bank Account Owner

Signature of Policy Owner, if other than Bank Account Owner For Home Office Use Only, Control No.:



Complete if applying for Universal or Variable Universal Life Insurance:

Your policy is designed to have flexible premiums. When using the Guard-O-Matic check drafting feature, we require that a minimum premium be drawn from your account to keep the policy in force. You will be notified by a lapse notice if it is necessary to increase this amount to keep the policy from lapsing.

Please check the box below if you wish to request this option:

Please deduct \$ _____ monthly from my account. I understand that this amount may need to be increased to keep the policy from lapsing.

If you have any questions about your policy or about the amounts to be drafted to pay premiums, please contact your agent.

"Please be advised that you will not automatically receive a confirmation statement for premium payments paid through the pre-authorized checking plan. Confirmation statements will be mailed only upon request. For details on the automatic monthly payments, please refer to your annual benefits statement, policy contract, or product prospectus. You will receive a confirmation if you have purchased a Park Avenue Variable Whole Life Insurance policy or a Park Avenue Variable Universal Life (97) Policy. Please contact our customer service department at 1-800-441-6455 for more information."

GUARD-O-MATIC General Information

You have elected to pay your insurance premiums and/or your policy loan by monthly deductions payable through your financial institution. To enjoy the benefits of this convenient method of payment, we suggest you review the following:

- Each month, deduct the amount(s) from your account balance. You may wish to attach a reminder to your account until this practice becomes automatic. The monthly deduction to your account for any policy premiums will be made on or about the 15th day of each month. The monthly deduction to your account for any policy loan payments will be made on the 1st business day of each month. (on or about the 15th of each month to pay the policy loan on Guardian policy(ies) administered by Berkshire).
- A canceled check or other notification of a charge to the account will be provided by your financial institution with its periodic statement. Compare your records when the statement is received.
- Please provide us with 30 days' advance notification of any change in your banking arrangements. If advance notification cannot be provided, sufficient funds should be left in the old account to honor charges until our records are changed.
- Please inform us of any change in name or address.
- When this service is no longer in effect, premiums will be due according to the most frequent payment mode we offer.

INDEMNIFICATION AGREEMENT**TO: The Bank named on the previous page.**

In consideration of your compliance with the request and authorization of the depositor named above,
THE GUARDIAN LIFE INSURANCE COMPANY OF AMERICA AND THE GUARDIAN INSURANCE & ANNUITY COMPANY, INC. AND BERKSHIRE LIFE INSURANCE COMPANY OF AMERICA (COLLECTIVELY, "GUARDIAN")
 AGREE THAT:

1. They will indemnify and hold you harmless from any liability, including costs, legal expenses and attorney fees, to any person having an account with you or to any beneficiary or other claimant under a policy covered by the Guard-O-Matic Arrangement arising out of the payment by you of any check or debit drawn by Guardian, its own order on the account of such depositor, or arising out of the dishonor by you, whether with or without cause, of any such check or debit drawn by Guardian, provided there are sufficient funds in such account to pay the same upon presentation, whether or not such claim or liability asserted against you be based upon the forfeiture, or alleged forfeiture, of a policy the premium on which is sought to be collected by Guardian by any such check or debit.
2. They will refund to you any amount erroneously paid by you to Guardian on any such check or debit if claim for the amount of such erroneous payment is made by you within fifteen months from the date of the check or debit on which such erroneous payment was made.

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

Authorized in a resolution approved by the Board of Directors of The Guardian Life Insurance Company of America on April 27, 1960, and by the Board of Directors of The Guardian Insurance & Annuity Company, Inc. on November 17, 1988 and by the Board of Directors of the Berkshire Life Insurance Company of America on July 19, 2002.

Berkshire Life Insurance Company of America
700 South Street • Pittsfield, Massachusetts 01201
1-800-819-2468

**DISABILITY BUY-OUT POLICY
REQUIRED OUTLINE OF COVERAGE**

Policy Form 3200

1. **READ THE POLICY CAREFULLY** – This outline of coverage briefly describes some of the important features of the Policy. This is not the insurance contract and only the actual policy provisions will control. The Policy itself sets forth, in detail, the rights and obligations of the Policyowner, You, and Berkshire Life Insurance Company of America. It is important that the Policyowner and You **READ THE POLICY CAREFULLY!**
2. **DISABILITY INCOME PROTECTION COVERAGE** – This type of coverage is designed to provide benefits for a Disability resulting from Injury or Sickness, subject to any limitations set forth in the Policy. Benefits are not provided for basic hospital, basic medical-surgical, or major medical expenses.
3. **BENEFITS OF THE POLICY** – The purpose of the Policy is to provide a benefit to an individual, entity or a business to buy out the business interest of another individual (the Insured) who becomes Totally Disabled. Coverage is contingent on the Insured being Gainfully Employed Full Time by the Business at the start of the Total Disability, and the Policyowner being obligated to buy the business interest of the Insured because of the Total Disability, and the Policyowner actually making payments to purchase that interest.

If You are Totally Disabled according to the terms of the Policy, and the Elimination Period of _____ days has been satisfied, benefits of up to \$ _____ (Maximum Aggregate Benefit) will be paid to the Policyowner. The Policyowner has chosen the funding method indicated below:

1. **Monthly Installment.** If the Monthly Installment Funding Method is elected, the benefits will become payable to the Policyowner after the end of the Elimination Period, or the Closing Date, if later. The monthly benefit payable will be the least of:
- the Monthly Purchase Amount;
 - the Maximum Monthly Installment Benefit; or
 - an amount equal to $(A \div B)$, where:

A is the Business Valuation Amount less the Prior Buy-Out Coverage, and
B is the number of months in the Monthly Installment Period.
2. **Lump Sum.** If the Lump Sum Funding Method is elected, the benefit will become payable to the Policyowner after the end of the Elimination Period, or the Closing Date, if later. The benefit payable will be the least of:
- the Purchase Amount;
 - the Maximum Aggregate Benefit; or
 - the Business Valuation Amount less the Prior Buy-Out Coverage
3. **Down Payment.** If the Down Payment Funding Method is elected, the benefits will become payable to the Policyowner after the end of the Elimination Period, or the Closing Date, if later. We will first pay the Policyowner the least of:
- the actual down payment amount paid to You by the Policyowner;
 - the Maximum Lump Sum Benefit; or
 - the Business Valuation Amount less the Prior Buy-Out Coverage.

Thereafter, the monthly benefit payable will be the least of:

- the Monthly Purchase Amount;
- the Maximum Monthly Installment Benefit; or
- an amount equal to $(A - B) \div C$, where:
 - A is the Business Valuation Amount less the Prior Buy-Out Coverage
 - B is the total amount of benefit already paid by Us, and
 - C is the number of months in the Monthly Installment Period.

Total Disability or Totally Disabled means that, solely due to Injury or Sickness, You are not able to perform the material and substantial duties of Your Occupation and You are not Gainfully Employed by the Business.

Your Occupation means the occupation (or occupations if more than one) in which You are Gainfully Employed during the 12 months prior to the time You become Totally Disabled.

Waiver of Premium Benefit – If You are Totally Disabled for the length of the Elimination Period due to Injury or Sickness not excluded from Coverage, We will refund the portion of any premium paid which applies to the period of Total Disability beyond the date that You were first Totally Disabled in the same claim. We will then waive any later premiums that are due while You are receiving benefits for the Total Disability.

Occupational Rehabilitation Benefit – If You are Totally Disabled and the Elimination Period has not been satisfied, You may be eligible for an Occupational Rehabilitation Benefit. If We agree in advance on a program of occupational rehabilitation, We will pay for the program as set forth in a signed written agreement. The program of occupational rehabilitation must be a formal plan that will help You to return to Gainful Employment in Your Occupation. The program must be directed by an organization or individual licensed or accredited to provide occupational rehabilitation or education to persons who are disabled.

OPTIONAL BENEFITS – Coverage will be provided for the following benefits only if an additional premium for the benefit is shown in the Schedule Page.

Future Increase Option Rider – This rider provides for the purchase of additional amounts of Disability Buy-Out insurance without evidence of medical insurability. Subject to the Conditions and Limitations provision of the rider, the Policyowner may exercise an Increase Option up to the Option Amount during an Option Period. The Option Amount means the additional Maximum Aggregate Benefit that may be applied for on each Option Date. The Option Amount is shown in the Schedule Page.

If the Policyowner does not exercise an Increase Option on an Option Date, the Policyowner may apply for up to twice the Option Amount on the next Option Date.

Each Option Amount applied for during an Option Period will be underwritten based on Our underwriting rules, including issue limits, then in use, or those in effect on the Effective Date of the Policy, whichever are more favorable to the Policyowner, to determine the total amount of allowable Maximum Aggregate Benefit, if any, available to the Policyowner.

An Increase Option may not be exercised when You are disabled, receiving disability benefits or eligible to receive disability benefits from any source.

These benefits are subject to a maximum option amount and certain other limitations listed in the rider.

4. EXCLUSIONS AND LIMITATIONS OF THE POLICY – There will be no benefits for any Total Disability:

- caused by, contributed to, or which results from armed forces training, or act of war, whether declared or undeclared, while You are serving in the armed forces or units auxiliary thereto;

- caused by, contributed to, or which results from Your commission of, or attempt to commit, a felony or Your participation in a riot or insurrection;
- caused by, contributed to, or which results from Your being engaged in an illegal occupation;
- caused by, contributed to, or which results from the suspension, revocation or surrender of Your professional or occupational license or certification;
- caused by, contributed to, or which results from an intentionally self-inflicted Injury; or
- due to any loss We have excluded by name or specific description and is attached to and made a part of the Policy.

PRE-EXISTING CONDITION LIMITATION – We will not cover any loss that begins in the first two years after the Effective Date from a Pre-existing Condition that was misrepresented or not disclosed in the application.

5. RENEWABILITY OF THE POLICY – The Policy is renewable by timely payment of premiums until the earliest of the following events or occurrences at which time the Policy will terminate:
1. The Policyowner, if an individual, no longer has an Ownership Interest in the Business;
 2. You no longer have an Ownership Interest in the Business;
 3. You are no longer Gainfully Employed Full Time by the Business for any reason other than Total Disability;
 4. You have actual and/or Constructive Ownership of more than 90% of the Business;
 5. You have an actual Ownership Interest of less than 5% of the Business;
 6. The Maximum Aggregate Benefit has been paid; or
 7. The first Policy Anniversary after Your 65th birthday.

This is a non-participating policy.

THIS OUTLINE OF COVERAGE IS ONLY A SUMMARY OF THE COVERAGE PROVIDED. THE POLICY ITSELF SHOULD BE CONSULTED TO DETERMINE GOVERNING CONTRACTUAL PROVISIONS AND AMOUNTS.