Berkshire Life Insurance Company of America
Home Office: 700 South Street, Pittsfield, MA 01201
A wholly owned stock subsidiary of The Guardian Life Insurance Company of America, New York, NY

APPLICATION FOR DISABILITY INSURANCE OPTION EXERCISES

Please complete all questions, except as directed otherwise. If additional space is needed, please use the Remarks & Special Requests Section 9. For purposes of this application only: "Originating Policy" means the policy or coverage that contains the increase option or other option from which you are seeking to exercise; and "Increase Policy" means the policy or additional coverage, if issued, resulting from an application to exercise such an option. The description of any policy provision stated herein does not modify or change those provisions.

SECTION 1: PROPOSED INSURED INFORMATION

A. First Name ______ Middle Initial ______ Last Name ______ Suffix ______

B. Social Security Number: ______

C Residence Address:

Street ______

City ______ State ______ Zip Code ______

D. Date of Birth (mm/dd/yyyy): ______ **E.** Phone: ______

F. Email Address: ______

G. Exercised from Policy #: ______

SECTION 2: OPTIONS

A. Option Requested:

1. ☐ Future Increase/Purchase Option (FIO/FPO)

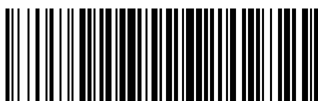
2. ☐ Benefit Purchase Rider (BPR)

3. ☐ Group Disability Replacement Option (GDR)
In the Remarks & Special Request Section 9, include the date your Group Long Term Disability ("LTD") coverage ended, the date your prior employment terminated (if applicable), and the start date of your new employment (if applicable).

4. ☐ Enhanced Portability Option (EPO)

5. ☐ Increase Option After Leaving Your Employer (IO)

6. ☐ Other: ______



SECTION 2: OPTIONS (CONTINUED)

B. If FIO/FPO or GDR, total amount to be exercised:

1. Monthly benefit: $ ______

2. Social Insurance Substitute (SIS) amount: $ ______

3. Lump Sum, if Disability Buy-Out (DBO): $ ______

C. 1. For FIO, I am applying to exercise due to a **Special Option Date** because of:

A. ☐ Loss of my Group LTD coverage.

B. ☐ A **Special Option Date** declared by Berkshire Life Insurance Company of America ("the Company").
*In the Remarks & Special Requests Section 9, include for loss of Group LTD coverage, the date and reason the coverage ended. For any **Special Option Date** declared by the Company, provide appropriate information supporting eligibility.*

2. For BPR, I am applying to exercise due to a **Special Benefit Purchase Option Offer** because:

A. ☐ I have had at least a 50% increase in my Income during the first three years since the Effective Date of the Originating Policy.

B. ☐ I have had at least a 50% increase in my Income since the last Review Date.

C. ☐ I have had a loss of my Group LTD coverage.
In Remarks & Special requests Section 9, include the date and reason the coverage ended.

3. For EPO and IO:

☐ I am applying to obtain additional coverage from the EPO or IO on the Originating Policy and am doing so because I am no longer employed by the Employer (as defined in the Originating Policy).

SECTION 3: BENEFIT CHANGE REQUESTS

Please check at least one of the following:

A. ☐ I am electing to continue all benefits eligible under the option exercise from the Originating Policy.

B. ☐ I am including the Request for Additional Benefits Supplement.

C. ☐ I am including the Request for Change in Benefits Supplement.

SECTION 4: EMPLOYMENT INFORMATION

A. 1. Current Employer Name and Address:

______

Street

______

City ______ State ______ Zip Code ______

2. Job Title: ______ **3.** Number of years with this Current Employer(s): ______

4. If less than two years, state prior employer: ______

SECTION 4: EMPLOYMENT INFORMATION (CONTINUED)

5. How many hours per week are you at work with this Current Employer(s)? ☐

6. Do you currently plan to leave this Current Employer within the next six months? ☐ Yes ☐ No

If yes, provide details:

B. Employment Type:

☐ Employee (no ownership) ☐ Sole Proprietor or 1099 Employee ☐ Partner ☐ % ownership

☐ S-Corp Shareholder ☐ % ownership ☐ C-Corp Shareholder ☐ % ownership

C. Are you currently disabled and/or collecting disability benefits from any source? ☐ Yes ☐ No

If yes, provide details:

SECTION 5: OCCUPATION INFORMATION
(COMPLETE ONLY FOR BPR, EPO, IO, OR TO IMPROVE YOUR OCCUPATION CLASS)

For BPR, EPO, and IO options, information provided is required for occupational underwriting. For FIO, FPO, and GDR options, information provided will only be used to determine if a more favorable occupation class is available on the Increase Policy.

A. Occupation(s) and Duties:

B. Number of years working in this occupation(s):

C. For Medical Occupations Only: Physicians, Fellows, Residents, and Students - Please list certification(s) or intended certification(s):

1. Medical Board Specialty Certification:

2. Medical Board Subspecialty Certification:

D. Academic degrees, professional licenses, and/or designations held (if none, so state):

E. 1. Are you any of the following? ☐ Student ☐ Resident ☐ Fellow ☐ None

2. If yes, what is your expected graduation date?

SECTION 6: PERSONAL FINANCIAL INFORMATION

For purposes of this section only, Earned Income means the income you are required to report to the Internal Revenue Service ("IRS") for income tax purposes. This includes W-2 wages, salary, bonuses, your share of net business income, and all other compensation you received for work or services. Explain in Remarks & Special Requests Section 9, any significant fluctuations between years.

A. Earned Income

1. Year-to-Date This Calendar Year: $ ☐

2. Actually Filed with the IRS for the Last Calendar Year: $ ☐

3. Actually Filed with the IRS for Two Calendar Years Ago: $ ☐

B. What percentage of your Earned Income is commission-based? ☐ (if none, enter 0)

C. Would you like to have contributions such as your 401(k) or 403(b) considered as part of your Earned Income? ☐ Yes ☐ No ☐ Not Applicable

If yes, complete question (D).

D. Total Annual Retirement Contributions:

Personal Contributions

1. Year-To-Date This Calendar Year: $ ☐

2. Last Calendar Year: $ ☐

3. Two Calendar Years Ago: $ ☐

Employer Contributions

4. Year-To-Date This Calendar Year: $ ☐

5. Last Calendar Year: $ ☐

6. Two Calendar Years Ago: $ ☐

E. Have you or a business you've owned ever filed, or plan to file, for bankruptcy? ☐ Yes ☐ No

If yes, Type:

☐ Personal ☐ Business Filing Date: ☐ Discharge Date: ☐

SECTION 7: OTHER INSURANCE COVERAGE

A. Do you have any disability insurance in force or applied for, or for which you are eligible within the next 12 months with any company, including The Guardian Life Insurance Company of America ("Guardian") or Berkshire Life Insurance Company of America ("Berkshire")? .... ☐ Yes ☐ No

If yes, list all coverages in the chart below.

Type: Individual (IDI); Long-Term Disability (LTD); Short-Term Disability (STD); Overhead Expense (OE); Disability Buy-Out (DBO); Retirement Protection (RP); if other, please specify.

Include all sources of insurance including Association, Employer, Group, Self-Purchased, etc.

		Column A	Column B	Column C	Column D
1.	Company Name				
2.	Type				
3.	Status (In-Force, Applied For, Eligible For)				
4.	Benefit Amount	$	$	$	$
5.	Benefit Period				
6.	Catastrophic Benefit	$	$	$	$
7.	Retirement Protection	$	$	$	$
8.	Employer-Paid*	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
9.	Is this coverage being replaced? If yes, date to be replaced	☐ Yes ☐ No Date: ________	☐ Yes ☐ No Date: ________	☐ Yes ☐ No Date: ________	☐ Yes ☐ No Date: ________
10.	Amount to be replaced	$	$	$	$

** "Employer-paid" means your employer pays the premium and does not include it as taxable income to you.*

SECTION 8: PREMIUM INFORMATION

A. Premium Structure: ☐ Level ☐ Graded

B. What percentage of the premium for the coverage you are applying for will be paid by your employer?

☐ None ☐ 100% ☐ Other ________ %

C. If your employer will pay any part of the premium, will it be reportable by you as taxable income? .... ☐ Yes ☐ No

D. If any part of the premium is paid by you, is it paid with: ☐ Pre-Tax dollars ☐ After-Tax dollars

E. Premium Mode: ☐ Annual ☐ Semi-annual ☐ Quarterly ☐ Monthly (available with Group Bill and Automatic Bank Draft only)

F. Billing Type: ☐ Paper Bill

☐ Automatic Bank Draft: ☐ New Service (Complete Request for Guard-O-Matic (GOM) Arrangement Form R223)

☐ Add to my existing Guardian or Berkshire services – GOM #: ________

☐ Group Bill: ☐ Existing Group # ________

☐ New – Billing Name: ________ Common Billing Day ________

G. Send premium notices to: ☐ Residence ☐ Owner's Address ☐ Business

☐ Other ________

H. Prepayment of Premium – *A prepayment must be accompanied by a signed Conditions of Coverage form.*

☐ No money has been submitted with this application.

☐ $ ________ has been submitted with this application.

SECTION 9: REMARKS & SPECIAL REQUESTS

SECTION 10: REPRESENTATIONS OF THE PROPOSED INSURED AND OWNER

Those parties, who sign below, agree that:

1. This application and any other supplements or amendments to the application will form the basis for, and become part of and attached to, any policy or new coverage issued by Berkshire Life Insurance Company of America ("Company").
2. All of the statements that are part of the application and any other supplements to the application are correctly recorded, and are complete and true to the best of the knowledge and belief of those persons who made them.
3. No agent, broker or medical examiner has any right to accept risks, make or change contracts, or to waive or modify any of the Company's rights or requirements.
4. Any misrepresentation or omission, if found to be material, may adversely affect acceptance of the risk, claims payment or may lead to rescission of any policy or new coverage that is issued based on this application.
5. All coverage you have identified to be replaced in answer to Question 7A of this application will be permanently terminated on or before the date(s) indicated. If not, it is understood and agreed that the Company reserves all rights provided in any policy issued and those available by law. Further, benefits under any policy or coverage issued based on this application may be reduced by any monthly indemnity or benefit under such existing policies.
6. Any policy or additional coverage issued as a result of this application may be subject to certain conditions and limitations in the Originating Policy, including those with respect to eligibility for benefits for a current disability, current claim for benefits, or for a continuation of a current or prior claim.
7. Insurance in the amount resulting from the exercise of the Future Increase Option, Future Purchase Option, Group Disability Replacement Option, or other increase option shall take effect in accordance with the Originating Policy, so long as the new policy or additional coverage is delivered, the required premium is paid, and there has been no change in the income level, status of employment, or other conditions of insurability of the Proposed Insured.
8. Insurance in the amount resulting from the exercise of the Benefit Purchase Rider (BPR), Enhanced Portability Option (EPO), or Increase Option After Leaving Your Employer (IO) shall take effect so long as the new policy or additional coverage is delivered, the required premium is paid, and there has been no change in the income level, status of employment, occupation, or other conditions of insurability of the Proposed Insured as stated in the BPR, EPO, or IO.
9. By paying premiums on a basis more frequently than annually, the total premium payable during one year's time may be greater than if the premium were paid annually. That is, the cost of paying annualized periodic premiums may be more than the cost of paying one annual premium.
10. The Proposed Insured has received a copy of the Insurance Information Practices.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Signed at City, State

Today's Date (mm/dd/yyyy)

Signature of Proposed Insured

Signature of Applicant/Owner if Other than Proposed Insured

Witness Signature

PRODUCER'S CERTIFICATION (COMPLETE IN ALL CASES)

This Producer's Certification is to be used with the application for insurance on:

First Name ______ Middle Initial ______ Last Name ______ Suffix ______

1. How well do you know the proposed insured?

☐ Known well for ______ years. ☐ Known slightly for ______ years. ☐ Met very recently. ☐ Relative? ______

2. A. Do you have knowledge or reason to believe that this application involves a replacement as defined under applicable state law or Company procedure? ☐ Yes ☐ No

B. If "Yes," did you deliver appropriate Notice Regarding Replacement, where applicable? ☐ Yes ☐ No

3. If submitting under a discount program, please provide the following details:
Program type:

☐ Student/Resident ☐ Association ☐ Qualified Sick Pay Program ☐ Voluntary Insurance Program

☐ Professional Group ☐ Group Conversion ☐ Executive Bonus (Sec. 162)

Program status: ☐ New ☐ Existing

If existing, provide program name and code: ______

4. Commissions:

Producer's Name	Producer's Code	Last 4 Digits of Producer's SSN	Servicing Producer (Check Only One)	Percentage	DIS Code (list once)
			☐	%	
			☐	%	
			☐	%	
			☐	%	
			☐	%	
			☐	%	

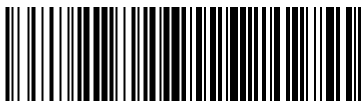
Answer questions 5 through 7 for new policies and option exercises with additional benefits, enhancements to existing benefits, or shortening of the elimination period:

5. Did you deliver to the proposed insured the notice of Insurance Information Practices, which includes the Fair Credit Reporting Act Disclosure, the MIB Pre-Notice, and Medical Records? ☐ Yes ☐ No

6. Have you suggested the possibility of an extra premium for any reason? ☐ Yes ☐ No

7. Have you suggested the possibility of an exclusion rider for any reason? ☐ Yes ☐ No

Remarks (and additional instructions):



I represent that, to the best of my knowledge and belief, the information provided in this report by the proposed insured and/or owner in the application is complete, accurate and correctly recorded, and there is nothing adversely affecting the insurability of the proposed insured other than as indicated in the application. I also represent that I gave all required forms on or before the date the application was taken. I represent that I am duly licensed in the state in which this application was signed.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Signed at City, State

Today's Date (mm/dd/yyyy)

Type or Print Producer's Name

Signature of Soliciting Producer

State(s) Where Licensed

Insurance Information Practices

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

Customer Service Office
Mailing Address
P.O. Box 981590
El Paso, TX 79998-1590

Thank you for your interest in insurance with our Company (Company referred to herein includes The Guardian Life Insurance Company of America and/or The Guardian Insurance & Annuity Company, Inc., and/or Berkshire Life Insurance Company of America). This brief description of our underwriting process is designed to help you understand how an application for insurance is handled, the types and sources of information we may collect, the circumstances under which we may disclose that information to others, and your right to learn the nature of that information upon written request. In order to underwrite your application for insurance, the Company or its affiliates to whom you are applying for insurance, will collect certain information it deems necessary to evaluate your application. Evaluating your eligibility for insurance is dependent on a number of factors such as your age, medical history, financial information, amount of coverage you are applying for, your occupation, your avocations and other personal information. In connection with this application, the Company may also review your credit report, or obtain or use a credit-based insurance score or other information that may be obtained using a third party.

This notice is given to you at the time you apply for 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 determine your eligibility for insurance or to service your claim for benefits under a policy. Your authorization will govern our requests for information and any later disclosure of that information. However, the information collected by the Company may in certain circumstances be disclosed to third parties without your specific authorization as permitted or required by law. 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 10 Hudson Yards, New York, NY 10001.

Fair Credit Reporting Act Pre-Notice

As part of underwriting your application, the Company may request investigative consumer report(s) from consumer reporting agency(ies). Such report(s) may include information about your character, general reputation, credit standing, credit worthiness, credit capacity, personal characteristics or mode of living, except as may be related directly or indirectly to your sexual orientation. It can be obtained through personal interviews with people who know you and/or through publicly available information. You may ask to be interviewed in connection with any report. Upon your written request, we will inform you if we have asked for an investigative consumer report. 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 and the nature and scope of the report. You can obtain a copy of a report by contacting the consumer reporting agency.

MIB Pre-Notice

MIB, Inc. is a not-for-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB Member company for life or disability insurance, or if a claim for benefits is submitted to such company, MIB, Inc., 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 MIB, Inc.

If you make a request of MIB, Inc., it will arrange to disclose the information it may have in your file. If you question the accuracy of the information in the its file, you may contact MIB, Inc. and seek to correct the information according to procedures set forth in the Federal Fair Credit Reporting Act. MIB, Inc.'s address is 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734 and its telephone number is 866-692-6901. Information for consumers about MIB, Inc. may be obtained on its website at www.mib.com.

Personal Information Telephone Interview

We may phone you to verify, acquire or supplement information you have given us on your application. The call will be made from our underwriting office, from a consumer reporting agency acting for us, or from a third party collecting the information on our behalf. You may be asked to provide a voice authorized signature during such interviews.

This notification must be given to the Proposed Insured.

Authorization to Obtain and Release Non-Medical Information and Insurance Information Practices

The insurer identified below will be herein referred to as the "Company."

Mailing Address
700 South Street
Pittsfield, MA 01201

BERKSHIRE LIFE INSURANCE COMPANY OF AMERICA

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

Insurance Information Practices

This notice is given to you at the time you apply for disability insurance to tell you about the information we may obtain with your application. Only qualified members of our Company's staff or its legal representatives will have access to your file to determine 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. However, the information collected by the Company may in certain circumstances be disclosed to third parties without your specific authorization as permitted or required by law. 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 10 Hudson Yards, New York, NY 10001.

Authorization to Obtain and Release Non-Medical Information

Name of Proposed Insured: ______________________ Date of Birth: __________

I authorize any insurance or reinsurance company, employer, or other organization, company, institution, consumer reporting agency or other reporting agency, Governmental Agency, including the Veteran's Administration, the Social Security Administration, MIB, Inc., the Department of Motor Vehicles, or person that has any records, excluding substance use disorder records, or knowledge of me to release any and all non-medical information in its possession about me, whether in paper or in electronic format, to the Company or its legal representatives. I authorize the Company to obtain information on disability coverage in force or applied for from the Disability Income Reporting System through MIB, Inc. Non-medical information includes information such as credit reports, consumer reports, employment, occupation, payment records, financial information or records, and/or publicly accessible sources.

I understand that the Company or its legal representatives will use the information obtained by this Authorization to determine eligibility for insurance or to evaluate 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. The Company or its legal representatives will not release any information obtained using this Authorization 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, agencies, companies or organizations performing business or legal services in connection with an application, claim, to perform actuarial or research studies perform analytics, or in evaluating our internal processes or experience or as may be lawfully permitted or required, or as I may further authorize.

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

I agree that this Authorization shall be valid for twenty-four (24) months from the date shown below and that a copy of this Authorization shall be as valid as the original. I agree that if I sign this Authorization electronically, including via voice authorization, 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.

Signatures

Signed at ______________________ this ________ day of ______________________, ________.
City and State — Day — Month — Year

______________________ Signature of Proposed Insured

______________________ Witness Signature (Not Required)

Notice of Producer Compensation

This notice is required by the New York State Department of Financial Services

Guardian Financial Representatives, Sales Managers, Disability Income Specialists, Long Term Care Specialists, Investment Specialists, Sales Representatives, Special Agents, Wholesalers, Brokers, Full Time Agents, Financial Professionals, General Agents, Professional Associate Brokers, and Protégés, sometimes referred to as "Producers", are committed to working with clients to help them achieve personal, family, and business goals. Your Producer has also been appointed by The Guardian Life Insurance Company of America, and some or all of its subsidiaries (collectively, Guardian), to offer its products to you.

As you consider this important purchase, there are a few things you should know:

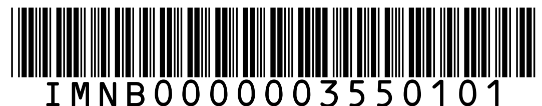
- Insurance producers are authorized by their license to confer with insurance purchasers about the benefits, terms, and conditions of insurance contracts; to offer advice concerning the substantive benefits of particular insurance contracts; to sell insurance; and to obtain insurance for purchasers. The role of the producer in any particular transaction typically involves one or more of these activities.
- Should you choose to purchase this policy/contract, your Producer will receive compensation from Guardian. Compensation for individual life insurance and annuity sales are strictly limited by New York State law.
- Further, compensation for group contracts is subject to the amounts on file with the New York State Department of Financial Services.
- Pursuant to New York State law, your Producer is prohibited from rebating any of his/her compensation to you.
- The compensation your Producer will receive on this policy/contract may depend on several factors, including:
    - the premium or deposit amount of the policy/contract
    - the policy or contract type you purchase
    - persistency (i.e. the percentage of all life insurance policies sold by your Producer that are in force year after year)
    - the tenure of your Producer with Guardian
    - the volume of sales (limited to sales of individual disability insurance)

After reading this, if you wish, you may request more detailed information about your Producer's compensation. You may also request and will receive information regarding your Producer's compensation for any other product that your Producer presented.

Thank you for considering this purchase. Kindly indicate your receipt and acknowledgment of this notice by signing below:

Signature of Policy or Contract Owner	Signature of Additional Policy or Contract Owner
Printed Name	Printed Name
Date	Date

☐ NMI ☐ RMI



Berkshire Life Insurance Company of America
Home Office: 700 South Street, Pittsfield, MA 01201
A wholly owned stock subsidiary of The Guardian Life Insurance Company of America, New York, NY

CONDITIONS OF COVERAGE

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

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

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

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

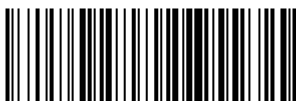
Should the amount submitted not be honored by the Proposed Insured's bank, the Company will discontinue consideration of the application.

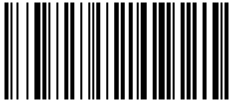
No agent or broker has the authority to waive or alter any of the terms or conditions of the application for insurance or these Conditions of Coverage.

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

I have read and understand the Conditions of Coverage.

Licensed Producer's Signature	Date	Applicant's Signature





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

DISABILITY INCOME PROTECTION COVERAGE
REQUIRED OUTLINE OF COVERAGE

Policy Form 18ID

1. READ THE POLICY CAREFULLY – This outline provides a very brief description of the Policy. This is not the insurance contract, and only the actual provisions will control. The Policy itself sets forth in detail the rights and obligations of both the Policyowner and the insurance company. It is, therefore, important that THE POLICY BE READ VERY CAREFULLY.

2. DISABILITY INCOME PROTECTION – Policies of this category are designed to provide, to persons insured, Coverage for Disabilities resulting from a covered Injury or Sickness, subject to any limitations set forth in the Policy. Coverage is not provided for basic hospital, basic medical-surgical, or major medical expenses.

3. BENEFITS OF THE POLICY – The Policy provides benefits for Total Disability.

   $________________ Monthly Benefit will be paid each month while You are Totally Disabled.

   Benefits start to accrue at the end of an Elimination Period of __________________.

   The Benefit Period is ______________________________.

   Total Disability Definition – The definition of Total Disability that applies to the Policy is checked below:

   ☐ Total Disability or Totally Disabled means that, solely due to Injury or Sickness, You are not able to perform the material and substantial duties of Your Occupation. You will be Totally Disabled even if You are Gainfully Employed in another occupation so long as, solely due to Injury or Sickness, You are not able to work in Your Occupation.

   If Your Occupation is limited to a Medical Doctor or Doctor of Osteopathy and more than 50% of Income is earned from Hands-on Patient Care, We will consider You to be Totally Disabled even if You are Gainfully Employed in Your practice or another occupation so long as, solely due to Injury or Sickness, You are not able to provide Hands-on Patient Care.

   Hands-on Patient Care means meeting with a patient in a clinical setting for the purposes of providing medical advice, evaluation, diagnosis, or treatment, that You regularly and personally provide, during the 12 months prior to Your Disability.

   If Your Occupation is limited to a Medical Doctor or Doctor of Osteopathy and more than 50% of Income is earned from performing Surgical Procedures, We will consider You to be Totally Disabled even if You are Gainfully Employed in Your practice or another occupation so long as, solely due to Injury or Sickness, You are not able to perform Surgical Procedures.

   Surgical Procedures means the medical interventions involving an incision with instruments performed by You in a clinical or hospital setting normally involving anesthesia and/or respiratory assistance, that You regularly perform, during the 12 months prior to Your Disability. These procedures can be performed on either an inpatient or outpatient basis. Providing hypodermic injections, in itself, is not a Surgical Procedure.

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

Working an average of more than 40 hours in a week, in itself, is not a material and substantial duty.

Your Occupation means the occupation (or occupations, if more than one) in which You are Gainfully Employed during the 12 months prior to the time You become Disabled. Your Occupation does not mean a specific job title, designation, industry, or job with a certain employer.

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

You will be Totally Disabled even if You are Gainfully Employed in another occupation so long as, solely due to Injury or Sickness, You are not able to work in Your Occupation.

Working an average of more than 40 hours in a week, in itself, is not a material and substantial duty.

Your Occupation means the occupation (or occupations, if more than one) in which You are Gainfully Employed during the 12 months prior to the time You become Disabled. Your Occupation does not mean a specific job title, designation, industry, or job with a certain employer.

If You have limited Your Occupation to the performance of the material and substantial duties of a single medical specialty or to a single dental specialty, We will deem that specialty to be Your Occupation.

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

You will be Totally Disabled even if You are Gainfully Employed in another occupation so long as, solely due to Injury or Sickness, You are not able to work in Your Occupation.

Working an average of more than 40 hours in a week, in itself, is not a material and substantial duty.

Your Occupation means the occupation (or occupations, if more than one) in which You are Gainfully Employed during the 12 months prior to the time You become Disabled. Your Occupation does not mean a specific job title, designation, industry, or job with a certain employer.

☐ Until We have paid benefits for two years in the same claim, Total Disability or Totally Disabled means that, solely due to Injury or Sickness, You are not able to perform the material and substantial duties of Your Occupation. You will be Totally Disabled even if You are Gainfully Employed in another occupation so long as, solely due to Injury or Sickness, You are not able to work in Your Occupation.

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

Working an average of more than 40 hours in a week, in itself, is not a material and substantial duty.

Your Occupation means the occupation (or occupations, if more than one) in which You are Gainfully Employed during the 12 months prior to the time You become Disabled. Your Occupation does not mean a specific job title, designation, industry, or job with a certain employer.

☐ Until We have paid benefits for two years in the same claim, Total Disability or Totally Disabled means that, solely due to Injury or Sickness, You are not able to perform the material and substantial duties of Your Occupation and You are not Gainfully Employed.

Thereafter, Total Disability or Totally Disabled means that, solely due to Injury or Sickness, You are not able to perform the material and substantial duties of Any Occupation.

Working an average of more than 40 hours in a week, in itself, is not a material and substantial duty.

Any Occupation means any occupation for which You are or become reasonably suited by Your education, training or experience.

Your Occupation means the occupation (or occupations, if more than one) in which You are Gainfully Employed during the 12 months prior to the time You become Disabled. Your Occupation does not mean a specific job title, designation, industry, or job with a certain employer.

AUTOMATIC BENEFIT ENHANCEMENT RIDER AND/OR BENEFIT PURCHASE RIDER – There is no premium charge for the riders checked below.

☐ Automatic Benefit Enhancement Rider ABID – This rider provides for an Automatic Increase of 4% in the Monthly Benefit of the Policy on each of six consecutive Policy Anniversaries. This rider may be renewable at six-year intervals but not past Age 60.

This rider terminates when the first of the following occurs:

- We do not renew this rider; or
- You attain Age 60; or
- the date of refusal of a second consecutive Automatic Increase; or
- any date on which the Monthly Benefit equals or exceeds the maximum amount of allowable Monthly Benefit available based on Our underwriting guidelines in effect as of the Effective Date of the Policy or the last Rider Review Date, whichever is later; or
- a Rider Review Date if You are Disabled; or
- a Rider Review Date if the Policy is suspended for active military service or unemployment; or
- Our receipt of the Policyowner's written request to terminate this rider; or
- the Policy terminates.

☐ Benefit Purchase Rider BPID – This rider gives You the opportunity to apply for additional disability income insurance in future years despite any change in Your health. We will review Your eligibility for an Increase Policy on every third Policy Anniversary while this rider is in effect. An Increase Policy may also be applied for one time prior to a Review Date if You meet certain conditions.

Each Increase Policy applied for during a Benefit Purchase Period or as part of a Special Benefit Purchase Option Offer will be underwritten to determine the maximum amount of Monthly Benefit, if any, available to You. You do not have to provide evidence of Your medical insurability.

To keep this rider in effect, You must submit an application and other evidence of insurability during the Benefit Purchase Period.

This rider terminates when the first of the following occurs:

- an application for an Increase Policy and required evidence of insurability are not received during any Benefit Purchase Period; or
- less than 50% of Our offer for an Increase Policy is accepted; or
- the initial premium for any Increase Policy is not paid; or
- Our receipt of the Policyowner's written request to reduce the Monthly Benefit of the Policy to which this rider is attached; or
- Our receipt of the Policyowner's written request to terminate this rider; or
- You attain Age 55; or
- the Policy terminates.

OPTIONAL BENEFITS – The optional benefits applied for are checked below. There is a separate premium charge for each added benefit.

☐ Social Insurance Substitute Rider SIID – This rider provides a Social Insurance Substitute Benefit for Disability. The Social Insurance Substitute Benefit each month is equal to the Social Insurance Substitute Maximum Monthly Benefit if You receive no Legislated Benefits. If You receive any Legislated Benefits, the Social Insurance Substitute Benefit is zero.

Your Social Insurance Substitute Maximum Monthly Benefit is $____________per month.

This benefit will be added to the Monthly Benefit of the Policy in each month when such benefit is payable for Disability.

This rider may not be renewed after the Expiration Date.

☐ Two-Year Partial Disability Benefit Rider 2PID – This rider provides a benefit when You are Partially Disabled.

Partial Disability means that You are Gainfully Employed and are not Totally Disabled under the terms of the Policy but, solely due to Injury or Sickness, Your Loss of Income is at least 15% of Your Prior Income.

For each month of the first 12 months that You are eligible for a Partial Disability benefit in the same claim, the policy will pay an Enhanced Initial Monthly Benefit. If you continue to be Partially Disabled after the Enhanced Initial Monthly Benefit has been paid for 12 months, the policy pays a Monthly Partial Benefit.

Benefits for Partial Disability may be payable for up to 24 months in any one claim.

This rider may not be renewed after the Expiration Date.

☐ Enhanced Partial Disability Benefit Rider EPID – This rider provides a benefit when You are Partially Disabled.

Partial Disability means that You are Gainfully Employed and are not Totally Disabled under the terms of the Policy but, solely due to Injury or Sickness, Your Loss of Income is at least 15% of Your Prior Income.

For each month of the first 12 months that You are eligible for a Partial Disability benefit in the same claim, the policy will pay an Enhanced Initial Monthly Benefit. If you continue to be Partially Disabled after the Enhanced Initial Monthly Benefit has been paid for 12 months, the policy pays a Monthly Partial Benefit.

This rider may not be renewed after the Expiration Date.

☐ 3% Compound Cost Of Living Adjustment Rider 3CID – This rider provides, on the anniversary of a claim while benefits are payable, a 3% adjustment in Monthly Benefit that will be applicable to benefits paid for the next 12 months.

This rider may not be renewed after the Expiration Date.

☐ Future Increase Option Rider FOID – This rider provides the right to apply for additional disability insurance during an Option Period despite any change in Your health or occupation.

The Total Increase Option Amount is $______________.

Each Increase Policy applied for during an Option Period as a result of an Option Date, or a Special Option Date, will be underwritten to determine the maximum amount of Monthly Benefit available, if any. You must provide evidence of Your Income, employment and all other disability insurance with any insurer that is in force, which has been applied for, or for which You are eligible. We may require additional evidence of financial insurability. You do not have to provide evidence of Your medical insurability or occupation.

This rider terminates when the first of the following occurs:

- You attain Age 55; or
- the Total Increase Option Amount has been issued; or
- the premium for this rider remains unpaid for more than 31 days; or
- Our receipt of the Policyowner's written request to terminate this rider; or
- the Policy terminates.

☐ Short-Term Residual Disability Benefit Rider SRID – This rider provides one-half of the Monthly Benefit when You are Residually Disabled after a period of Total Disability. You must be Totally Disabled for the duration of the Elimination Period before You become Residually Disabled. The Monthly Residual Benefit of this rider is payable for up to six months in the same claim.

Residual Disability means that You are Gainfully Employed and You are not Totally Disabled under the terms of the Policy but, solely due to Injury or Sickness:

- You are unable to perform one or more of the material and substantial duties of Your Occupation; or
- You are unable to perform the material and substantial duties of Your Occupation for more than one-half of the time normally required.

This rider may not be renewed after the Expiration Date.

☐ Enhanced Catastrophic Disability Benefit Rider ECID – This rider provides a Catastrophic Disability Benefit if You are Catastrophically Disabled.

Catastrophically Disabled means that due to Injury or Sickness You are unable to perform two or more of the Activities of Daily Living without Human Standby Assistance, You are Cognitively Impaired or You are Irrecoverably Disabled. The Activities of Daily Living are Bathing, Dressing, Eating, Transferring, Toileting, and Continence.

$_______________ Catastrophic Disability Benefit will be paid at the end of each month while You are Catastrophically Disabled.

Benefits start to accrue at the end of a Catastrophic Disability Elimination Period of _______________.

The Catastrophic Disability Benefit Period is _______________.

On the anniversary of a claim while the Catastrophic Disability Benefit is payable, We will adjust the Catastrophic Disability Benefit by 3% on a compound basis, not to exceed the Maximum Monthly Catastrophic Disability Benefit. Maximum Monthly Catastrophic Disability Benefit is equal to two times the Catastrophic Disability Benefit shown in the Schedule Page.

This rider may not be renewed after the Expiration Date.

☐ Basic Catastrophic Disability Benefit Rider BCID – This rider provides a Catastrophic Disability Benefit if You are Catastrophically Disabled.

Catastrophically Disabled means that due to Injury or Sickness You are Cognitively Impaired or You are Irrecoverably Disabled.

$_______________ Catastrophic Disability Benefit will be paid at the end of each month while You are Catastrophically Disabled.

Benefits start to accrue at the end of a Catastrophic Disability Elimination Period of _______________.

The Catastrophic Disability Benefit Period is _______________.

This rider may not be renewed after the Expiration Date.

☐ 6% Maximum Cost Of Living Adjustment Rider 6CID – This rider provides, on the anniversary of a claim while benefits are payable, an adjustment in Monthly Benefit that will be applicable to benefits paid for the next 12 months. We will adjust Your Monthly Benefit based on changes in the Consumer Price Index for All Urban Consumers (CPI-U), but the adjustment to the Monthly Benefit will never be less than 3%, nor more than 6%.

This rider may not be renewed after the Expiration Date.

☐ Four-Year Delayed Cost Of Living Adjustment Rider 4CID – This rider provides, starting on the fourth anniversary of a claim while benefits are payable, a 3% adjustment in Monthly Benefit that will be applicable to benefits paid for the next 12 months.

This rider may not be renewed after the Expiration Date.

☐ Graded Lifetime Benefit for Total Disability Rider GLID – This rider provides lifetime benefits if You become Totally Disabled before Age 65 and remain continuously Totally Disabled in the same claim after the Expiration Date. The Lifetime Monthly Benefit Percentage is based on Your Age when the continuous Total Disability begins. The Lifetime Monthly Benefit Percentage decreases by 5% each year after Age 45.

This rider terminates when the first of the following occurs:

- You attain Age 65 and You are not Totally Disabled; or
- the premium for this rider remains unpaid for more than 31 days; or
- Our receipt of the Policyowner’s written request to terminate this rider; or
- when the Lifetime Monthly Benefit is no longer payable; or
- the Policy terminates before the Expiration Date.

☐ Retirement Protection Plus (RPP) Disability Benefit Rider RPID – This rider provides an RPP Monthly Benefit payable to an irrevocable trust if You are Totally Disabled and not Gainfully Employed.

$_______________ RPP Monthly Benefit will be paid at the end of each month while You are Totally Disabled and not Gainfully Employed.

Benefits start to accrue at the end of an RPP Elimination Period of ________________.

The RPP Benefit Period is _____________________.

This rider terminates when the first of the following occurs:

- the RPP Expiration Date; or
- the premium for this rider remains unpaid for more than 31 days; or
- Our receipt of the Policyowner's written request to terminate this rider; or
- the Policy terminates.

☐ Lump Sum Disability Benefit Rider LSID – This rider provides a lump sum benefit at Age 60. The Lump Sum Benefit Amount will only be paid if the Policy and this rider are in force at Age 60, and if the sum of Contributing Payments is equal to or greater than the Qualifying Amount. The Lump Sum Benefit Amount is equal to the sum of Contributing Payments multiplied by 35%.

Contributing Payments are any Total Disability benefits, Residual Disability benefits, and Partial Disability benefits paid under the Policy up to Age 60.

Your Qualifying Amount is $______________________.

This rider terminates when the first of the following occurs:

- the Lump Sum Benefit Amount has been paid; or
- You attain Age 60; or
- the premium for this rider remains unpaid for more than 31 days; or
- Our receipt of the Policyowner's written request to terminate this rider; or
- the Policy terminates.

☐ Basic Partial Disability Benefit Rider PTID –This rider provides a Monthly Partial Benefit when You are Partially Disabled.

Partial Disability or Partially Disabled means You are Gainfully Employed and You are not Totally Disabled under the terms of the Policy, but solely due to Injury or Sickness:

- You experience a Loss of Income that is at least 20% of Your Prior Income; and either
- You are unable to perform one or more of the material and substantial duties of Your Occupation; or
- You are able to perform all of the material and substantial duties of Your Occupation but not for the length of time they normally require.

During the first six months in which the Monthly Partial Benefit is payable, We will deem Your Loss of Income to be 50% of Your Prior Income or the actual percentage of loss, if greater.

This rider may not be renewed after the Expiration Date.

☐ Supplemental Benefit Term Rider SBID –This rider provides a Supplemental Monthly Benefit when You are Totally Disabled.

$_______________ Supplemental Monthly Benefit will be paid at the end of each month while You are Totally Disabled.

Benefits start to accrue at the end of a Supplemental Benefit Elimination Period of __________.

This rider terminates when the first of the following occurs:

- the Supplemental Benefit Termination Date; or
- the premium for this rider remains unpaid for more than 31 days; or
- Our receipt of the Policyowner's written request to terminate this rider; or
- the Policy terminates.

4. EXCLUSIONS AND LIMITATIONS OF THE POLICY – We will not pay benefits for any Disability:

- caused by, contributed to by, or which results from, war or an act of war, whether declared or undeclared, while You are serving in the armed forces or a military auxiliary unit, either active or reserve; or
- caused by, contributed to by, or which results from, Your commission of, or attempt to commit, a felony, or Your participation in a riot or insurrection; or
- caused by, contributed to by, or which results from, Your being engaged in an illegal occupation or professional misconduct; or
- caused by, contributed to by, or which results from, an intentionally self-inflicted injury; or
- caused by, contributed to by, or which results from, a normal pregnancy until 90 days have elapsed from the date of Disability or the Elimination Period has been satisfied, if later; or
- due to any loss We have excluded by name or description.

LIMITATION WHILE OUTSIDE THE UNITED STATES, ITS POSSESSIONS, CANADA OR MEXICO – Benefits for Disability will be limited to a total of twelve months during Your lifetime unless You are living full time in the United States, its Possessions, Canada or Mexico for at least six consecutive months in each calendar year. United States refers to the 50 states that comprise the United States of America and the District of Columbia.

If benefits under the Policy have ceased because of this limitation and You return to the United States, its Possessions, Canada or Mexico, benefits may resume under the Policy if all terms and conditions of the Policy are satisfied.

If You continue to reside outside of the United States, its Possessions, Canada, or Mexico, premiums will become due beginning three months after benefits under the Policy have ceased.

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

Pre-existing Condition means a physical or mental condition:

- for which You received professional medical advice, diagnosis or treatment within two years before the Effective Date; or
- that caused symptoms within one year before the Effective Date for which a prudent person would usually seek professional medical advice, diagnosis or treatment.

MENTAL AND/OR SUBSTANCE-RELATED DISORDERS LIMITATION – If the Policy includes a Mental and/or Substance-Related Disorders Benefit Limitation, it is shown in the Schedule Page. Under this limitation, benefits We pay for a Disability caused by, contributed to by, or which results from, a Mental and/or Substance-Related Disorder are limited during Your lifetime to the number of months specified in the Schedule Page.

After We have paid benefits for a Disability caused by, contributed to by, or which results from, a Mental and/or Substance-Related Disorder for the number of months specified in the Schedule Page, We will not pay benefits for a Disability caused by, contributed to by, or which results from, a Mental and/or Substance-Related Disorder unless You are:

- continuously confined in a Hospital for treatment of a Disability caused by, contributed to by, or which results from, a Mental and/or Substance-Related Disorder; and
- under the regular care of a Physician.

Under no circumstance will We pay benefits for a Disability caused by, contributed to by, or which results from, a Mental and/or Substance-Related Disorder that We have excluded by name or description.

This limitation will not apply to Catastrophic Disability due to a Cognitive Impairment, as defined in the Basic Catastrophic Disability Benefit Rider or Enhanced Catastrophic Disability Benefit Rider, if attached to the Policy.

5. RENEWABILITY OF THE POLICY –After the Expiration Date, the Policy may be conditionally renewed on each Policy Anniversary, if:
   - You are not Disabled; and
   - You are Gainfully Employed Full Time for at least ten months each year; and
   - the premium is paid on time; and
   - the Policy is in force up to the Expiration Date.

   If the Policyowner renews the Policy after the Expiration Date, We can require satisfactory written proof that You have continued to be Gainfully Employed Full Time for at least ten months each year. Upon Our approval, We will issue a new Schedule Page.

   The only Coverage that will continue after the Expiration Date is for Total Disability, unless otherwise stated. The Benefit Period after the Expiration Date is shown in the Schedule Page.

   The premium at each renewal will be based on Our premium rates in effect for Your Age, gender, Class of Risk, Occupation Class, any special class rating under the Policy, and other factors We are adding on a class basis at that time. We have the right to change such premiums on a class basis on any Policy Anniversary.

   Any premium paid after the Expiration Date for a period not covered by the Policy will be refunded.

Bank Draft Authorization

Any insurer below, individually or collectively, is herein referred to as the "Company."

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

Please print.

SECTION 1: Type of Request

☐ Establish a new bank draft authorization for periodic payments.
☐ Update financial institution information for 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): ____________________

SECTION 2: Financial Institution Information

Financial institution name ____________________

Type of account (Check one.) ☐ Checking ☐ Savings ☐ Business*

*Type of 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 Account Holder ____________________

Address ____________________
Address City State Zip

Cell phone ____________________ Email ____________________

SECTION 3: Premium Arrangement Information

Please note the "Amount to Be Deducted" is only required for universal life/variable life policies. For traditional life and disability policies, the premium amount to be deducted is the modal premium described in your policy. The effective date of change will be the date your next premium payment is due.

Policy Number	Draft Date[1]	Insured Name	Amount to be Deducted[2]	Premium Mode[3]
			$	☐ Monthly ☐ Annual ☐ Semi-Annual
			$	☐ Monthly ☐ Annual ☐ Semi-Annual
			$	☐ Monthly ☐ Annual ☐ Semi-Annual
			$	☐ Monthly ☐ Annual ☐ Semi-Annual
			$	☐ Monthly ☐ Annual ☐ Semi-Annual
			$	☐ Monthly ☐ Annual ☐ Semi-Annual

[1] Policies beginning with S, V, and U are limited to the 15th. For other products, if no date is selected, due date will be used.
[2] 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.
[3] If a change in premium mode results from your election, depending on the timing of this change additional funds may be required to be withdrawn to pay your policy to the next due date. S, V, and U policies are limited to monthly mode only.

SECTION 4: Optional Payment Information

Loan Repayment(s)

Policy number	Amount	Draft date[1]	Mode
	$		☐ Monthly ☐ Annual
	$		☐ Monthly ☐ Annual
	$		☐ Monthly ☐ Annual

[1] Loan repayments for certain policies (policy numbers beginning with "L") can only be made on or about the 15th of each month.

Loan Interest[2]

Policy number	Draft day	Policy number	Draft day	Policy number	Draft day

[2] Loan interest amount is determined by the amount due each anniversary and can only be paid annually on or around the anniversary. There is no need to specify a month, as that is determined by the anniversary and the day elected.

Purchase of Unscheduled Paid-Up Additions (PUA) Rider (for scheduled PUA changes please see the Policy Admin form)

Policy number	Amount[3]	Draft date	Mode
	$		☐ Monthly ☐ Annual
	$		☐ Monthly ☐ Annual
	$		☐ Monthly ☐ Annual

[3] Payments under the Purchase of Paid-Up Additions (PUA) rider are subject to the minimum and maximum amounts defined in your rider form. If the maximum PUA payment has been reached in a given policy year, drafts for PUA will cease for that year, and will resume beginning in the following policy year.

Remarks ______________________________

____

SECTION 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 specified account or to initiate electronic funds transfer from your chosen bank or financial institution on or about the date you selected and at the frequency selected to make a payment on the designated policy. Due to timing of the authorization, the initial electronic funds transfer processed may result in more than one payment being withdrawn.
2. The Company's treatment of each debit, and its' rights with respect to it, will be the same as if it were signed or initialed personally by the Authorized Account Holder. If any debit is dishonored by the bank or financial institution for any reason, the payment will be reversed and will not be considered paid. This may cause the policy to lapse or terminate in accordance with the provisions of the policy and result in the forfeiture of insurance.
3. Completion of this Bank Draft Authorization shall not constitute a payment. Multiple payments may be required to bring the policy to a current due date.
4. This Bank Draft Authorization may be terminated by the Policy Owner, the Company, or the Authorized Account Holder (if different from the Policy Owner). The Policy Owner or Authorized Account Holder 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. The Company may try a second time for any withdrawal returned due to insufficient funds. The Company may terminate this Authorization immediately in the event any withdrawal or electronic fund transfer is dishonored for any reason.
6. A confirmation statement for 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.

SECTION 5: Terms and Conditions (continued)

7. If the premium mode selected is different than your current premium mode, you are authorizing the Company to change the premium mode for your policy for payment of future premiums. For details on the cost of paying premiums more frequently than annually, please refer to the Policy Owner's policy or product prospectus, as applicable.
8. 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.
9. The Company should be provided with 30 days' advance notification of any change to the banking information provided. If advance notification cannot be provided, sufficient funds should be left in the authorized account to honor charges until the Company's records are changed.
10. Any change in name or address of the Authorized Account Holder or Policy Owner must be communicated immediately to the Company.
11. If this service is no longer in effect, premiums will be due and billed according to the mode selected but no more frequently than quarterly. Any draft payments scheduled, regardless of type, will no longer be automatically deducted and future payments will be the Policy Owner's responsibility.
12. If this form is being used to set up recurring payments under the Purchase of Paid-Up Additions (PUA) rider, these payments will be considered unscheduled payments under the terms of such rider. They will not be paid by the Company under any Waiver of Specified Amount benefit in the event of disability.
13. Any bank fees are the responsibility of the Authorized Account Holder.
14. The Company and its officers, directors, agents, employees and representatives are authorized to make any inquiries that the Company considers necessary to validate the account identified and/or investigate any dispute involving your payment, which may include verifying the information I/we provide and/or that the Company acquired against third party databases.
15. The Company (or its agent or representative) are authorized to initiate one or more debits by electronic fund transfers (withdrawals), and the bank or financial institution that holds my/our account is authorized to deduct such payments, in the amounts and frequency designated.

Policy Owner email ______________________________

☐ By checking this box, the person(s) signing below authorizes the Company to communicate electronically regarding this transaction.

Note: If the email entered is different from the email we have on file, you will need to update your email address via the customer portal at guardianlife.com.

______________________________ ______________
Signature of Policy Owner Date

______________________________ ______________
Signature of Authorized Account Holder (required if different from Policy Owner) Date

Life Insurance

The Guardian Life Insurance Company of America
Individual Life Service and Administration
P.O. Box 981590
El Paso TX, 79998-1590

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

The Guardian Insurance & Annuity Company
Park Avenue Variable Life
P.O. Box 981588
El Paso TX 79998-1588

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

Disability Income Insurance

Berkshire Life Insurance Company of America
Policy Services
P.O. Box 981594
El Paso TX 79998-1594

Email: Diprocessing@glic.com
Customer Call Center: 1-888-GUARDIAN (482-7342)
Fax: 413-395-5992