

**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 The Guardian Life Insurance Company of America, New York, NY

**The Guardian Life Insurance Company of America**

Administrative Office: 700 South Street, Pittsfield, MA 01201

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## Disability Insurance Application Instructions / Checklist

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**THIS APPLICATION PACKAGE INCLUDES:****Application for Disability Insurance – pages 1-7**Complete sections 1-12 in all cases (see instruction below for section 7). Do you have the correct state forms (must be where the applicant lives or works)? **Product Supplements to the Application**When applying for Overhead Expense and Disability Buy Out, also complete the appropriate supplement to the application for insurance. No supplement needed when applying for IDI, RPP\* and reducing term. *\*Be sure to complete the proper RPP Assignment form and submit with the application.***Financial Information (section 5)**Obtain W-2, recent paystub, tax return or employment agreement. Financial verification is required in all cases, except residents applying within the resident limits and cases submitted through the Enhanced Quick Issue Program. **Health Information (section 7)**Completion of the Health Information of the Proposed Insured section 7 is recommended, but optional when a Berkshire or Guardian paramedical exam is completed. Section 7 must be completed to submit a prepayment. If any part of questions 7f through 7i or 7u through 7x is answered "Yes", do not take a prepayment or issue a Conditional Receipt. **Remarks & Special Requests (section 10)**Use this section to provide answer details when space is not sufficient. Identify each detail by question number. If additional space is needed, use the Supplement to the Application for Insurance (C-APP-SUPP). **Representations of Proposed Insured and Owner (section 12)**Signature of the proposed insured on this form confirms their agreement that the application is complete, correctly recorded and true to the best of his or her knowledge. **Notice of Insurance Information Practices Authorization to Obtain/Release Information**Please provide this form to the applicant. This form authorizes the Company to obtain medical and other information about the proposed insured. **Conditional Receipt**Obtain appropriate signatures; submit one copy with the application. A Conditional Receipt must be submitted with every prepayment. Refer to the Conditional Receipt Guidelines for information on our policy dating and prepayment refunding procedures. **Authorization for Disclosure of Protected Health Information (AA1542)**Discuss with your client completing this form. This form provides underwriting the authority to discuss details of the case with the agent. **Automatic Payment Plan**If a new service, complete and submit the Request for Guard-O-Matic Arrangement form (R223). Submit a copy of a canceled check or a savings deposit slip. **Producer's Certification**All commissioned agents must be licensed and appointed where application was signed and at the time it is signed. Include the endorsing agent when submitting under an exclusive endorsed group (e.g. association, resident-student program). **Medical Requirements**All medical requirements must be ordered through and received directly from our approved medical vendors (e.g. labs, paramedical exams, Attending Physician Statements (APS).) **TeleMed**Complete and submit the TeleMed Request form to the vendor. Indicate TeleMed on the New Business Transmittal If not using TeleMed or if using TeleMed - Interview Only, you must order the necessary medical requirements. **New Business Transmittal (AA1732)**Submit a transmittal to specify instructions for application processing. If you are submitting or recently have submitted a life insurance application with Guardian, please notify us of this **Combo Case** status on the Transmittal. 

Additional forms may be required but are not part of this package. If relevant to this case, complete additional forms and submit with the application package.



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Administrative Office: 700 South Street, Pittsfield, MA 01201  
*(Please check appropriate company(ies). Any insurer checked above is herein referred to as the "Company.")*

## Application for Disability Insurance

### I. Proposed Insured Information

<p>a. Name (First, Middle Initial, Last) _____</p> <p>b. Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female</p> <p>c. Social Security #: _____</p> <p>d. Residence Address (Street, City, State, Zip): _____ _____ How long at this address? _____</p> <p>e. Date of Birth (mm/dd/yyyy): _____</p> <p>f. Place of Birth: _____</p>	<p>Suffix _____</p> <p>Previous Last Name, if applicable _____</p> <p>g. Telephone: Home _____ Cell _____</p> <p>E-mail Address: _____</p> <p>h. Are you a U.S. citizen <input type="checkbox"/> Yes <input type="checkbox"/> No If no, please provide: Visa Type ____ Visa Duration _____ How long have you lived in the U.S. on a full-time basis? _____ <i>(If residence has not been continuous, give dates, and explain in Remarks and Special Requests section 10)</i> Do you expect to remain in the U.S. permanently? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, include details: _____ When do you expect to obtain U.S. citizenship or permanent residency? _____</p>
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### 2. Business Information

<p>a. Current Employer: _____ Number of years with current employer _____</p> <p>b. Business Address (Street, City, State, Zip): _____ _____</p> <p>c. Business Telephone: _____ Business Website: _____</p>	<p>d. Nature of Business: _____</p> <p>e. Occupation: _____ Number of years in this occupation _____</p> <p>f. Job Title (if medical or dental occupation, state specialty): _____</p> <p>g. Professional licenses and designations held (if none, so state): _____</p>
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### 3. Occupational Information

a. Describe all activities performed in connection with the duties of your occupation, including but not limited to invasive surgical, travel, sales and supervisory duties. **If the space provided is not adequate, provide additional details in Remarks & Special Requests section 10.**

Description of Specific Duties	% of Time Devoted to Each Duty

- b. Describe exact physical duties of your occupation (lifting, climbing, driving, etc.). If none, so state.  
\_\_\_\_\_
- c. Describe any tools or equipment you use to perform the duties of your occupation. If none, so state.  
\_\_\_\_\_

d. Is this a home-based occupation?  Yes  No If yes, what percentage of time do you spend working outside the home? \_\_\_\_%

e. How many hours per week are you at work in this occupation? \_\_\_\_ hours

f. Have you been continuously at work full time performing the usual duties of your occupation for the past six months?  Yes  No  
If no, explain in section 10 Remarks and Special Requests.

g. Do you supervise any employees?  Yes  No If yes, how many? \_\_\_\_

h. Employment Status:  Employee (no ownership)  Sole Proprietor  Partner \_\_\_\_% ownership  
 S-Corporation Shareholder \_\_\_\_% ownership  C-Corporation Shareholder \_\_\_\_% ownership

i. Do you plan to change your occupation, job or employment within the next six months?  Yes  No If yes, provide details:

j. Do you have any other part- or full-time occupations, jobs or employment?  Yes  No If yes, provide details:

**4. Other Insurance 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?  Yes  No

b. Do you plan to apply for or are you currently applying for any other life, long-term care, disability or accident insurance? (In Remarks and Special Requests section 10, include amount applying for and company applying with, and whether this other insurance will be in addition to or in lieu of insurance with Berkshire or Guardian.)  Yes  No

c. Describe all disability income pending and in force coverage. **If none, check here**   
Type of Insurance: Individual (IDI), Group (G), Group with Conversion Option (GC), 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	Catastrophic Benefit	Employer paid? (Y/N)	Is coverage being replaced? (Y/N)	Amount to be Replaced?	Date to be Replaced?
1.										
2.										
3.										
4.										

**5. Personal Financial Information of the Proposed Insured**

For purposes of this section, **Earned Income** and **Unearned Income** mean the income you are required to report for federal income tax purposes. **Earned Income** includes W-2 wages, salary, tips, fees, bonuses, your share of the distribution of the owners actively involved in a business, net business income, and other sources of revenue. **Unearned income** includes passive income, income from dividends, capital gains, interest (including tax exempt interest), rentals, royalties, retirement plans, alimony, investments, and business interests as an inactive owner. Fill in the income amounts below using your individual and/or business tax returns and supporting schedules. "Actual filed" means the amount of income disclosed in your filed federal income tax return for the requested year. Explain in Section 10 Remarks and Special Requests, any significant fluctuations between years or changes since the end of the most recent calendar year. Show loss amounts in parentheses.

a. **Earned Income** 1. Year-To-Date This Calendar Year \$ \_\_\_\_\_ 2. Actual Filed Last Calendar Year \$ \_\_\_\_\_ 3. Actual Filed Two Calendar Years Ago \$ \_\_\_\_\_

b. **Unearned Income** Sources: \_\_\_\_\_ 1. Actual Filed Last Calendar Year \$ \_\_\_\_\_ 2. Actual Filed Two Calendar Years Ago \$ \_\_\_\_\_

c. Do you participate in a qualified retirement plan such as a 401(k), 403(b), SIMPLE, IRA or profit sharing?  Yes  No

d. Total Annual Retirement Contribution (including your contribution and employer contributions):  
1. Year-To-Date This Calendar Year \$ \_\_\_\_\_ 2. Actual Last Calendar Year \$ \_\_\_\_\_ 3. Actual Two Calendar Years Ago \$ \_\_\_\_\_

e. Do you wish to have this retirement contribution considered as part of your earned income?  Yes  No

f. Total Net Worth if 6 million dollars or more (assets minus liabilities, excluding primary residence) \$ \_\_\_\_\_  
Sources: \_\_\_\_\_

g. Have you ever filed bankruptcy?  Yes  No  
If yes, Type:  Personal  Business Date Filed: \_\_\_\_\_ Date Discharged: \_\_\_\_\_

## 6. Additional Information of the Proposed Insured

(Please provide details in Section 10 Remarks and Special Requests to all "Yes" answers)

- a. Do you plan to reside or travel outside of the U.S.? (If yes, indicate location, frequency, for work or pleasure, date of departure, length of stay.)  Yes  No
- b. Do you drive a motor vehicle?  Yes  No  
 \_\_\_\_\_ Driver's License State \_\_\_\_\_ Driver's License #
- c. Within the past five years, have you been charged with 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.)  Yes  No
- d. Within the last 10 years, have you been convicted of a felony, or is such a charge pending against you?  Yes  No
- e. Indicate "yes" if any apply: 1) your professional license has ever been suspended or revoked; 2) there is a pending investigation or complaint concerning you with a regulatory, governmental, or other entity that oversees your profession; 3) you have ever been disbarred; or 4) you have ever been fined or sanctioned by an entity that oversees your profession.  Yes  No
- f. Within the last three years, have you participated, or do you plan to participate in any of the following activities: piloting any type of aircraft; mountain or rock climbing; scuba diving; hang gliding; parachuting or skydiving; motor vehicle racing; or other hazardous activity? (If yes to any, complete Aviation and/or Avocation Supplement.)  Yes  No
- g. Within the past five years, have you had any application for insurance declined, postponed, modified, rated, cancelled, rescinded, or have you withdrawn a pending application, or had a renewal or reinstatement request refused?  Yes  No
- h. Have you used tobacco, nicotine, or any nicotine delivery system in any form in the last 12 months? (If you have quit, date last used: \_\_\_\_\_)  Yes  No
- i. Are you currently a member of, or do you plan on joining, any branch of the United States Military, including the Army, Navy, Air Force, Marine Corps, Coast Guard, National Guard, or any reserve military unit?  Yes  No
- j. Are you currently employed by, or seeking employment with, any company or entity which provides military, paramilitary, or security services outside of the United States?  Yes  No
- k. Have you been alerted to, received orders for, or had any indication of an overseas assignment or active service with any branch of the United States Military, including the Army, Navy, Air Force, Marine Corps, Coast Guard, National Guard, or any reserve military unit?  Yes  No

## 7. Health Information of the Proposed Insured

This Section 7 is left intentionally blank. Information pertaining to my health and medical history will be provided by me in a separate Guardian or Berkshire form or forms which become part of my application. Additional questioning of your health and medical history may be required even when Section 7 is completed.

- a. Name of your primary care physician: If none, check here  Address of primary care physician (Street, City, State, Zip):  
 \_\_\_\_\_
- b. Date and reason last consulted? \_\_\_\_\_
- c. What treatment or medication was given or recommended? \_\_\_\_\_ Primary care physician telephone: \_\_\_\_\_
- d. Height \_\_\_\_\_ feet \_\_\_\_\_ inches Current Weight \_\_\_\_\_ lbs.
- e. Weight change past year:  None  Gain\*: \_\_\_\_\_ lbs.  Loss\*: \_\_\_\_\_ lbs. \*Reason for change: \_\_\_\_\_

(Please provide details to all "Yes" answers in Section 10 Remarks and Special Requests. If any part of questions 7f through 7i is left blank or answered "Yes", no prepayment should be taken and no Conditional Receipt issued.)

- f. Have you ever had or been treated for cancer, heart attack, stroke, diabetes, or any disease of the liver, lungs, kidneys, or heart, or any disorder of the back or spine or Chronic Fatigue Syndrome?  Yes  No
- g. Are you currently receiving any medical advice, counseling or treatment for any medical, surgical or psychiatric condition?  Yes  No
- h. Within the past 10 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?  Yes  No
- i. Are you now pregnant? If yes, expected delivery date: \_\_\_\_\_  Yes  No

- j. Are you currently taking prescription medication, or have you been prescribed any medication within the last six months?  Yes  No
- k. Have you ever had or been treated for cancer or tumor?  Yes  No
- l. In the last 10 years, have you had, been treated for or received a consultation or counseling for:
1. high blood pressure, chest pain or disorder of the heart or circulatory system?  Yes  No
  2. diabetes or disorder of the glands, bone, blood or skin?  Yes  No
  3. arthritis, rheumatism, or disorder of the joints, limbs or muscles?  Yes  No
  4. disorder or condition of the back, neck or spine?  Yes  No
  5. disorder of the eyes, ears, nose or throat?  Yes  No
  6. hernia, hepatitis, or disorder of the liver, gall bladder, esophagus, stomach, pancreas, spleen, intestines, colon or rectum?  Yes  No
  7. epilepsy, stroke, dizziness, headache, muscle weakness, or disorder of the brain or spinal cord?  Yes  No
  8. allergy, asthma, sinusitis, emphysema, disorder of the lungs or respiratory system, or sleep apnea?  Yes  No
  9. complications of pregnancy, infertility, or any disorder of the breasts, reproductive or genital organs, prostate, kidneys, or urinary systems?  Yes  No
  10. anxiety, depression, nervousness, stress, mental or nervous disorder, or other emotional disorder?  Yes  No
  11. Chronic Fatigue Syndrome, Fibromyalgia, Epstein Barr Virus or Lyme Disease?  Yes  No
- m. Do you have any loss of hearing or sight, an amputation of any kind, or any physical deformity, impairment or handicap?  Yes  No
- n. Have you ever used stimulants, hallucinogens, narcotics or any other controlled substance, or been advised to have counseling or treatment for alcohol or drug use? (If yes, complete the Alcohol and Drug Usage Supplement.)  Yes  No
- o. Within the past five years, have you had a sickness or injury for which you have made a benefits claim or for which you will make a benefits claim?  Yes  No
- p. Within the past five years, have you had a physical exam or check-up of any kind?  Yes  No
- q. Within the past five years, have you been advised to have surgery or any diagnostic tests that were not performed, except for HIV tests?  Yes  No
- r. Other than previously stated on this application, in the last five years have you received medical advice or counseling from physician(s), medical or mental health professional(s), counselor(s), psychotherapist(s), chiropractor(s), or other practitioner(s), or have you been a patient in a hospital, clinic, sanatorium, or other medical facility?  Yes  No
- s. Within the past 12 months, have you had symptoms of any condition listed in this Section 7, except those conditions listed in question 7h, for which you have not sought medical attention or advice?  Yes  No
- t. Do either of your parents have a history of: diabetes; cancer; high blood pressure; heart disease; Huntington's Disease or mental illness?  Yes  No

	Age if Living	Age at Death	Cause of Death
FATHER			
MOTHER			

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

(If any part of questions 7u through 7x is answered "Yes," no prepayment should be taken and no Conditional Receipt issued.)

- u. 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
- v. 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
- w. 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
- x. 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

**8. Premium Information**

- a. What percentage of the premium for the coverage you are applying for will be paid by your employer?  None  100%  Other \_\_\_\_%
- b. If your employer will pay any part of the premium, will it be reportable by you as taxable income?  Yes  No
- c. If paid by the proposed insured, is it paid by:  Pre-tax dollars  After-tax dollars
- d. Premium Mode:  Annual  Semiannual  Quarterly  Monthly – available with Group Bill and Automatic Bank Draft only
- e. Billing Type:  Paper Bill  
 Automatic Bank Draft:  New service  Add to my existing Guardian or Berkshire service  
 Group Bill:  Existing Account # \_\_\_\_\_  
 New – Billing Name \_\_\_\_\_ Common Billing Day \_\_\_\_\_
- f. Send premium notices to:  Residence  Owner's Address  Business  Other \_\_\_\_\_
- g. Prepayment of Premium – A prepayment must be accompanied by a signed Conditional Receipt and section 7 must be completed.  
 No money has been submitted with this application.  
 \$ \_\_\_\_\_ has been submitted with this application for proposed insurance.

**9. Coverage Applied For**

Indicate all insurance applied for with this application and specify coverage desired. Complete the appropriate product supplement for Overhead Expense, Disability Buy-Out and Income ProVider. Complete column A and question h when applying for ProVider Plus, column B and question i for Retirement Protection as a stand-alone policy, and column C and questions j through n for Reducing Term.

	Column A	Column B	Column C	Column D	Column E
	Disability Income	Disability Income – Retirement Protection	Reducing Term	Overhead Expense	Disability Buy-Out
a. Indemnity/Benefit Amount	\$ _____	\$ _____	\$ _____	\$ _____	Complete Supplement
b. Policy Form Number					
c. Own Occupation Definition of Disability	<input type="checkbox"/> True <input type="checkbox"/> Modified	Modified	Modified	True	True
d. Premium Structure	<input type="checkbox"/> Level <input type="checkbox"/> Graded	<input type="checkbox"/> Level <input type="checkbox"/> Graded	Level	Level	Level
e. Elimination Period		<input type="checkbox"/> 180 days <input type="checkbox"/> 360 days			
f. Benefit Period/Term		To Age 65			
g. Occupation Class					
Supplemental Benefits	Complete question h	Complete question i	Complete questions j – n	Complete Supplement	Complete Supplement

**Complete the Following When Applying for Disability Income**

h. Supplemental Benefits – ProVider Plus

	ProVider Plus	ProVider Plus Limited
Residual Disability Benefits	<input type="checkbox"/> Residual Disability <input type="checkbox"/> Partial Disability	<input type="checkbox"/> Basic Residual Disability
Cost of Living Adjustments	<input type="checkbox"/> 3% Compound <input type="checkbox"/> 6% Maximum <input type="checkbox"/> Four-Year Delayed	<input type="checkbox"/> 3% Maximum (CPI-Tied)
Extended Benefits	<input type="checkbox"/> Lump Sum Disability Benefit <input type="checkbox"/> Graded Lifetime Indemnity for Total Disability	
	<input type="checkbox"/> Future Increase Option \$ _____	
Benefits listed at right are available with both ProVider Plus and ProVider Plus Limited	<input type="checkbox"/> Catastrophic Disability Benefit \$ _____	
	<input type="checkbox"/> Retirement Protection Plus: Monthly Indemnity \$ _____ Elimination Period <input type="checkbox"/> 180 days <input type="checkbox"/> 360 days	
	<input type="checkbox"/> Social Insurance Substitute \$ _____	
	<input type="checkbox"/> Unemployment Waiver of Premium	
	<input type="checkbox"/> Other _____ <input type="checkbox"/> Other _____	

**Complete the Following When Applying for Retirement Protection (separate policy)**

## i. Supplemental Benefits – ProVider Plus: Retirement Protection

- Cost of Living Adjustment:  3% Compound  6% Maximum  
 Future Increase Option \$ \_\_\_\_\_  
 Other \_\_\_\_\_

**Complete the Following When Applying for Reducing Term Insurance**

j. Loss Payee Name: \_\_\_\_\_

*(Must be the individual or entity that the money is owed to.)*

Loss Payee Tax ID #: \_\_\_\_\_

Business Address (Street, City, State, Zip):  
\_\_\_\_\_  
\_\_\_\_\_

Owner Name: \_\_\_\_\_

Owner Tax ID #: \_\_\_\_\_

k. Provide type and reason that the obligation was incurred:

- Business Loan  
 Purchase Agreement  
 Employment Contract  
 Student Loan – Have you deferred payments of this loan or do you intend to do so?  
 Yes  No If yes, describe how long below.

*Details:* \_\_\_\_\_ Other \_\_\_\_\_

l. Date obligation took effect (mm/dd/yyyy): \_\_\_\_\_

m. Names of all debtors or guarantors:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

n. Periodic payment in the amount of \$ \_\_\_\_\_ is to be made each month for \_\_\_\_\_ months

Periodic payment in the amount of \$ \_\_\_\_\_ is to be made each month for \_\_\_\_\_ months

Periodic payment in the amount of \$ \_\_\_\_\_ is to be made each month for \_\_\_\_\_ months

I am responsible for payments for a total of \_\_\_\_\_ months

**10. 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, chiropractors, practitioners or hospitals. Also include in this section any special policy requests such as specific policy date other than as provided by the terms of this application. For additional space use the Supplement to the Application for Insurance (C-APP-SUPP).*





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](http://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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[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

This Authorization applies to the Proposed Insured named above. It can only be signed by the Proposed Insured, or the parent or legal guardian of the Proposed Insured in the case of a minor under the age of 18.

**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, employer or laboratory that has any records or knowledge of the Proposed Insured or his/her health to release any and all medical and non-medical information in its possession about the Proposed Insured, 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 the Proposed Insured. 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 understand that any information disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal regulations governing privacy (such as the HIPAA Privacy Rule).

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 Parent/Legal Guardian

\_\_\_\_\_  
Witness Signature





- 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  
The Guardian Life Insurance Company of America, New York, NY
- THE GUARDIAN LIFE INSURANCE COMPANY OF AMERICA**  
Administrative Office: 700 South Street, Pittsfield, MA 01201  
*(Please check appropriate company(ies). Any insurer checked above is  
herein referred to as the "Company.")*

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## Conditional Receipt for Disability Insurance

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**This receipt does not create any temporary or interim insurance. This receipt sets the date and conditions under which the insurance being applied for will go into effect. Unless all of the conditions in paragraph 2 below are met in full, no insurance will become effective. No agent of the Company and no broker is authorized to alter or waive any of the Company's requirements.**

If Questions 7f, 7g, 7h or 7i on the accompanying Application for Insurance are left blank or answered "Yes" no prepayment should be taken and no Conditional Receipt can be issued. However, with respect to question 7g, if the proposed insured's only medical advice, counseling, or treatment was a routine physical examination resulting in no diagnosis being made or treatment rendered, or for the common cold with a complete recovery, then a prepayment can be taken and a Conditional Receipt can be issued.

If Question 7u, 7v, 7w or 7x is answered "Yes," no prepayment should be taken and no Conditional Receipt can be issued.

1. **Effective Date** – As used herein, "Effective Date" means the latest of (i) the date of the Application for Insurance, (ii) the date of the Representations to the Medical Examiner (or the date of the latest if more than one is required), (iii) the date of this receipt, (iv) the date of the latest completion of any medical examinations, tests, x-rays and electrocardiograms that the Company requires, or (v) the Policy Date, if any, requested in the Application.
2. **Conditions Under Which Insurance May Become Effective** – The insurance in the amount and for the policy applied for will, subject to the limitations in paragraph 4, become effective as of the Effective Date only if all of the following conditions are met:
  - (a) an initial premium payment has been made as acknowledged below and honored on first presentation for payment. The check must be made payable to the Company (do not make check payable to the producer or leave payee blank);
  - (b) on the Effective Date the proposed insured is, in the opinion of the Company authorized officers, insurable and an acceptable risk under the Company rules, limits and standards for the proposed insurance amount, policy, and benefits exactly as applied for without restriction or modification;
  - (c) on the date of this receipt, all answers and statements in any part of the application(s) having an earlier date are complete and true as though given on the date of this receipt;
  - (d) information required by the Company to determine insurability must be received at the Company's Home Office within 60 days of the date of this receipt.

**If any one of these conditions is not met, this receipt is void and there shall be no liability on the part of the Company. The Company will return the payment accompanying this receipt in the form of a Company check.**

3. **Amendment of Application** – If the Company does not approve the application as applied for or if I request a modification as to the amount of insurance, policy, or benefits subsequent to the date of this receipt, then I understand that this receipt is void and there shall be no liability on the part of the Company. Should the Company offer insurance other than as applied for or in response to my request for a modification, such insurance shall not be effective unless and until:
  - (a) the modified policy is delivered; and
  - (b) an amendment of the application to adjust the provisions of the contract is signed by the proposed insured and the owner; and
  - (c) the health and other conditions affecting the insurability of the proposed insured continues to remain the same as described in the Application for Insurance and the Representations to the Medical Examiner.

**One Copy to Applicant**

**One Copy to Company**

**Conditional Receipt for Disability Insurance | Continued**

4. **Maximum Limits** – If the disability of the proposed insured occurs prior to the Company's approval, and the proposed insured satisfies the conditions set forth in paragraph 2 above, the Company's liability shall not be greater than the total amount of insurance (for the policy applied for) set forth in the schedule to the right. This amount shall be inclusive of all of the insurance on the proposed insured under conditional receipt pending and insurance in force with the Company.

Age*	Disability Income Limits	Total Disability Buy-Out Limits	Disability Overhead Expense Limits
under 56	\$5,000/mo.	\$500,000	\$5,000/mo.
56-60	4,000/mo.	400,000	4,000/mo.
61-64	0	**	**

\*Age means age of proposed insured at birthday nearest date of Conditional Receipt.  
 \*\*Products not available.

5. **Acknowledgement of Payment** – We have received from \_\_\_\_\_ (applicant):

(a) the sum of \$\_\_\_\_\_ to pay all or part of the first premium for the proposed disability income insurance policy;

(b) the sum of \$\_\_\_\_\_ to pay all or part of the first premium for the proposed disability buy-out insurance policy;

(c) the sum of \$\_\_\_\_\_ to pay all or part of the first premium for the proposed overhead expense insurance policy;

on \_\_\_\_\_ (proposed insured) in accordance with the Application(s) for insurance.

6. **Period of Coverage** – If less than the first full premium has been paid according to the mode of payment selected for the policy type and the amount of insurance applied for, any insurance effective under paragraphs 2 and 3 above shall be in force only for the pro rata portion of the policy year for which the premium has been paid. This portion of the policy year begins on the Effective Date and does not include any grace period.

**I have read this receipt and have received a copy signed by the producer. I understand that insurance becomes effective only if all the conditions of paragraph 2 are met and then only from the Effective Date, and for not more than the limitations in paragraph 4. I understand that if a policy date is requested in the application that is later than the date of either the Application for Insurance or the Representations to the Medical Examiner, I am waiving some rights under this receipt. I further understand that this receipt is void if there is any incorrect, untrue, incomplete or omitted statement of material fact in the Application for Insurance, Representations to the Medical Examiner, or any supplemental form that becomes part of any policy issued.**

Signed \_\_\_\_\_ Applicant(s)      Date \_\_\_\_\_ (mm/dd/yyyy)

Signed \_\_\_\_\_ Producer      Date \_\_\_\_\_ (mm/dd/yyyy)

**One Copy to Applicant**

**One Copy to Company**



- 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 15<sup>th</sup> of each month to pay premiums due and/or on the 1<sup>st</sup> business day of each month to pay the policy loan on the policy(ies) identified below (on or about the 15<sup>th</sup> 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 15<sup>th</sup> day of each month. The monthly deduction to your account for any policy loan payments will be made on the 1<sup>st</sup> business day of each month. (on or about the 15<sup>th</sup> 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.*

- The Guardian Life Insurance Company of America**
- Berkshire Life Insurance Company of America**  
700 South Street  
Pittsfield, MA 01201

## CONSENT FOR HIV TESTING

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

---

*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*

---

### Special Instructions for the Soliciting Agent and the Medical Professional When Drawing Blood for Company's Proposed Insured

#### Soliciting Agent

1. If the state of residence of the Company's Proposed Insured is Arizona, have the Proposed Insured read and complete this consent form when completing the Application for Insurance.
2. Deliver original to the Proposed Insured.
3. Forward 1 copy to the Company (Agency of Record) with the completed Application for Insurance.
4. Forward 2 copies to the Medical Professional drawing the blood.

#### Medical Professional

1. Retain 1 copy for your records.
2. Forward 1 copy to the lab along with the blood drawn.

- The Guardian Life Insurance Company of America**
- Berkshire Life Insurance Company of America**  
700 South Street  
Pittsfield, MA 01201

## NOTICE AND CONSENT FORM FOR AIDS VIRUS (HIV) ANTIBODY/ANTIGEN TESTING

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

---

*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*

---

To evaluate your eligibility for insurance coverage, it is requested that you consent to be tested to determine the presence of antibodies or antigens to the Human Immunodeficiency Virus (HIV). By signing and dating this form, you agree that these tests may be performed and that underwriting decisions (for example, the decision to accept or reject your application) will be based on the test results. You may have ten (10) days to decide whether you wish to sign this form. You may refuse to be tested. However, such refusal may be used by the insurer as a reason to deny coverage. Please see below for additional counseling information.

### Information on HIV

HIV, the virus that causes AIDS, is transmitted from one person to another through blood, semen and vaginal fluids. The disease is spread primarily during anal, vaginal, or oral intercourse, the sharing of needles and syringes used for shooting drugs, or from a mother to her unborn child. *HIV is not spread through casual contact, such as eating with or touching a person infected with the virus. There is no medical evidence that HIV is spread by kissing.*

Persons most at risk of contracting HIV are men who have sex with other men; Intravenous ("IV") drug users; prostitutes (male or female), persons who have had many sexual partners since 1977; persons who received transfusions of blood or blood products prior to March, 1985; the sexual partners of persons in any of these groups; and infants born to infected mothers.

### Pre-Test Counseling Considerations

Many public health organizations have recommended that before taking an HIV antibody/antigen test, a person seek counseling to become fully informed about the implications of such tests. You may wish to consider obtaining such counseling at your own expense prior to being tested. Free confidential counseling is available in most Arizona communities. If you need information about the availability of counseling in your area contact your county health department, or:

Phoenix metropolitan area: 234-2752 (Arizona AIDS Information Line)  
Outside the Phoenix area: 1-800-334-1540 (Arizona Department of Health Services)

### Disclosure of Test Results

All test results will be treated confidentially. The results of the tests will be reported to the insurer identified on this form. Results of the tests will not otherwise be disclosed without your written consent except as required or allowed by law including, but not limited to, the Department of Health Services as provided by law. Disclosure of HIV test results pertaining to your application for insurance is governed by A.R.S. §20-448.01.

### Meaning of Positive Test Results

The most commonly used test for HIV is designed to detect the presence of antibodies to the virus. Antibodies are made by the body's immune system to fight infection. While positive HIV antibody test results do not mean that you have AIDS, they do indicate that you have been infected by HIV, the virus that causes AIDS. About 50% of infected individuals have developed AIDS within 10 years after being infected with the virus.

Positive HIV antibody/antigen test results will adversely affect your application for insurance. This means that your application will probably be declined.

### Consent

I have read and I understand this Notice and Consent Form. I voluntarily consent to testing and disclosure as described above. I understand that I or my legal representative have a right to request and receive a copy of this form. This authorization is valid for 180 days from the date of my signature below. A photocopy of this form will be as valid as the original.

---

Signature of Proposed Insured or Parent/Guardian

---

Date

**Note to Producer: Original to Proposed Insured**  
**1 Copy to the Insurer 1 Copy to the Examiner 1 Copy to the Lab**

- The Guardian Life Insurance Company of America**
- Berkshire Life Insurance Company of America**  
700 South Street  
Pittsfield, MA 01201

**NOTICE AND CONSENT FORM FOR AIDS VIRUS (HIV) ANTIBODY/ANTIGEN TESTING**

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

---

*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*

---

**Optional Release of Information to Personal Physician**

In addition to the release of information as described above, I hereby authorize the release of my HIV test results to my personal physician named below:

\_\_\_\_\_  
Physician's Name

\_\_\_\_\_  
Address

\_\_\_\_\_  
City, State, Zip

\_\_\_\_\_  
Signature of Proposed Insured or Parent/Guardian

\_\_\_\_\_  
Date

- The Guardian Life Insurance Company of America**
- Berkshire Life Insurance Company of America**  
700 South Street  
Pittsfield, MA 01201

## NOTICE AND CONSENT FORM FOR AIDS VIRUS (HIV) ANTIBODY/ANTIGEN TESTING

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### Pre-Test Counseling Considerations

Many public health organizations have recommended that before taking an HIV antibody/antigen test, a person seek counseling to become fully informed about the implications of such tests. You may wish to consider obtaining such counseling at your own expense prior to being tested. Free confidential counseling is available in most Arizona communities. If you need information about the availability of counseling in your area contact your county health department, or:

- Phoenix metropolitan area: 234-2752 (Arizona AIDS Information Line)
- Outside the Phoenix area: 1-800-334-1540 (Arizona Department of Health Services)

### Disclosure of Test Results

All test results will be treated confidentially. The results of the tests will be reported to the insurer identified on this form. Results of the tests will not otherwise be disclosed without your written consent except as required or allowed by law including, but not limited to, the Department of Health Services as provided by law. Disclosure of HIV test results pertaining to your application for insurance is governed by A.R.S. §20-448.01.

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---

Signature of Proposed Insured or Parent/Guardian

---

Date

**Note to Producer: Original to Proposed Insured**  
**1 Copy to the Insurer 1 Copy to the Examiner 1 Copy to the Lab**

- The Guardian Life Insurance Company of America**
- Berkshire Life Insurance Company of America**  
700 South Street  
Pittsfield, MA 01201

**NOTICE AND CONSENT FORM FOR AIDS VIRUS (HIV) ANTIBODY/ANTIGEN TESTING**

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

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*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*

---

**Optional Release of Information to Personal Physician**

In addition to the release of information as described above, I hereby authorize the release of my HIV test results to my personal physician named below:

\_\_\_\_\_  
Physician's Name

\_\_\_\_\_  
Address

\_\_\_\_\_  
City, State, Zip

\_\_\_\_\_  
Signature of Proposed Insured or Parent/Guardian

\_\_\_\_\_  
Date

- The Guardian Life Insurance Company of America**
- Berkshire Life Insurance Company of America**  
700 South Street  
Pittsfield, MA 01201

## NOTICE AND CONSENT FORM FOR AIDS VIRUS (HIV) ANTIBODY/ANTIGEN TESTING

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- Phoenix metropolitan area: 234-2752 (Arizona AIDS Information Line)
- Outside the Phoenix area: 1-800-334-1540 (Arizona Department of Health Services)

### Disclosure of Test Results

All test results will be treated confidentially. The results of the tests will be reported to the insurer identified on this form. Results of the tests will not otherwise be disclosed without your written consent except as required or allowed by law including, but not limited to, the Department of Health Services as provided by law. Disclosure of HIV test results pertaining to your application for insurance is governed by A.R.S. §20-448.01.

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### Consent

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\_\_\_\_\_  
Signature of Proposed Insured or Parent/Guardian

\_\_\_\_\_  
Date

**Note to Producer: Original to Proposed Insured**  
**1 Copy to the Insurer 1 Copy to the Examiner 1 Copy to the Lab**

- The Guardian Life Insurance Company of America**
- Berkshire Life Insurance Company of America**  
700 South Street  
Pittsfield, MA 01201

**NOTICE AND CONSENT FORM FOR AIDS VIRUS (HIV) ANTIBODY/ANTIGEN TESTING**

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

---

*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*

---

**Optional Release of Information to Personal Physician**

In addition to the release of information as described above, I hereby authorize the release of my HIV test results to my personal physician named below:

\_\_\_\_\_  
Physician's Name

\_\_\_\_\_  
Address

\_\_\_\_\_  
City, State, Zip

\_\_\_\_\_  
Signature of Proposed Insured or Parent/Guardian

\_\_\_\_\_  
Date

- The Guardian Life Insurance Company of America**
- Berkshire Life Insurance Company of America**  
700 South Street  
Pittsfield, MA 01201

**AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION**

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

*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*

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

This authorization is at the request of the individual whose name appears below.

In the event my application for insurance is not approved or if my policy is issued at a rate or with benefits other than as applied for, I authorize the Company to disclose the specific reasons for the underwriting decision to my agent or broker and/or to his or her marketing organization. I understand that the Company will not condition eligibility for coverage, underwriting or risk rating determination, or payment of benefits on any provision of this authorization. **I understand that this disclosure may involve specific, protected health information regarding me. I also understand that authorizing this disclosure is optional and I am not required to sign this authorization.**

**REDISCLASURE OF INFORMATION**

I understand that if the person(s) or organization(s) that receives information provided pursuant to this authorization is not subject to federal privacy regulations, the information may be redisclosed and will no longer be protected by the federal privacy regulations.

**REVOICATION OF AUTHORIZATION**

As described in the Company's Notice of Privacy Practices, I understand that I may revoke this authorization in writing at any time by sending a written revocation to the Company, ATTN: PRIVACY ADMINISTRATOR, Underwriting Department, 700 South Street, Pittsfield, Massachusetts 01201. I also understand that any such revocation will not be effective to the extent that action has been taken by the Company in reliance on this authorization or the extent that the Company has legal right to contest a claim under the policy which I have applied for or to contest the policy itself.

**EXPIRATION OF AUTHORIZATION**

This authorization will be valid for 24 months from the date of my signature below.

A copy of this authorization is as valid as the original.

\_\_\_\_\_  
**Applicant's Name (Please Print)**

\_\_\_\_\_  
**Applicant's Signature**

\_\_\_\_\_  
**Date**

**RETURN ONE COPY TO HOME OFFICE, LEAVE ONE COPY WITH APPLICANT**