INSTRUCTIONS FOR COMPLETING THE LIFE INSURANCE APPLICATION  
(For Producer Use Only)

All questions must be answered completely. Use blue or black ink. Any changes to these answers must be initialed by the Owner. In addition, the Proposed Insured must initial any change to answers pertaining to his/her personal information or any answer pertaining to insurability. An agent has no authority to waive, change or limit any question on the application.

1. This application is for insureds age 14 years 6 months and older. This application is for fully underwritten cases, that are not Pension Trust cases. If changing an inforce policy, exercising a Guaranteed Insurability Option, or converting term coverage, please use the appropriate Change Request or Conversion application.

2. The basic forms needed for a complete application are: The Part 1 application, the Authorization, the Notice of Information Practices (must be left with Proposed Insured), the appropriate Part 2 supplement (Non-Medical or Medical), and the Agent’s Certification.

3. You may also need any or all of the following forms depending on the particulars of the case in question:
   - Replacement form(s). Generally, you will need to obtain the appropriate state replacement form if the answer to the replacement question in the application is Yes. Note that, in some states, the replacement form is required if the owner has any existing individual life or annuity contracts, even if no replacement is occurring. Please refer to the summary documents for Replacements that can be found in the Life Resource Center of Guardian Online.
   - Guard-O-Matic forms if requesting GOM mode.
   - Conditional Receipt if accepting cash with application. There are specific conditions that appear on the Receipt form under which the receipt cannot be used. Please do NOT complete and provide the Receipt if the case does not qualify for accepting cash with the application. In addition to the conditions on the Receipt form, please note that we do not allow cash with application for variable life policies, survivorship type policies, or any policy where the face amount is over $5,000,000. If using the Receipt, please complete the form and leave with owner. Please ensure the question regarding the Prepayment of Premium in the application is answered and that the client understands the terms and conditions of the temporary coverage provided.

   If a client provides money with the application, and therefore you have provided a conditional receipt, an illustration (signed or unsigned) must be submitted with the application. The illustration must match what the client is applying for (base policy and riders) in section G of the application. The amount of money to be collected must be at least 1/12 of the annual premium shown on the illustration. If not, the conditional receipt will be void and the money will be returned to the client.
   - Consent for HIV testing, if required by state. Important: when a consent form is required, it must be signed prior to testing. So if your client is sent for a medical examination prior to completing the Part 1 application, the HIV form must be signed before the HIV test. In this situation, signing the consent form at time of application is too late.
   - Underwriting supplements (aviation, avocation, alcohol/drug, military, foreign residence/travel). The application form has instructions as to when one of these forms would be needed. In addition, an Underwriter can always request a supplement.
   - If this is an application for Variable Life, we require the Variable Life Supplement, the Patriot Act Notice, and appropriate PAS forms. Please see iPipeline for guidance.
   - Other miscellaneous disclosure forms, depending on the product and state.

All of the above forms are not contained in this application package, but are available on the iPipeline system.
APPLICATION FOR LIFE INSURANCE
Part 1

SECTION A  Proposed Insured Information

1. First Name_________________________ MI _____ Last Name_________________________

2. Previous Name (if changed in the last 5 years) ________________________________

3. Social Security # ____________________________ 4. Sex  ☐ Male  ☐ Female

5. Date of Birth (mm/dd/yyyy) ____________________________ 6. Place of Birth ____________________________

7. Are you a U.S. citizen?  ☐ Yes  ☐ No (If no, please complete Foreign Travel and Residence Questionnaire)

8. Marital Status:  ☐ Married  ☐ Single  ☐ Divorced  ☐ Separated  ☐ Widowed

9. Driver’s License Number ____________________________ Driver’s License State __________
   (If none, provide a government photo ID number, issuer and expiration date in Remarks section)

10. Primary Residence (Do not use P.O. Box) ____________________________

City_________________________ State _____ Zip ______________

11. How long at this address? ____________ (If less than 2 years at current address, please provide prior address in Remarks section)

12. Home phone ____________________________ 13. E-mail address ____________________________

14. Telephone Interview – if more information is needed, a representative may call you. Show the most convenient place and range of times for such a call weekdays between the hours of 9:00 a.m. and 9:00 p.m.
   ☐ Home  ☐ Business  ☐ Other – Phone ____________________________ Times ____________________________

SECTION B  Employment Information

1. Name of Employer ____________________________

2. Street Address ____________________________

City_________________________ State _____ Zip ______________


5. Occupation ____________________________ 6. Job Title ____________________________

7. Nature of Business ____________________________

8. How many years employed? ____________ (If less than 2 years please furnish information on previous employer in Remarks section, including name and address of previous employer, occupation, nature of business and job title.)
SECTION C  Owner Information

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

1. Owner:  □ Individual  □ Trust  □ Business Entity  □ Charity

2. Owner name (First, MI, Last) or name of trust, business entity or charity:

3. Social Security No./Tax ID No. ........................................ 4. Relationship to proposed insured ........................................

5. Full Address (Do not use P.O. Box) ......................................

6. Telephone Number .......................................................... 7. Owner’s E-Mail Address ........................................................

If Owner is an individual, please answer Questions 8 and 9

8. Date of Birth (mm/dd/yyyy) .................................................. 9. Driver’s License No. and State ..................................................
   (if none, provide a government photo ID number, issuer and expiration
   date in Remarks section)

10. If the Owner is an individual, is he/she a U.S. citizen? If Owner is a Trust, Business Entity, or Charity, is such entity established
    or organized under the laws of a state of the U.S.?  □ Yes  □ No (if no, provide details in Remarks)

11. Complete if Policy is Trust Owned (also, complete either Trust Certification form or provide copy of trust agreement):
    Date of Trust ........................................................................
    Complete Names of Authorized Trustees ............................

SECTION D  Change of Ownership

1. Is there an intention that any group of investors will obtain any right, title, or interest in any policy issued on the life of the
   proposed insured as a result of this application?  □ Yes  □ No

2. Will you (the owner/applicant) borrow money to pay the premiums for this policy or have someone else pay these premiums in
   return for an assignment of policy values back to them?  □ Yes  □ No
   (If Yes to either of these questions, please complete Statement of Owner Intent form)

SECTION E  Beneficiary Information

If you indicate shares, please ensure that the % for all the beneficiaries in each type (primary, contingent, tertiary) total 100%. Please
use whole numbers only. If you do not indicate shares, all Primary Beneficiaries who survive the Insured shall share equally. If no
Primary Beneficiary survives the Insured, benefits will be paid in equal shares to the Contingent Beneficiaries, etc., who survive the
Insured.

<table>
<thead>
<tr>
<th>Name (First, MI, Last)</th>
<th>Date of Birth</th>
<th>Soc. Sec. No.</th>
<th>Relationship to Insured</th>
<th>Share (enter %)</th>
<th>Beneficiary Type (see key)</th>
</tr>
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<td>□ P  □ S</td>
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Key: P = Primary Beneficiary;  S = Secondary Beneficiary;  T = Tertiary Beneficiary

SECTION F  Purpose of Insurance

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

□ Buy-Sell  □ Deferred Compensation  □ Charitable Planning  □ Family Income  □ Mortgage
□ Key Person  □ Split Dollar  □ Estate Planning  □ Retirement  □ Other ____________________
□ Executive Bonus  □ Collateral for Debt  □ Wealth Accumulation  □ Education

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### SECTION G  Proposed Insurance

1. Plan of Insurance  
2. Base Policy Face Amount $ 

3. Riders

**Whole Life** (Note: Option Q and R riders are elected in the Dividends Section)
- [ ] Waiver of Premium (WP)
- [ ] Accelerated Benefit Rider (EABR) *(please complete required disclosure form)*
- [ ] Scheduled/Unscheduled Paid-Up Additions (PUA) Rider
  - If a Scheduled PUA Payment is desired, indicate annual amount $ 
  - If an Initial PUA Payment is to be made, indicate amount (not including first Scheduled payment) $ 
  - If Waiver of Specified Amount benefit is requested, indicate annual Specified Amount $ 
- [ ] Guaranteed Purchase Option (GIO) select one: [ ] Regular GIO  [ ] Limited GIO  [ ] L10 GIO *(for L10 plan only)*
  - Indicate GIO Option Amount: $ 
- [ ] Accidental Death Benefit (ADB)  
  - Indicate ADB Face Amount: 
- [ ] 10 Year Annually Renewable Term  
  - Term Amount: $ 
- [ ] Select Security Rider (Amendment to “Owner” provision)  [ ] Exchange of Insureds
- [ ] DuoGuard (Survivor Insurance Purchase Option (SIPO) Rider) *(List names & amounts for Designated Lives. Complete a separate application for each Designated Life.)*

### Term

- [ ] Waiver of Premium  [ ] Waiver Plus *(for Level Term only)*  [ ] Initial Period Waiver of Premium *(For LifeSpan only)*
- [ ] Extended Conversion Rider  [ ] Whole Life Purchase Option  
  - Option Amount $ 
- [ ] Accidental Death Benefit (ADB)  
  - ADB Face Amount: $ 

### Universal Life and Variable Life Riders

- [ ] Additional Sum Insured *(Do NOT include this amount in Base Face Amount shown above)* $ 
- [ ] Secondary Guarantee Coverage Rider  [ ] Alternate Net Cash Surrender Value Benefit
- [ ] Accelerated Benefit Rider (EABR) *(please complete required disclosure form)*
- [ ] Waiver of Monthly Deductions
- [ ] Disability Benefit Rider (Waiver of Specified Amount)  
  - Indicate Monthly Specified Amount: $ 
- [ ] Guaranteed Insurability Option (GIO/WLPO)  
  - Option Amount $ 
- [ ] Accidental Death Benefit (ADB)  
  - ADB Face Amount: $ 
- [ ] Select Security Rider (Amendment to “Owner” provision)  [ ] Exchange of Insureds

### Riders for Survivorship Products *(Estateguard WL, SUL, etc.)*

- [ ] Survivorship Waiver of Premium (Death Waiver) *(available on one or both of the base policy insureds)*
  - [ ] (1st Insured) $ 
  - [ ] (2nd Insured) $ 
- [ ] Policy Split Option $ 
- [ ] Four Year Term Rider for SUL *(on both insureds)*  
  - Term Amount: $ 
- [ ] Single Life Term/RTR 85 *(available on one or both of the base policy insureds)*
  - [ ] (1st Insured) $ 
  - [ ] (2nd Insured) $ 
- [ ] Second to Die DuoGuard (Survivorship Insurance Purchase Option (SIPO) Rider) *(List names & amounts for Designated Lives. Complete a separate application for each Designated Life.)*

- [ ] First To Die DuoGuard (Beneficiary Insurance Purchase Option (BIO) Rider) *(available on one or both of the base policy insureds)*
  - [ ] (1st Insured) $ 
  - [ ] (2nd Insured) $ 

*Note the Policy Split Option rider will automatically be included for Estateguard SUL and SUL-SG products, if the policy is eligible for such rider. The rider is not automatically included on Estateguard WL policies and should be elected, if desired.*

### Other Riders

- [ ] Other $ 
- [ ] Other $ 

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SECTION H  Premiums

1. Mode
   - Annual
   - Semiannual
   - Quarterly
   - Monthly (list bill only – this may not be available for all products)
   - Guard-O-Matic (complete the appropriate Request Form)
     - New Service
     - Add to my existing service
     - Existing Policy Number _______________________
   - Other _______________________

2. Who is to pay premiums?

3. Send premium notices to:
   - Residence
   - Business
   - Owner’s address
   - Other _______________________
   - List Bill
     - New – Billing Name _______________________
     - Common billing date _______________________
     - Existing account # _______________________

4. Automatic Premium Loan (if available)
   - Yes
   - No (if left blank, default will be Yes)

5. Complete for VUL/UL policies:
   - Initial Premium $ _______________________
   - Planned Premium (at the mode indicated above) $ _______________________

6. Prepayment of Premium
   - No money is being submitted with this application.
   - Money is being submitted with this application, in the amount of $ _______________________. By signing this application, agent is attesting that the above amount of money was collected, that the Conditional Temporary Coverage Agreement and Receipt was provided to the client and that the conditions for providing such Receipt were met. By signing this application, applicant is attesting that the 3 medical questions asked in the Conditional Temporary Coverage Agreement and Receipt form were all answered “NO”, and that the applicant has received the Receipt form and agrees to its terms.

SECTION I  Dividends (for participating policies only)

If you apply for a participating life insurance policy, and do not elect a dividend option, the following default options will apply: for Whole Life policies, Option D: for Term policies, Option C, for Universal Life policies, any dividend paid will be used to increase the unloaned policy account value. Note that for Term and Universal Life policies, we do not expect to ever pay a dividend. For any participating product, dividends are never guaranteed.

- A-Paid in cash
- B-Reduce premiums
- C-Left at interest (Complete W-9 form if elected)
- D-Paid-Up Additional Insurance
- F-Term Insurance face amount not in excess of cash value/Balance to purchase paid-up additional insurance
- G-Term Insurance face amount not in excess of cash value/Balance to reduce premium
- L-Term insurance face amount not in excess of 2X face amount of basic policy/Balance to purchase paid-up additional insurance
- P-Term Insurance face amount not in excess of 2X face amount of basic policy/Balance to reduce premium
- Q-One Year Term Insurance not to exceed Target Face Amount* of $ _______________________
- R-One Year Term Insurance with Increasing Target Face Amount* Initial Target $ _______________________
  - Level Increases % _______________________
  - Compound Increases % _______________________
- S-Premium Offset — (available only if a PUA rider is requested. Premiums to be offset at the end of the first policy year by use of PUA rider additions and future dividends) Yes with Target Face Amount* not to exceed $ _______________________
  - U-Loan Repayment/Balance to Paid-up Additions
  - Other _______________________

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

SECTION J  Additional Information for VUL/UL Policies

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

2. Section 7702 Test (Note, the choice of 7702 Test may not apply to all policies)
   Section 7702 of the Internal Revenue Code defines Life Insurance and specifies the rules under which the growth of life insurance policy cash values is excludable from gross income. If the plan being applied for provides a choice of test under 7702 to qualify the policy as life insurance, please check one of the tests shown below. Once a test is elected, it cannot be changed. If there is a choice of Test and none is elected, the Guideline Premium Test will be used.
   - Guideline Premium Test
   - Cash Value Accumulation Test

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**SECTION K  Financial Information**

1. Is the applied for policy in accordance with your insurance objectives and your anticipated financial needs?  □ Yes  □ No

2. Do you believe you have the financial ability to continue making premium payments on this policy?  □ Yes  □ No  *(If yes, give full details and date of discharge in Remarks section.)*

3. Have you ever filed for personal or business bankruptcy?  □ Yes  □ No  *(If yes, give full details and date of discharge in Remarks section.)*

4. **Personal Finances** *(If this policy is business owned, please also complete the Business Finances section below.)*

<table>
<thead>
<tr>
<th>Proposed Insured</th>
<th>Owner (if other than insured)</th>
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<tr>
<td>Total Assets</td>
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<td>Total Liabilities</td>
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<td>Net Worth</td>
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<td>Earned Income (prior year)</td>
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<td>Unearned Income (if over $10,000)</td>
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**Business Finances** *(Complete only if policy is business owned)*

5. **Type of Business** *(Check One): □ Limited Liability Co. □ Sole Proprietor □ Partnership □ S Corp □ C Corp □ Other _________


9. Net Profit After Taxes for past Two Years: Last Year $ ____________________ Previous Year $ ____________________

10. How long has the business been established? __________________________________________

11. What is the nature of the business? _________________________________________________

12. What percentage of the business is owned by the proposed insured? ______________________

13. Is there business insurance applied for or in force on other key members of this firm?  □ Yes  □ No
    *(If "yes", please provide details: ________________________________)*

**SECTION L  Insurance History**

1. Please list below all existing life insurance policies in force **on the proposed insured**. If none, check here  □

<table>
<thead>
<tr>
<th>Name of Company</th>
<th>Type <em>(e.g. individual or group)</em></th>
<th>Year Issued</th>
<th>Total Amount</th>
<th>Who Owns the Policy?</th>
<th>Has WP Rider?</th>
<th>Has ADB Rider?</th>
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2. Has the proposed insured ever had life, disability, accident or medical insurance declined, postponed, modified, rated, cancelled or withdrawn a pending application, or had a renewal or reinstatement refused?  □ Yes  □ No *(if yes, provide full details in Remarks)*

3. Are any other life, disability or accident insurance products currently being applied for on the life of the insured, or is there any plan to do so in the near future?  □ Yes  □ No *(If "Yes", in the Remarks section, please include amount and company applied with, and whether this other insurance will be in addition to or in lieu of insurance with Guardian/GIAC.)*
SECTION M  Replacement

1. Does the Owner/Applicant have any existing individual life insurance policies or annuity contracts (including those that may have recently been lapsed or surrendered)? ☐ Yes ☐ No

IMPORTANT: If “Yes”, please complete the appropriate state replacement form(s).

SECTION N  Personal History of the Proposed Insured

(These questions apply to the Proposed Insured. If “Yes” to Question 1, 3, 4 or 5, provide details in Remarks section.)

1. Do you intend to change your occupation?.................................................................................................................. ☐ Yes ☐ No

2. Do you intend to reside outside of the U.S.? (If Yes, complete Foreign Travel and Residence Questionnaire)............... ☐ Yes ☐ No

3. Do you intend to travel outside of the U.S.?................................................................................................................. ☐ Yes ☐ No

4. Have you ever had your driver’s license suspended or revoked, or been convicted of DUI or DWI, or within the past five years, have you been charged with and/or convicted of any motor vehicle moving violations? (If yes, details must include date of violation, description of violation and penalty.) ............................................................................................................ ☐ Yes ☐ No

5. Within the last 10 years, have you been convicted of, or pled guilty or no contest to, a felony, or is such a charge pending against you?.................................................................................................................. ☐ Yes ☐ No

6. Within the last 3 years have you flown as a licensed pilot, student pilot, or crew member in any type of aircraft, or do you intend to do so in the future? (If yes, complete Aviation Supplement.) ................................................................. ☐ Yes ☐ No

7. Within the past 3 years, have you participated in, or do you intend to participate in, any of the following activities: mountain climbing, rock climbing, scuba diving, hang gliding, parachuting, skydiving; or motor vehicle racing?........... ☐ Yes ☐ No

(If yes, complete Avocation Supplement.)

8. Are you, or do you intend to become, a member of the armed forces, including the Reserves, or are you on alert? (If yes, please complete Military Status Questionnaire) .................................................................................................................. ☐ Yes ☐ No

9. Have you ever used tobacco or any other nicotine product such as cigarettes, cigars, pipe, chewing tobacco, snuff, nicotine gum, nicotine patch, or electronic nicotine delivery device? If yes, please complete chart below........ ☐ Yes ☐ No

<table>
<thead>
<tr>
<th>Product Type(s)</th>
<th>Date Last Used</th>
<th>Frequency of Use</th>
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</table>
SECTION O  Alternate/Additional Life Policy

Owner: If the “Alternate Policy” box is checked below, you are indicating that you are applying for either the policy applied for in Section G or the policy indicated below. You do not intend to have both policies issued. If the “Additional Policy” box is checked, you are indicating that you are applying for both the policy shown in Section G and the policy indicated below. The total amount of insurance you are applying for is the sum of both policies.

Please indicate: ☐ Alternate Policy  ☐ Additional Policy

Plan of Insurance: ___________________________ Face Amount: ___________________________

Details (Riders, Benefits, Dividend Option, etc.):

SECTION P  Illustration

This section does not need to be completed if (a) the policy applied for is variable life insurance; (b) a signed illustration is not required by law for the policy applied for; or (c) the applicant has signed an illustration that matches the policy as applied for. Note that for most of our life insurance products, the applicant should be receiving and signing a sales illustration.

Agent’s Certification (Check One)

☐ No illustration was used in the sale of this life insurance policy.

☐ An illustration was used in the sale of life insurance, but the illustration used does not match the policy applied for herein.

☐ A computer screen illustration was used in the sale that which complied with state requirements for which no hard copy was furnished to the applicant.

My signature on this application certifies that I will provide the applicant with an illustration conforming to the policy as issued, no later than the time the policy is delivered.

Applicant’s Certification

My signature on this application is my acknowledgement that (a) I have not received a sales illustration that conforms to the life insurance policy I have applied for, and (b) I understand that a sales illustration conforming to the policy as issued will be provided by the Company no later than at the time the policy is delivered.

SECTION Q  Remarks Section

__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________

SECTION R  Amendments or Corrections (For Home Office Or Customer Service Office Use Only)
Representations of the Proposed Insured and Owner

Those parties who sign below, agree that:

1. This application, (Part 1, Part 2, the Authorization, any amendments to the application, and any required supplements or questionnaires) will form the basis for, and will be attached to and become a part of, any policy issued. That all of the statements that are part of the application are correctly recorded, and are complete and true to the best of the knowledge and belief of those persons who made them. Any misrepresentation or omission, if found to be material, may adversely affect acceptance of the risk, claims payment or may cause the Company to seek rescission of any policy that is issued based on this application.

2. No agent, broker or medical examiner has any right to accept risks, make or change contracts, or to waive or modify any of the Company's rights or requirements. No information acquired by any Representative of the Company shall bind the Company unless it shall have been set out in writing in this application.

3. For any policy that will be issued, the policy date is the date from which premiums are calculated and become due. The effective date is the date the policy is delivered and accepted by the owner, and the first premium is paid. Except as provided in the Conditional Temporary Coverage and Receipt (if an advance payment has been made and such Receipt has been issued and its terms complied with) coverage does not begin until the effective date assuming the first premium is paid during the lifetime of, and prior to any change in the health, of the Proposed Insured.

4. Changes or corrections made by the Company and noted in the "Amendments or Corrections" section are ratified by the Owner upon acceptance of a policy containing this application with the noted changes or corrections. Amendments as to plan, amount, classification, age at issue, or benefits, will be made only with the Owner's written consent.

5. By paying premiums on a basis more frequently than annually, the total premium payable during one year's time will be greater than if the premium were paid annually. That is, the cost of paying annualized periodic premiums will be more than the cost of paying one annual premium.

6. Unless the policy applied for is a Level Term policy, a variable life policy, or GIAC's Universal Life Secondary Guarantee products, a sales illustration is required. If no illustration was given at the time of application, the producer has explained why in Section P of this application. The owner understands that an illustration will be provided no later than at time of policy delivery.

7. ☐ Check here if backdating to save age is being requested. Note that a request to backdate to save age can only be honored if permitted by state law. If not backdating to save age, but a specific policy date is being requested, please enter date here:

Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Signed by Owner at: ____________________________ on mm/dd/yyyy
City and State

Signature of Proposed Insured (or Parent/Guardian if Insured under age 18)

X

Signature of Applicant/Owner if Other than Proposed Insured

X

Date of Signature for Proposed Insured (mm/dd/yy)

X

Signature of Additional Owner

X

Witness (for applications taken by mail – should not be beneficiary)

☐ Check here if this application was sent to the Proposed Insured for signature by mail. If so, the signature of the agent does not attest to the signature of the Proposed Insured.

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

X

Signature of Licensed Agent

License Number(s)

Agent's Name

State(s) where licensed

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SUPPLEMENTAL IDENTIFICATION INFORMATION FOR OWNER, BENEFICIARY AND INSURED

Please read these instructions carefully. Due to regulatory requirements, we request the following supplemental identification information for the beneficiary, owner and/or insured. The information we are requesting depends on which application type was used, as follows:

- If you completed the Regular Life Insurance Application (form L-AP-2011, or state variation thereof), please provide the address and phone number for each named beneficiary. Please ensure that you completed all other requested information on the application itself.

- If you completed the Juvenile Life Insurance Application (form JUV-AP-2006, or state variation thereof), please provide the address, phone number, Social Security Number and Date of Birth for each named beneficiary, as well as the phone number for the proposed insured.

- If you completed the Simplified Issue/Guaranteed Issue Life Insurance Application (form L-AP-SIGI-2008, or state variation thereof), please provide the address, phone number and Social Security Number for each named beneficiary. Also, if the policy is to be owned by an individual other than the proposed insured, please provide this individual’s date of birth.

- If you completed the Pension Trust Life Insurance Application (form PT-AP-2011, or state variation thereof), please provide the address, phone number and Social Security Number for each named beneficiary. However, if the Trust is to be the beneficiary of the policy, you do not need this form.

- If you completed the Life Insurance Change Request Form (form L-AP-CHG-2005, or state variation thereof), and you are requesting a conversion or an exchange or you are exercising a GIO rider, please provide the address, phone number, Social Security Number and Date of Birth of each named beneficiary and also the Owner. If the Change form was completed for any other reason, you do not need this form.

******************************************************************************

ADDITIONAL INFORMATION FOR BENEFICIARIES (Please complete appropriate sections as described above)

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<thead>
<tr>
<th>BENEFICIARY NAME</th>
<th>ADDRESS</th>
<th>PHONE NUMBER</th>
<th>SSN</th>
<th>DATE OF BIRTH</th>
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SUPP ID INFO

IMNB0013000650102
ADDITIONAL INFORMATION FOR OWNER (Please complete appropriate sections as described on page 1)

<table>
<thead>
<tr>
<th>OWNER NAME</th>
<th>ADDRESS</th>
<th>PHONE NUMBER</th>
<th>SSN</th>
<th>DATE OF BIRTH</th>
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ADDITIONAL INFORMATION FOR INSURED

Please indicate phone number for Proposed Insured if Juvenile Application was completed
APPLICATION FOR LIFE INSURANCE
Part 2 – Health and Personal History of Proposed Insured

PROPOSED INSURED INFORMATION

Please print:

1a. First Name ___________________________  MI _____  Last Name ___________________________

b. Date of Birth (mm/dd/yyyy) ___________________________

c. Name and Address of your personal physician. If none, so state.

________________________________________________________________________

d. Date and reason last consulted ___________________________

e. What treatment or medication was given or recommended? ___________________________

f. Height: __________ ft. __________ in.  Weight: __________ lbs.

g. Weight change past year: ☐ Gain  ☐ Loss __________ lbs.
   Reason for change: ____________________________________________

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

2. In the past seven years, have you had any known indication of, or been treated for cancer or tumor?  Yes ☐  No ☐

3. In the past seven years, have you had any known indication of, or been treated for or received a consultation or counseling for:
   i. high blood pressure, chest pain or disorder of the heart or circulatory system?  ☐
   ii. diabetes or disorder of the glands, bone, blood or skin?  ☐
   iii. complications of pregnancy, infertility, or any disorder of the breasts, reproductive or genital organs, prostate, kidneys, or urinary systems?  ☐
   iv. hernia, hepatitis, or disorder of the liver, gall bladder, stomach, pancreas, spleen, intestines or rectum?  ☐
   v. arthritis, rheumatism, or disorder of the joints, limbs or muscles?  ☐
   vi. disorder or condition of the back, neck or spine?  ☐
   vii. allergy, asthma, sinusitis, emphysema, disorder of the lungs or respiratory system, or sleep apnea?  ☐
   viii. epilepsy, stroke, dizziness, headache, or disorder of the brain, or spinal cord?  ☐
   ix. disorder of the eyes, ears, nose or throat?  ☐
   x. anxiety, depression, nervousness, stress, mental or nervous disorder, or other emotional disorder?  ☐
   xi. Chronic Fatigue Syndrome, Fibromyalgia, Epstein Barr virus or Lyme Disease?  ☐

4. Do you have any loss of hearing or sight, an amputation of any kind, or any known symptom of or known indication of any physical deformity, impairment or handicap?  ☐

5. Within the past seven years, have you been diagnosed by or received treatment from a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or any deficiency of the immune system such as Human Immunodeficiency Virus?  ☐

6.  i. Are you currently taking prescribed medication?  ☐
   ii. Are you currently taking non-prescription medication?  ☐
7. i. Within the past seven years, have you ever used stimulants, hallucinogens, narcotics or any other controlled substance?  

ii. Within the past seven years, have you ever had or been advised to have counseling or treatment for alcohol or drug use?  
(If yes to either question, complete the Alcohol and Drug Usage Supplement.)

8. Are you now pregnant?  
If yes, expected delivery date: .................................................................

9. 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? .................................................................

10. Within the past five years, have you had a physical exam or check-up of any kind? .................................................................

11. Within the past five years, have you been advised to have surgery or any diagnostic tests that were not performed, except for HIV tests? .................................................................

12. Within the past 12 months, have you had any known symptoms of or any known indication of any condition listed, except those conditions listed in question 5, for which you have not sought medical attention or advice? ........

13. Other than as previously stated on this application, in the last five years have you received medical advice from physicians, medical or mental health professionals, counselors, psychotherapists, or other practitioners, or have you been a patient in a hospital, clinic, sanatorium, or other medical facility? .........................

14. Do you have a family history of: diabetes, cancer, high blood pressure, heart disease, mental illness or suicide? .................................................................

<table>
<thead>
<tr>
<th></th>
<th>Age if Living</th>
<th>Cause of Death</th>
<th>Age at Death</th>
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<td>MOTHER</td>
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<td>BROTHERS and SISTERS</td>
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<td>No. Living</td>
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<td>No. Dead</td>
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15. DETAILS OF "YES" ANSWERS. IDENTIFY QUESTION & NUMBER. CIRCLE APPLICABLE ITEMS:  
Give 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. Additional paper may be attached if necessary to explain details.

________________________________________________________________________
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I understand and agree that the statements and answers in this Part 2 application are written as made by me; to the best of my knowledge and belief are full, complete and true; and that they shall be a part of the contract of insurance, if issued.

Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Signed at __________________________, this __________ day of __________________________, _________.
City and State   Day       Month       Year

________________________________________
Witness

________________________________________
Signature of Proposed Insured

L-AP-NOMED-2004 MD Rev 12
Authorization to Obtain and Release Information

Name of Proposed Insured __________________________________________ Date of Birth ______________________________

Address of Proposed Insured __________________________________________

_This Authorization is Designed To Comply 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, MIB, Inc., insurance or reinsurance company, or employer or other organization, institution or person 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. 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, and psychological conditions, and drug or alcohol abuse.

_I agree_ that this authorization shall be valid for two years from the date shown below and that a copy of the authorization shall be as valid as the original. I agree that if I sign this authorization electronically, that it will be equally as effective and valid as if I signed the form through traditional means. I understand, however, that I am under no obligation to sign this document electronically.

_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, MIB, Inc., 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 authorize_ the Company or its legal representatives to make a brief report of my personal health information to the MIB, Inc.

_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 ________________________________________________________
City and State ____________________________________________________
this __________________ day of __________________, ________.
Day Month Year

______________________________________________________________
Signature of Proposed Insured or Parent/Legal Guardian

______________________________________________________________
Witness Signature

C-AUTH-2013 MD
AGENT’S CERTIFICATION

(Please Print)
This Agent’s Certification is to be used with the application for life insurance on the life of __________________________
(Proposed Insured) for the application dated ______________________. Proposed Insured’s Date of Birth: ________________

1. Is the sale of this product being made in conjunction with a specific corporate marketing initiative? Please check one of
the following (select the most appropriate):

☐ No Marketing Initiative☐ Wealth Steps
☐ Business Resource Center☐ CPA Referral
☐ Living Balance Sheet☐ Di to Life Program
☐ Take Advantage/Rapid App☐ Other __________________________

2. a. Is there a current individual Disability Income or Long-Term Care application pending with Berkshire? ☐ Yes ☐ No

b. Has an individual Disability Income or Long-Term Care application been submitted to Berkshire within the past 6 months? ☐ Yes ☐ No

For a yes answer to either question, please provide the policy number and other details in the “Remarks” section.

3. How long have you known the Proposed Insured? ________ Years; the Proposed Owner? ________ Years

4. If Proposed Insured is not gainfully employed, indicate amount of insurance on premium payor’s life and relationship to
   Proposed Insured. __________________________

5. If beneficiary is estate, explain in Remarks why, and who will ultimately receive the proceeds of the policy?

6. Do you have knowledge of any existing life insurance policy or annuity contract in force on the Proposed Insured?
   ☐ Yes ☐ No

7. Do you have knowledge or reason to believe that replacement of an existing life insurance policy or annuity may be
   involved by reason of this transaction? ☐ Yes ☐ No

8. Will the sale of this policy involve the use of Premium Financing? ☐ Yes ☐ No
   (If yes, please provide the name of the lending institution and other details in the Remarks section.)

9. a. Did every person signing this application communicate in English well enough to understand and answer each question
   in English? ☐ Yes ☐ No (If no, please answer questions 9b, 9c, and 9d)

   b. Who acted as interpreter? __________________________

   c. If English was not used as the primary language, which language and/or dialect(s) was the sales interview
      conducted in? __________________________

   d. For the purpose of completing any Personal Information Telephone Interview, the proposed insured can converse
      comfortably in: __________________________

10. Was a preliminary inquiry previously submitted to Underwriting in connection with this application? ☐ Yes ☐ No
    If yes, please indicate application (policy) number: __________________________

11. Is the premium for this policy to be paid by a person or entity other than the policyowner? ☐ Yes ☐ No
    If yes, please provide a letter of authorization (with all required signatures) and also indicate payor’s Tax ID number.

12. Was this application signed and dated in a state other than the state in which the policyowner lives or works?
    ☐ Yes ☐ No (if yes, please provide details in Remarks)

IMNB0008000120302

L-AP-AC-2004
13. **Complete if Medical Examination necessary.** Medical Requirements being submitted:

- [ ] Chest X-ray
- [ ] EKG
- [ ] Stress EKG
- [ ] Full Blood
- [ ] Saliva
- [ ] Urine
- [ ] Paramed Exam
- [ ] Medical Exam
- [ ] Other

14. **Remarks (and additional instructions):**

________________________________________________________________________

________________________________________________________________________

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15. **Commissions**

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<tr>
<th>Producer’s Name</th>
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<th>Servicing Agent (Check 1)</th>
<th>Producer’s Social Security Number</th>
<th>Percentage</th>
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Unless this application was taken by mail as indicated in the Representations section, I certify that I have taken this application in the presence of the Proposed Insured (and Owner, if Other than the Proposed Insured, for Variable Life) and that I have truly and accurately recorded on this application the information supplied by the Proposed Insured.

For all applications: The answers to all questions on this application are full, complete and true to the best of my knowledge and belief. I represent that, to the best of my knowledge and belief, the insurance being applied for is suitable for the Owner’s insurance needs and financial objectives. I know nothing unfavorable about this risk which is not fully set forth in these papers. The writing agent or broker is duly appointed and licensed in the state in which this application was signed and for the product(s) proposed.

Signed at: ___________________________ on __________________

City and State                        mm/dd/yyyy

Type or print Agent’s/Dealer’s name   Signature of Soliciting Agent

Signature of Approved Registered Principal (For Variable Life Only)  Signature of General Agent
THE GUARDIAN LIFE INSURANCE COMPANY OF AMERICA
ACCELERATED BENEFIT RIDER SUMMARY AND DISCLOSURE STATEMENT

This Disclosure Statement provides a brief summary of the important features of an Accelerated Benefit Rider; it does not alter any of the rider’s provisions. The actual provisions of the rider set forth its full details and conditions.

EFFECTS OF AN ACCELERATED BENEFIT PAYMENT ON A LIFE INSURANCE POLICY

WHEN AN ACCELERATED BENEFIT IS PAID, A LIEN IS CREATED AGAINST THE POLICY EQUAL TO THE AMOUNT OF THE ACCELERATED BENEFIT WE PAY, PLUS LIEN CARRYING CHARGES TO THE NEXT POLICY ANNIVERSARY. ANY LIEN CREATED WILL BEAR CARRYING CHARGES WHICH ARE PAYABLE IN ADVANCE ON THE DATE THE LIEN WAS CREATED AND ON EACH SUBSEQUENT POLICY ANNIVERSARY. THE INTEREST RATE VARIES DEPENDING ON THE AMOUNT OF THE OUTSTANDING LIEN. IF THE OUTSTANDING LIEN IS LESS THAN OR EQUAL TO THE CASH VALUE OF THE POLICY PLUS THE CASH VALUE OF ANY ADDITIONS DISCOUNTED TO THE DATE THE LIEN CARRYING CHARGES ARE DETERMINED, THE LIEN CARRYING CHARGE RATE IS EQUAL TO THE LESSER OF THE FIXED LOAN INTEREST RATE THEN IN EFFECT UNDER THE POLICY OR AN ADJUSTABLE LOAN INTEREST RATE AS ALLOWED BY LAW. THE RATE FOR ANY AMOUNT OF AN OUTSTANDING LIEN WHICH EXCEEDS THE CASH VALUE OF THE POLICY PLUS THE CASH VALUE OF ADDITIONS DISCOUNTED TO THE DATE THE LIEN CARRYING CHARGES ARE DETERMINED IS EQUAL TO AN ADJUSTABLE LOAN INTEREST RATE AS ALLOWED BY LAW. THE ADJUSTABLE LOAN INTEREST RATE IS BASED ON THE MOODY’S CORPORATE BOND YIELD AVERAGE PUBLISHED BY MOODY’S INVESTORS SERVICE, INC., OR ANY SUCCESSOR THERETO, AS OF THE CALENDAR MONTH ENDING TWO MONTHS BEFORE THE FIRST DAY OF THE MONTH OF THE POLICY ANNIVERSARY.

THE CASH SURRENDER VALUE, LOAN VALUE, AND DEATH PROCEEDS PAYABLE WILL BE REDUCED BY ANY LIEN OUTSTANDING DUE TO THE PAYMENT OF AN ACCELERATED BENEFIT. IN ADDITION, THE DIVIDEND PAYABLE WILL BE AFFECTED BY ANY OUTSTANDING LIEN AND LIEN CARRYING CHARGES DURING THE POLICY YEAR. HOWEVER, THE POLICY’S FACE AMOUNT AND CASH VALUE ARE NOT AFFECTED BY ANY OUTSTANDING LIEN. WHILE A LIEN IS OUTSTANDING, THE POLICY WILL REMAIN IN FORCE AND THE FULL POLICY PREMIUM WILL STILL BE DUE (UNLESS THE POLICY IS PAID-UP OR PREMIUMS ARE THEN BEING WAIVED UNDER A WAIVER OF PREMIUM RIDER). HOWEVER, IF THE TOTAL LOAN PLUS OUTSTANDING LIEN, INCLUDING LIEN CARRYING CHARGES, EXCEEDS THE POLICY’S FACE AMOUNT PLUS THE FACE AMOUNT OF ANY ADDITIONS, THEN THE POLICY AND ANY OTHER RIDERS WILL END.

UPON RECEIPT OF A REQUEST FOR AN ACCELERATED BENEFIT PAYMENT, GUARDIAN WILL NOTIFY THE OWNER AND ANY IRREVOCABLE BENEFICIARY OF THE EFFECT THAT SUCH PAYMENT WILL HAVE ON POLICY BENEFITS AND VALUES.

TAX CONSEQUENCES

ALTHOUGH THE PAYMENTS MADE UNDER THIS RIDER ARE INTENDED TO QUALIFY FOR FAVORABLE TAX TREATMENT UNDER SECTION 101(g) OF THE FEDERAL INTERNAL REVENUE CODE, PAYMENTS UNDER THIS RIDER MAY BE TAXABLE. THE OWNER SHOULD CONSULT A COMPETENT TAX ADVISOR TO DETERMINE THE CURRENT TAX CONSEQUENCES BEFORE REQUESTING ANY ACCELERATED PROCEEDS.
GOVERNMENT ENTITLEMENTS

YOUR ELIGIBILITY FOR PUBLIC ASSISTANCE PROGRAMS, SUCH AS MEDICAL ASSISTANCE (MEDICAID), AID TO FAMILIES WITH DEPENDENT CHILDREN, AND SUPPLEMENTAL SECURITY INCOME (“SSI”) MAY BE AFFECTED BY HAVING AN ACCELERATED BENEFIT RIDER AS PART OF YOUR LIFE INSURANCE POLICY OR BY RECEIVING AN ACCELERATED BENEFIT PAYMENT. Exercising the option to receive an accelerated benefit payment and receiving such payment before applying for these programs, or while other government benefits are being received, may affect initial or continued eligibility. The appropriate social services agency (for example, the Medicaid Unit of the local Department of Public Welfare and Social Security Administration Office) should be consulted for more information concerning how receipt of an accelerated benefit payment will affect the eligibility of the recipient and/or the recipient’s spouse or dependents.

LIMITS OF AN ACCELERATED BENEFIT RIDER

THE ACCELERATED BENEFIT RIDER IS NOT HEALTH, NURSING HOME, OR LONG TERM CARE INSURANCE, AND IT IS NOT INTENDED OR DESIGNED TO ELIMINATE YOUR NEED FOR SUCH COVERAGE. There are no restrictions or limits on the use of an accelerated benefit payment. An accelerated benefit payment may not be enough to cover your medical, nursing home or other bills.

OTHER OPTIONS

Even though it is attached to a policy, an Accelerated Benefit Rider does not have to be exercised. An Accelerated Benefit Rider provides you with an additional means of accessing cash under a life insurance policy, although it is not the only method of doing so. Alternatively, you may elect to receive a loan (if available under your policy) or to make a surrender.

DEFINITIONS

Activities of Daily Living: This means the basic human functional abilities which relate to the insured’s ability to live independently. They are bathing, continence, dressing, eating, toileting and transferring.

Chronically Ill or Chronic Illness: This means that the insured has been certified, within the preceding 12 months, by a Physician as: (a) being permanently unable to perform (without Substantial Assistance from another individual) two or more Activities of Daily Living due to loss of functional capacity; or (b) requiring substantial supervision from another individual to protect the insured from threats to health and safety due to permanent Severe Cognitive Impairment.

Severe Cognitive Impairment: This means a deterioration or loss of intellectual capacity that is: (a) comparable to (and includes) Alzheimer’s disease and similar forms of irreversible dementia; and (b) measured by clinical evidence and standardized tests that reliably measure impairment.

Substantial Assistance: This means Hands-on Assistance or Standby Assistance. Hands-on Assistance means the physical assistance of another person without which the individual would be unable to perform the Activity of Daily Living. Standby Assistance means the presence of another person within arm’s reach of the individual that is necessary to prevent, by physical intervention, injury to the individual while he or she is performing an Activity of Daily Living.

Terminally Ill or Terminal Illness: This means that the insured has been certified by a physician as having an illness or physical condition which can reasonably be expected to result in death within 12 months.

THE ACCELERATED BENEFIT PAYMENT

An accelerated benefit payment may be made to the owner of a life insurance policy if the owner provides proof acceptable to Guardian that the insured is either chronically ill or terminally ill as defined above. This proof includes a physician’s certification regarding the insured’s medical condition. Guardian must receive at its home office the owner’s written request for an accelerated benefit payment and the physician’s certification regarding the insured’s medical condition.

The accelerated benefit payment will be paid to the owner in a lump sum.

LIMITATIONS OR CONDITIONS ON ELIGIBILITY OF BENEFITS

Accelerated Benefit Payments are limited by both the Annual Lien Limit and the Total Lien Limit. The owner may take a maximum of 4 liens per policy year. The insured must be at least attained age 15 in order for an accelerated benefit to be paid. If the policy was issued as part of a pension plan, in order for an Accelerated Benefit to be paid, the policy must be out of the pension plan and individually owned. The policy must be in force other than as extended term insurance on the date the accelerated benefit is requested. If the policy is in force as paid-up insurance on the date the first accelerated benefit is requested, the amount of paid-up insurance must be at least $100,000. Guardian must receive at its home office the written consent of any assignee and any irrevocable beneficiary to the payment of the accelerated benefit. And, when a lien is outstanding under the policy, no changes may be made to the plan or amount of the policy.
ANNUAL LIEN LIMIT

Guardian imposes a maximum limit on the amount the owner may receive in a single calendar year. This maximum amount for base policy face amounts of $250,000 and greater is the Per Diem Limitation declared each year by the Internal Revenue Service, multiplied by 365. In the first year in which accelerated benefits are paid Guardian will prorate this amount for the portion of the calendar year in which the insured is eligible for benefits.

If the face amount of the policy is less than $250,000, the Annual Lien Limit is reduced proportionally based on the ratio of the policy’s face amount to $250,000.

TOTAL LIEN LIMIT

The Total Lien Limit is the policy’s Cash Value as of the date to which premiums have been paid plus a percentage of the Net Amount at Risk, varying by age:

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<th>Age</th>
<th>Percentage</th>
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<tr>
<td>Up to 67</td>
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<td>68</td>
<td>24%</td>
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<td>69</td>
<td>28%</td>
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<td>32%</td>
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<td>80</td>
<td>72%</td>
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<tr>
<td>81</td>
<td>76%</td>
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<tr>
<td>82 and over</td>
<td>80%</td>
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The percentage will be locked in, at the insurance attained age, when the first accelerated benefit payment is made.

Net Amount at Risk: Net Amount at Risk on a given date means the face amount of the base policy plus any additions, less the cash value of the base policy and any additions, as of the date to which premiums have been paid.

ADMINISTRATIVE FEE

A one-time Administrative Fee of $250 will be charged the first time that an Accelerated Benefit is paid under this rider. This charge is associated with Guardian’s administrative costs for processing an Accelerated Benefit payment to the owner. This charge is deducted from the Accelerated Benefit payable, and it is included in the lien that is created as a result of that payment.
COST
There is no additional premium charged to add an Accelerated Benefit Rider to a life insurance policy.

TERMINATION
This Accelerated Benefit Rider will terminate on the earliest of:

- The date the life insurance policy terminates;
- The date of the insured’s death;
- Upon receipt of proper written request for cancellation at Guardian’s home office. This rider must be sent to the home office for cancellation. However, if there is a lien outstanding, the rider cannot be cancelled unless the lien is repaid;
- Upon election of a policy value option providing for extended term insurance;
- Upon election of a policy value option providing for reduced paid-up insurance, if the amount of reduced paid-up insurance is less than $100,000 and no accelerated benefit has ever been paid under this rider; or
- The date the loan plus total lien, including lien carrying charges, exceeds the policy face amount plus the face amount of any additions. If this happens, this policy and any other riders also terminate.

ACKNOWLEDGEMENT
I hereby acknowledge that I have received and read this Accelerated Benefit Rider Summary and Disclosure Statement.

__________________________________________________________ Date
Signature of Proposed Insured

__________________________________________________________ Date
Signature of Proposed Owner (if other than Proposed Insured)

__________________________________________________________ Date
Signature of Agent Agent Code

__________________________________________________________ Date
Agent

The Guardian Life Insurance Company of America
IMPORTANT NOTICE:
REGARDING REPLACEMENT OF LIFE INSURANCE OR ANNUITIES

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

(Please check appropriate company)

This document shall be signed by the applicant and the insurance producer, if there is one, and a copy left with the applicant.

You are contemplating the purchase of a life insurance life insurance policy or annuity contract. In some cases this purchase may involve discontinuing or changing an existing life insurance life insurance policy or annuity contract. If so, a replacement is occurring. Financed purchases are also considered replacements.

A replacement occurs when a new life insurance policy or annuity contract is purchased and, in connection with the sale you discontinue making premium payments on the existing life insurance policy or annuity contract, or an existing life insurance policy or annuity contract is surrendered, forfeited, assigned to the replacing insurer, or otherwise terminated or used in a financed purchase.

A financed purchase occurs when the purchase of a new life insurance policy involves the use of funds obtained by the withdrawal or surrender of or by borrowing some or all of the life insurance policy values, including accumulated dividends, of an existing life insurance policy, to pay all or part of any premium or payment due on the new life insurance policy. A financed purchase is a replacement.

You should carefully consider whether a replacement is in your best interest. You will pay acquisition costs and there may be surrender costs deducted from your life insurance policy or annuity contract. You may be able to make changes to your existing life insurance policy or annuity contract to meet your insurance needs at less cost. A financed purchase will reduce the value of your existing life insurance policy and may reduce the amount paid upon the death of the insured.

We want you to understand the effects of replacements before you make your purchase decision and ask that you answer the following questions and consider the questions on the back of this form.

1. Are you considered discontinuing making premium payments, surrendering, forfeiting, assigning to the insurer, or otherwise terminating your existing life insurance policy or annuity contract?
   _______YES _______NO

2. Are you considering using funds from your existing policies or annuity contracts to pay premiums due on the new life insurance policy or annuity contract?
   _______YES _______NO

If you answered “yes” to either of the above questions, list each existing life insurance policy or annuity contract you are contemplating replacing (include the name of the insurer, the insured or annuitant, and the life insurance policy or annuity contract number if available) and whether each life insurance policy or annuity contract will be replaced or used as a source of financing:

<table>
<thead>
<tr>
<th>INSURER NAME</th>
<th>ANNUITY CONTRACT OR LIFE INSURANCE POLICY #</th>
<th>INSURED OR ANNUITANT</th>
<th>REPLACED (R) OR FINANCING (F)</th>
</tr>
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</table>

1st signed copy – Applicant; 2nd signed copy – Replacing Insurer; 3rd signed copy – Agency
Make sure you know the facts. Contact your existing company or its agent for information about the old life insurance policy or annuity contract. If you request one, an in-force illustration, life insurance policy summary, or available disclosure document must be sent to you by the existing insurer. Ask for and keep all sales material used by the insurance producer in the sales presentation. Be sure you make an informed decision.

The existing life insurance policy or annuity contract is being replaced because:

I certify that the responses herein are, to the best of my knowledge, accurate:

Applicant’s Printed Name ___________________________ Applicant’s Signature ___________________________

Date ____________________________________________

Insurance Producer’s Printed Name ___________________________ Insurance Producer’s Signature ___________________________

Date ____________________________________________

I do not want this notice read aloud to me. ____________ (Applicants must initial only if they do not want the notice read aloud.)

A replacement may not be in your best interest, or your decision could be a good one. You should make a careful comparison of the costs and benefits of your existing life insurance policy or annuity contract and the proposed life insurance policy or annuity contract. One way to do this is to ask the company or insurance producer that sold you your existing life insurance policy or annuity contract to provide you with information concerning your existing life insurance policy or annuity contract. This may include an illustration of how your existing life insurance policy or annuity contract is working now and how it would perform in the future based on certain assumptions. Illustrations should not, however, be used as a sole basis to compare life insurance policies or annuity contracts. You should discuss the following with your insurance producer to determine whether replacement or financing your purchase makes sense:

**PREMIUMS:**

Are they affordable?

Could they change?

You are older ---- are premiums higher for the proposed new life insurance policy?

How long will you have to pay premiums on the new life insurance policy? On the old life insurance policy?

**LIFE INSURANCE POLICY VALUES:**

New policies usually take longer to build cash values and to pay dividends.

Acquisition costs for the old life insurance policy may have been paid, and you will incur costs for the new one.

What surrender charges do the policies have?

What expense and sales charges will you pay on the new life insurance policy?

Does the new life insurance policy provide more insurance coverage?
INSURABILITY:

If your health has changed since you bought your old life insurance policy, the new one could cost you more, or you could be turned down.

You may need a medical exam for a new life insurance policy.

Claims on most new policies for up to the first 2 years can be denied based on inaccurate statements.

Suicide limitations may begin anew on the new coverage.

IF YOU ARE KEEPING THE OLD LIFE INSURANCE POLICY AS WELL AS THE NEW LIFE INSURANCE POLICY:

How are premiums for both policies being paid?

How will the premiums on your existing life insurance policy be affected?

Will a loan be deducted from death benefits?

What values from the old life insurance policy are being used to pay premiums?

IF YOU ARE SURRENDERING AN ANNUITY OR LIFE PRODUCT:

Will you pay surrender charges on your old annuity contract?

What are the interest rate guarantees for the new annuity contract?

Have you compared the annuity contract charges or other life insurance policy expenses?

OTHER ISSUES TO CONSIDER FOR ALL TRANSACTIONS:

What are the tax consequences of buying the new life insurance policy?

Is this a tax-free exchange? (See your tax advisor.)

Is there a benefit from favorable “grandfathered” treatment of old life insurance policy under the Internal Revenue Code?

Will the existing insurer be willing to modify the old life insurance policy?

How does the quality and financial stability of the new company compare with your existing company?
Qualified Retirement Plan/IRA Distribution Acknowledgement Form

Has your Agent recommended that you take a current or future distribution from your qualified retirement plan or IRA to pay the current or future premiums on a permanent life insurance policy for which you have applied?

Yes ☐ No ☐

By signing below, the Owner or Plan Participant acknowledges that the information above is accurate.

X
Signature of Owner or Plan Participant

Date of Signature of Owner or Plan Participant  
(MM/DD/YYYY)

By signing below, the Agent certifies that the information above is accurate.

X
Signature of Agent

Date of Signature of Agent (MM/DD/YYYY)
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, Suite 400, Braintree, MA 02184-8734, and its telephone number is 866-692-6901 (TTY 866-346-3642 for the 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.
APPLICATION SUPPLEMENT
Index Participation Rider (IPR)

Complete this Supplement ONLY if applying for Index Participation Rider.

1. Initial Allocation Percentage

Please indicate your Allocation Percentage for the amount of paid-up additions that will be used in the calculation of an Index Adjustment for the specified index. An Index Period will begin on an Index Start Date when (1) Accessible Paid-up Additions are in effect and (2) the Allocation Percentage is greater than zero. (The percentage allocated to the indexes must be a whole number not to exceed 100%)

__________ % S&P 500 Price Return Index *

* The S&P 500 Price Return Index "the Index" is a product of S&P Dow Jones Indices LLC or its affiliates ("SPDJI"), and has been licensed for use by The Guardian Life Insurance Company of America ("the Company"). Standard & Poor’s® and S&P® are registered trademarks of Standard & Poor’s Financial Services LLC ("S&P") and Dow Jones® is a registered trademark of Dow Jones Trademark Holdings LLC ("Dow Jones"). The trademarks have been licensed to SPDJI and have been sublicensed for use for certain purposes by the Company. The Index Participation Rider (IPR) is not sponsored, endorsed, sold or promoted by SPDJI, Dow Jones, S&P, any of their respective affiliates (collectively, “S&P Dow Jones Indices”). S&P Dow Jones Indices does not make any representation or warranty, express or implied, to the owners of policies that contain the IPR or any member of the public regarding the advisability of investing in securities generally or the ability of the Index to track general market performance. S&P Dow Jones Indices only relationship to the Company with respect to the Index is the licensing of the Index and certain trademarks, service marks and/or trade names of S&P Dow Jones Indices and/or its licensors. The Index is determined, composed and calculated by S&P Dow Jones Indices without regard to the Company or the IPR. S&P Dow Jones Indices has no obligation to take the needs of the Company or the owners of policies that contain the IPR into consideration in determining, composing or calculating the Index. S&P Dow Jones Indices is not responsible for and has not participated in the determination of the prices, and adjustments associated with the IPR or the timing of the issuance or sale of the IPR or in the determination or calculation of the equation by which IPR is to be converted into cash, surrendered or redeemed, as the case may be. S&P Dow Jones Indices has no obligation or liability in connection with the administration, marketing or trading of the IPR. There is no assurance that investment products based on the Index will accurately track index performance or provide positive investment returns. S&P Dow Jones Indices LLC is not an investment advisor. Inclusion of a security within an Index is not a recommendation by S&P Dow Jones Indices to buy, sell, or hold such security, nor is it considered to be investment advice.

S&P DOW JONES INDICES DOES NOT GUARANTEE THE ADEQUACY, ACCURACY, TIMELINESS AND/OR THE COMPLETENESS OF THE INDEX OR ANY DATA RELATED THERETO OR ANY COMMUNICATION, INCLUDING BUT NOT LIMITED TO, ORAL OR WRITTEN COMMUNICATION (INCLUDING ELECTRONIC COMMUNICATIONS) WITH RESPECT THERETO. S&P DOW JONES INDICES SHALL NOT BE SUBJECT TO ANY DAMAGES OR LIABILITY FOR ANY ERRORS, OMISSIONS, OR DELAYS THEREIN. S&P DOW JONES INDICES MAKES NO EXPRESS OR IMPLIED WARRANTIES, AND EXPRESSLY DISCLAIMS ALL WARRANTIES, OF MERCHANTABILITY OR FITNESS FOR A PARTICULAR PURPOSE OR USE AS TO RESULTS TO BE OBTAINED BY THE COMPANY, OWNERS OF THE POLICIES WHICH CONTAIN THE IPR, OR ANY OTHER PERSON OR ENTITY FROM THE USE OF THE INDEX OR WITH RESPECT TO ANY DATA RELATED THERETO. WITHOUT LIMITING ANY OF THE FOREGOING, IN NO EVENT WHATSOEVER SHALL S&P DOW JONES INDICES BE LIABLE FOR ANY INDIRECT, SPECIAL, INCIDENTAL, PUNITIVE, OR CONSEQUENTIAL DAMAGES INCLUDING BUT NOT LIMITED TO, LOSS OF PROFITS, TRADING LOSSES, LOST TIME OR GOODWILL, EVEN IF THEY HAVE BEEN ADVISED OF THE POSSIBILITY OF SUCH DAMAGES, WHETHER IN CONTRACT, TORT, STRICT LIABILITY, OR OTHERWISE. THERE ARE NO THIRD PARTY BENEFICIARIES OF ANY AGREEMENTS OR ARRANGEMENTS BETWEEN S&P DOW JONES INDICES AND THE COMPANY, OTHER THAN THE LICENSORS OF S&P DOW JONES INDICES.

L-AP-IPR SUPP 2015 MD
II. Acknowledgements

I, the undersigned, acknowledge that:

- I am applying for the Index Participation Rider that includes an Index Adjustment.
- The Index Adjustment provided by this rider is linked, in part, to an external index.
- While an Index Adjustment may be affected by an external index, the paid-up additions purchased under the underlying Policy do not directly participate in any investments comprising the Index.
- The Index Adjustment is subject to an Index Floor, Index Cap and a Participation Rate. Any Index Adjustment may be positive or negative, resulting in an increase or decrease in the dividend payable under your policy.
- There is a charge for this rider that is paid for through the surrender of paid-up additions.
- The above allocation instruction indicates the percentage of Accessible Paid-up Additions that will be used in the calculation of an Index Adjustment.

Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

______________________________  _______________________
Signature of Owner                      Date

______________________________  _______________________
Signature of Licensed Agent/Representative  Date
CONDITIONAL TEMPORARY COVERAGE AGREEMENT AND RECEIPT

Received from _____________________________ the amount of $________________ for the application for insurance on the life of _____________________________ (Proposed Insured) dated _____________________________.

Provided that the above payment is equal to at least 1/12 of the annual premium for the insurance applied for in Section G of the application referred to above, we will provide conditional temporary life insurance coverage. We will pay a death benefit to the beneficiary named in the application if the proposed insured dies while coverage under this Agreement is in effect and subject to the terms and conditions stated herein. For Universal Life policies, the “annual premium” is the Target Premium for the insurance applied for.

IMPORTANT NOTE TO APPLICANT: This receipt is to be given for advance payment on first premium. All premium checks must be made payable to the company, as checked above. Do not make check payable to the agent/dealer or leave payee blank. Cash payments and money orders cannot be accepted.

IMPORTANT NOTE TO AGENT: This receipt may only be used if all of the following are true:
(a) The Insured answers “no” to all 3 medical questions asked below; (b) The insured is not younger than 30 days old, and not older than 64 years, 6 months old; (c) Payment is made concurrent with the signing of the application and such payment is at least equal to one-twelfth of the annual premium for the amount of all insurance applied for on the application referred to above. Note: depending on the contractual provisions of the policy(ies) being applied for, the minimum payment referred to above may not be sufficient to put the policy(ies) in force. (d) The application is not taken by mail.

1) Has the Proposed Insured, within the last 12 months, been treated for or had any known heart attack, stroke or cancer?  [ ] Yes [ ] No

2) Has the Proposed Insured, within the last 12 months, had an electrocardiogram because of chest pain or any other physical problem?  [ ] Yes [ ] No

3) Within the past 7 years, has the Proposed Insured been diagnosed by or received treatment from a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or any deficiency of the immune system, such as Human Immunodeficiency Virus (HIV)?  [ ] Yes [ ] No

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

Limitation on Coverage: The amount of life insurance available under this receipt cannot exceed the face amount of the insurance applied for in the application referred to above, including the amount of any Accidental Death Benefit rider, any Renewable Term Rider and any Paid-up Additions Rider (but only for any Initial PUA payment that is paid in full on the date the application is signed).

Special Provision Relating to Additional and Alternate policies: If the application referred to above indicates that Alternate or Additional coverage has been requested, then the following provisions apply. If an Alternate policy has been requested, the temporary coverage under this Agreement will be deemed to relate to the coverage applied for in Section G of the application, and not the Alternate policy requested. If an Additional policy has been requested, coverage is available under this Agreement for both policies, provided the initial premium amount collected is equal to at least the sum of 1/12 of the annual premium for each of these policies. Otherwise, coverage will be provided only for the policy applied for in Section G of the application.

If the amount of coverage described above, combined with the amount of coverage under any other Conditional Temporary Coverage Agreement in effect on the proposed insured listed above, exceeds $1,000,000, the maximum total amount of coverage payable under all such Agreements shall be $1,000,000. In no event will we pay more than $1,000,000 in Conditional Temporary Coverage on a single insured, regardless of the amount of premium collected under all applications on that insured.

L-AP-CR-2011 MD REV12
Conditions:
The temporary insurance shall be effective on the later of:

(a) the date of the Part I application;

(b) the date of whatever Part II application, including any medical examination, that is initially required by the Company’s published underwriting rules; and

(c) the date of any lab work that is initially required by the Company’s published underwriting rules.

Coverage is not effective if the Part I or any Part II, including any medical examination, and/or initial lab work, required by our published underwriting rules, is not completed. Coverage ends 60 days after it is effective, or if earlier on the date the insurance applied for in the application is issued.

The Proposed Insured must be insurable as a standard or better risk under our underwriting rules, for the amount, plan and benefits applied for, without restriction or modification. Information required by the Company to determine insurability must be received at its Customer Service Office within 60 days of the date of this receipt.

If the Proposed Insured should die within 60 days of the effective date of this receipt and:

- After the required Parts I and II have been received at the Home Office; and
- After the last of any required medical examinations, including any required lab work, have been completed;

Then the Company shall not deny liability because of failure to submit any additional evidence of insurability it may have required. Instead, it shall determine insurability as of the effective date described above.

For the temporary insurance to be payable, there must be no material misrepresentation on this form or on the application referred to above. Also, the insured’s death must not have been the result of suicide. If the Proposed Insured dies within 60 days of the effective date of this receipt, but the temporary coverage is not payable because any of the above conditions were not met, we will refund the initial premium that was paid with the application.

This receipt will be void if any check or draft given in exchange for the receipt is dishonored when first presented for payment.

Special rules for 1035 exchanges: If the applied for coverage is intended to be part of an exchange under Section 1035 of the Internal Revenue Code, and if the Proposed Insured is determined to be, within 60 days of the effective date of the receipt, a standard or better risk under our underwriting rules, then coverage will not end 60 days after the receipt and the premium will not be refunded. Instead, the temporary coverage will continue until: (a) the policy is issued, or (b) the existing carrier indicates that our request for the proceeds under the existing insurance can not or will not be processed.

Dated at ______________________ on ______________________

City and State month day year

Signature of Agent/ Dealer

Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

I have read the terms of this receipt and have had them explained to me by the agent/dealer. I understand that the insurance applied for shall not be effective unless and until the conditions of this receipt have been complied with exactly. If these conditions are not met, the Company shall have no liability under this receipt except to return the payment made. All statements are complete and true to the best of my knowledge and belief.

__________________________ __________________________
Signature of Proposed Insured Signature of Owner, if other than Proposed Insured

L-AP-CR-2011 MD REV12
BANK DRAFT AUTHORIZATION
(REQUEST FOR GUARD-O-MATIC ARRANGEMENT)

1. Type of Request (Check all that apply.)

☐ Establish a new Bank Draft Authorization for monthly payments
☐ Update Financial Institution Information on an existing Bank Draft Authorization
☐ Change draft date option and/or draft amount on an existing Bank Draft Authorization
☐ Add policy(ies) to existing Bank Draft Authorization:
   List one policy from existing arrangement: ________________________________
☐ Revoke Bank Draft Authorization for Policy Number(s): ________________________________

2. Bank Information

For Individual Life Policies: Please submit a voided check, bank statement or authorization of account letter for checking and business accounts. Starter checks are not acceptable. Please submit a copy of bank deposit slip for savings accounts.

Below is an example of a check highlighting the location of the routing/ transit number and bank account number:

![Sample Check Image]

Financial Institution Information:

Financial Institution Name: ________________________________

Type of Account (Check one.): Checking Savings Business ________________________________

Transit/ABA Number (Always 9 digits.) Account Number

Account Holder Information (All fields required. Please print.):

Full Title of Account (e.g. John Smith or The John Smith Irrevocable Trust dtd 01/02/2016): ________________________________

Individual Joint Trust Custodial Business Other: ________________________________

Authorized Signer of Account: ________________________________

Address: ________________________________ Address City State Zip

Phone: ________________________________ Email: ________________________________

R223 ADMIN (7/16)
3. Premium Arrangement Information

Please note the "Monthly Amount to Be Deducted" will be the monthly modal premium described in your policy. The "Effective Date of Change" will be the date your next premium payment is due.

<table>
<thead>
<tr>
<th>Policy Number</th>
<th>Draft Date*</th>
<th>Insured Name</th>
<th>Monthly Amount to Be Deducted**</th>
<th>Effective Date of Change (mm/yy)</th>
<th>Control Number (For Home Office Use Only.)</th>
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* Variable Life and Universal Life Policies allow for premium payments on the 15th only; Premium payments for Traditional Life and Disability Policies can be made on the 1st or the 15th of each month; If no selection is made, the draft date will default to the 15th of each month.

** For UL/VL policies only. Indicate an amount for UL/VL policies if the amount to be deducted will be different from the planned premium.

4. Loan Payment Information

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<thead>
<tr>
<th>Policy Number</th>
<th>Monthly Amount to Be Deducted*</th>
<th>Policy Number</th>
<th>Monthly Amount to Be Deducted*</th>
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* Loan payments for policies administered by Berkshire will be made on or about the 15th of each month; For all other policies, loan payments will be made on the 1st business day of each month.

5. Terms and Conditions

By the signature(s) below, I or we agree and consent to all of the terms and conditions stated herein.

1. The Company is authorized to debit the account or to initiate electronic funds transfer from the financial institution identified above on or about the 15th or 1st of each month to pay premiums due and/or to pay the policy loan on the policy(ies) identified above. If neither, or both the 1st or 15th is selected, the 15th will be the default date for drafting. Due to timing of the authorization, the initial transfer processed may result in more than one premium payment being withdrawn.

2. The Company is authorized to make monthly withdrawals from the specified account. The Company's treatment of each check or debit, and its' rights with respect to it, will be the same as if it were signed or initialed personally by the Authorized Signer of Account. If any check or debit is dishonored by the bank or financial institution for any reason, the premium payment will be reversed and the premium will not be considered paid. This may cause the policy to lapse in accordance with the provisions of the policy and result in the forfeiture of insurance.

3. Completion of this form shall not constitute a premium payment and/or loan payment. Multiple months' premiums may be required to bring the policy to a current due date.

4. This Bank Draft Authorization (Request for Guard-O-Matic Arrangement) may be terminated by the Policy Owner, the Company, or the Authorized Signer of Account (if different from Policy Owner) upon written notice. The Policy Owner or Authorized Signer of Account may cancel this Authorization by giving the Company 30 days' written notice. This Authorization is to remain in effect until the Company receives written notice of its revocation unless the Company ends it earlier.
5. If the Loan Payment Authorization is cancelled, any outstanding loans will remain unpaid.

6. The Company may try a second time for any withdrawal returned due to insufficient funds. The Company may terminate this Authorization immediately by written notice in the event any withdrawal or electronic fund transfer is dishonored for any reason.

7. A confirmation statement for premium payments paid through this Bank Draft Authorization will not be sent. Information provided by the bank or financial institution may be helpful to reconcile the deductions.

8. For details on the bank draft monthly payments, please refer to the Policy Owner's annual benefits statement, policy, or product prospectus, as applicable. For any questions about the policy or about the amounts to be drafted to pay premiums or loan principal, please contact the servicing agent on the policy or the Customer Call Center at the number provided below.

9. For Universal or Variable Universal Life Insurance, the policy is designed to have flexible premiums. Policy Owners should consider paying the necessary amount each month to keep the policy in force. The Policy Owner will receive notification if additional payments are required to keep the policy from lapsing.

10. The Company should be provided with 30 days’ advance notification of any change in the banking information provided above. If advance notification cannot be provided, sufficient funds should be left in the account identified above in this form to honor charges until the Company’s records are changed.

11. Any change in name or address of the Authorized Signer of Account or Policy Owner must be communicated immediately to the Company.

12. If this service is no longer in effect, premiums will be due according to the most frequent payment mode offered for the policy. Loan repayments scheduled under the Loan Payment Arrangement will no longer be automatically deducted. Any future loan repayment will be the Policy Owner’s responsibility.

13. Any bank fees are the responsibility of the Authorized Signer of Account.

Signature of Bank Account Owner

Date

Signature of Policy Owner, if other than Bank Account Owner

Date

Life Insurance

The Guardian Life Insurance Company of America
Individual Life Service and Administration
Northeastern Regional Office
P.O. Box 26100
Lehigh Valley, PA 18002-6100

Email: ILSolutions@glic.com
Customer Call Center: 1-888-482-7342
Fax: 610-807-2720

The Guardian Insurance & Annuity Company
Park Avenue Variable Life
P.O. Box 26125
Lehigh Valley, PA 18017

Email: VULSolutions@glic.com
Customer Call Center: 1-888-482-7342
Fax: 610-807-2940

Disability Income Insurance

Berkshire Life Insurance Company of America
Policy Services
700 South Street
Pittsfield, MA 01201

Email: DIPprocessing@glic.com
Customer Call Center: 1-800-819-2468
Fax: 413-395-5992