

SERFF Tracking Number: GARD-126407940 State: Arkansas
Filing Company: The Guardian Insurance & Annuity Company State Tracking Number: 44282
Inc.
Company Tracking Number: L-AP-2004
TOI: L06I Individual Life - Variable Sub-TOI: L06I.003 Single Life - Single Premium
Product Name: Life App04 GIAC
Project Name/Number: Life App04 GIAC (Refile AR only)/L-AP-2004

Filing at a Glance

Company: The Guardian Insurance & Annuity Company Inc.

Product Name: Life App04 GIAC

SERFF Tr Num: GARD-126407940 State: Arkansas

TOI: L06I Individual Life - Variable

SERFF Status: Closed-Approved-
Closed State Tr Num: 44282

Sub-TOI: L06I.003 Single Life - Single Premium Co Tr Num: L-AP-2004

State Status: Approved-Closed

Filing Type: Form

Reviewer(s): Linda Bird

Authors: Lisa Capella, Peter
Diggins, Margaret Lewis-Forbes,
John Monahan, Carol Nardella,
Monica Wilson, Connie Gelfat,
Carline Hamilton, Kathleen Tobin

Disposition Date: 12/10/2009

Date Submitted: 12/09/2009

Disposition Status: Approved-
Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: Life App04 GIAC (Refile AR only)

Status of Filing in Domicile: Authorized

Project Number: L-AP-2004

Date Approved in Domicile:

Requested Filing Mode: Review & Approval

Domicile Status Comments:

Explanation for Combination/Other:

Market Type: Individual

Submission Type: New Submission

Group Market Size:

Overall Rate Impact:

Group Market Type:

Filing Status Changed: 12/10/2009

Explanation for Other Group Market Type:

State Status Changed: 12/10/2009

Deemer Date:

Created By: Connie Gelfat

Submitted By: John Monahan

Corresponding Filing Tracking Number:

Filing Description:

State of Arkansas

Re: The Guardian Insurance & Annuity Company, Inc. (GIAC)

NAIC Number: 429-78778

SERFF Tracking Number: GARD-126407940 State: Arkansas
 Filing Company: The Guardian Insurance & Annuity Company State Tracking Number: 44282
 Inc.
 Company Tracking Number: L-AP-2004
 TOI: L06I Individual Life - Variable Sub-TOI: L06I.003 Single Life - Single Premium
 Product Name: Life App04 GIAC
 Project Name/Number: Life App04 GIAC (Refile AR only)/L-AP-2004

Application Forms L-AP-2004 AR, JUV-AP-2006 AR
 L-AP-CHG-2005 AR and L-AP-SIGI-2008 AR

Dear Commissioner:

We are enclosing 4 revised individual life application forms for your approval.

These applications will be used to apply for individual universal and variable life insurance policies issued by The Guardian Insurance & Annuity Company, Inc (GIAC). These forms will also be used to apply for life insurance policies issued by GIAC's parent company, The Guardian Life Insurance Company of America (Guardian), and are being filed on behalf of Guardian under separate cover. Two of these forms will also be used with another affiliated company, Berkshire Life Insurance Company of America, and are being filed on behalf of Berkshire under separate cover.

These forms replace previously approved application forms as shown in the table below.

New Form Number	Replaced Form Number	-----	Previous Approval Date
L-AP-2004 AR	-----	L-AP-2004	----- 12/16/04 - Dept File #28174
JUV-AP-2006 AR	-----	JUV-AP-2006	----- 9/19/06 - Dept File #33708
L-AP-CHG-2005 AR	-----	L-AP-CHG-2005	----- 12/16/05 - Dept File #31368
L-AP-SIGI-2008 AR	-----	L-AP-SIGI-2008	----- 5/28/08 - Dept File #39086

The reason for the submission of these new application forms is that we have changed the replacement question that appears in our application in anticipation of your state's upcoming changes to its regulation for life insurance replacements. Specifically, we have changed Question 11 of form L-AP-2004 AR, Question 10 of form JUV-AP-2006 AR, Question 8 of form L-AP-CHG-2005 AR, and Question 10 on L-AP-SIGI-2008 AR, to ask a question of the applicant regarding whether he/she has existing insurance. This is in place of the old question, which asked whether the applicant was intending to replace existing insurance. If the question regarding existing insurance is answered "yes" the applicant will be provided with, and must complete, the appropriate disclosure form as required in your regulation. Aside from this change, the enclosed application forms are identical to the previously approved forms.

The question regarding existing insurance that we are required to ask of our agent is done on our Agent's Certification, which is a separate form, and is not part of the application form itself, though we require the form to be submitted with the application. A copy of the form is enclosed in this filing for information only.

None of the other ancillary forms we use with these applications (such as the Authorization, Notice of Information Practices, etc.) have changed.

SERFF Tracking Number: GARD-126407940 State: Arkansas
 Filing Company: The Guardian Insurance & Annuity Company State Tracking Number: 44282
 Inc.
 Company Tracking Number: L-AP-2004
 TOI: L06I Individual Life - Variable Sub-TOI: L06I.003 Single Life - Single Premium
 Product Name: Life App04 GIAC
 Project Name/Number: Life App04 GIAC (Refile AR only)/L-AP-2004

Any applicable certifications, transmittals and filing fees are enclosed as required. We have enclosed a table that shows all of the policy forms that can be applied for with these applications.

I hope this information is satisfactory and that we may receive your Department's approval of these forms at your earliest convenience. If you have any questions, please feel free to contact me at (212) 598-8419, or toll-free at 877-600-1460, or by e-mailing me at John_Monahan@glic.com.

Sincerely,
 John J. Monahan, Director
 Individual Markets Compliance

Company and Contact

Filing Contact Information

Kathleen Tobin, Life Team Leader Kathleen_Tobin@glic.com
 7 Hanover Square 212-919-8727 [Phone]
 New York, NY 10004 212-919-2592 [FAX]

Filing Company Information

The Guardian Insurance & Annuity Company CoCode: 78778 State of Domicile: Delaware
 Inc.
 7 Hanover Square Group Code: 429 Company Type:
 New York, NY 10004 Group Name: State ID Number:
 (212) 598-8000 ext. [Phone] FEIN Number: 13-2656036

Filing Fees

Fee Required? Yes
 Fee Amount: \$200.00
 Retaliatory? No
 Fee Explanation: \$50.00 per form X 4
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
The Guardian Insurance & Annuity Company Inc.	\$200.00	12/09/2009	32618235

SERFF Tracking Number: GARD-126407940 State: Arkansas
Filing Company: The Guardian Insurance & Annuity Company State Tracking Number: 44282
Inc.
Company Tracking Number: L-AP-2004
TOI: L06I Individual Life - Variable Sub-TOI: L06I.003 Single Life - Single Premium
Product Name: Life App04 GIAC
Project Name/Number: Life App04 GIAC (Refile AR only)/L-AP-2004

CHECK NUMBER	CHECK AMOUNT	CHECK DATE
	\$200.00	

SERFF Tracking Number: GARD-126407940 State: Arkansas
Filing Company: The Guardian Insurance & Annuity Company State Tracking Number: 44282
Inc.
Company Tracking Number: L-AP-2004
TOI: L06I Individual Life - Variable Sub-TOI: L06I.003 Single Life - Single Premium
Product Name: Life App04 GIAC
Project Name/Number: Life App04 GIAC (Refile AR only)/L-AP-2004

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved- Closed	Linda Bird	12/10/2009	12/10/2009

SERFF Tracking Number: GARD-126407940 *State:* Arkansas
Filing Company: The Guardian Insurance & Annuity Company *State Tracking Number:* 44282
Inc.
Company Tracking Number: L-AP-2004
TOI: L06I Individual Life - Variable *Sub-TOI:* L06I.003 Single Life - Single Premium
Product Name: Life App04 GIAC
Project Name/Number: Life App04 GIAC (Refile AR only)/L-AP-2004

Disposition

Disposition Date: 12/10/2009

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: GARD-126407940 State: Arkansas
 Filing Company: The Guardian Insurance & Annuity Company State Tracking Number: 44282
 Inc.
 Company Tracking Number: L-AP-2004
 TOI: L06I Individual Life - Variable Sub-TOI: L06I.003 Single Life - Single Premium
 Product Name: Life App04 GIAC
 Project Name/Number: Life App04 GIAC (Refile AR only)/L-AP-2004

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Yes	Yes
Supporting Document	Application	Yes	Yes
Supporting Document	Life & Annuity - Acturial Memo	No	No
Supporting Document	Agent's Cert	Yes	Yes
Supporting Document	Juvenile Agent's Cert	Yes	Yes
Form	Life Insurance Application Form Part 1	Yes	Yes
Form	Juvenile Life Insurance ApplicationForm Part 1	Yes	Yes
Form	Life Insurance Change Request Form	Yes	Yes
Form	Simplified Issue/Guaranteed Issue Insurance Application Form	Yes	Yes

SERFF Tracking Number: GARD-126407940 State: Arkansas
 Filing Company: The Guardian Insurance & Annuity Company State Tracking Number: 44282
 Inc.
 Company Tracking Number: L-AP-2004
 TOI: L06I Individual Life - Variable Sub-TOI: L06I.003 Single Life - Single Premium
 Product Name: Life App04 GIAC
 Project Name/Number: Life App04 GIAC (Refile AR only)/L-AP-2004

Form Schedule

Lead Form Number: L-AP-2004 AR

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	L-AP-2004 AR	Application/ Enrollment Form	Life Insurance Application Form Part 1	Revised	Replaced Form #: L-AP-2004 AR Previous Filing #: L-AP-2004	51.600	L-AP-2004 AR.pdf
	JUV-AP-2006 AR	Application/ Enrollment Form	Juvenile Life Insurance Application Form Part 1	Revised	Replaced Form #: JUV-AP-2006 AR Previous Filing #: JUV-AP-2006	46.900	JUV-AP-2006 AR.pdf
	L-AP-CHG-2005 AR	Application/ Enrollment Form	Life Insurance Change Request Form	Revised	Replaced Form #: L-AP-CHG-2005 AR Previous Filing #: L-AP-CHG-2005	45.600	L-AP-CHG-2005 AR.pdf
	L-AP-SIGI-2008 AR	Application/ Enrollment Form	Simplified Issue/Guaranteed Issue Insurance Application Form	Revised	Replaced Form #: L-AP-SIGI-2008 AR Previous Filing #: L-AP-SIGI-2008	46.100	L-AP-SIGI-2008 AR.pdf



Customer Service Office
3900 Burgess Place
Bethlehem, PA 18017

- THE GUARDIAN LIFE INSURANCE COMPANY OF AMERICA
THE GUARDIAN INSURANCE & ANNUITY COMPANY, INC.
BERKSHIRE LIFE INSURANCE COMPANY OF AMERICA
(Please check appropriate company. In this application, "the Company" is the insurer checked above.)

APPLICATION FOR LIFE INSURANCE
Part 1

Please print

(Page 1 of 7)

I. Proposed Insured Information

a. First Name MI Last Name

b. Social Security # c. Sex Male Female

d. Date of Birth (mm/dd/yyyy) e. Place of Birth

f. Are you a U.S. citizen? Yes No
If no, give: Visa Type Visa Duration Other
g. Marital Status Married Single Separated Widowed Divorced

h. Address City State Zip

i. How long at this address?

j. Home phone k. e-mail address

l. If less than 2 years at current address, please furnish previous address:
Address City State Zip

m. 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 a.m. p.m.

2. Employment Information

a. Name of Employer

b. Address City State Zip Business Phone Business Web Site

c. If address is P.O. Box, include street address as well:
Address City State Zip

d. Occupation e. Job Title

f. Nature of Business

g. How many years employed? (If less than 2 years please furnish previous employer below)

h. Former Employer Address City State Zip

i. Occupation j. Job Title

k. Nature of Business



3. Owner Information

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

- a. Owner name (First, MI, Last) or name of trust, company or other owner:
b. Social Security No./Tax ID No. c. Relationship to proposed insured
d. Street Address
e. Telephone Number
f. Tax Qualified Plan? Yes No
g. Complete if Policy is Trust Owned:
Date of Trust
Complete Names of Authorized Trustees

4. Beneficiary Information

Print full name and relationship to Proposed Insured. (Unless otherwise indicated, 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., if surviving the Insured, unless otherwise specified).

- a. Primary Beneficiary
b. Contingent Beneficiary
c. Tertiary Beneficiary

5. Purpose of Insurance

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

- Buy-Sell, Key Person, Executive Bonus, Deferred Compensation, Split Dollar, Collateral for Debt, Charitable Planning, Estate Planning, Wealth Accumulation, Family Income, Retirement, Education, Mortgage, Spouse/Child Insurance, Other

6. Financial Information

Personal Finances (This section applies to the proposed insured. If this policy is business owned, please also complete the Business Finances section below.)

- a. Total Assets \$ b. Total Liabilities \$ c. Net Worth \$
d. Earned Income \$ e. Unearned Income (if in excess of \$10,000) \$

Business Finances (Complete if policy is business owned)

- f. Type of Business (Check One): Limited Liability Co. Sole Proprietor Partnership S Corp C Corp Other
g. Total Assets \$ h. Total Liabilities \$ i. Net Worth \$
j. Net Profit After Taxes for past Two Years: Last Year \$ Previous Year \$
k. How long has the business been established?
l. What is the nature of the business?
m. What percentage of the business is owned by the proposed insured?
n. Is there business insurance applied for or in force on other key members of this firm? Yes No
If "yes", please provide details:

7. Proposed Insurance

a. Plan of Insurance _____ Base Policy Face Amount \$ _____

b. Riders

Traditional Life/Term Riders (Note: Option Q and R riders are elected in the Dividends Section)

- Accidental Death Benefit (ADB) ADB Face Amount: \$ _____
Waiver of Premium (WP) Initial Period Waiver of Premium (For LifeSpan only)
Scheduled/Unscheduled Paid-Up Additions (EPUA) Rider Unscheduled Only Paid-Up Additions (EPUA) Rider
Guaranteed Purchase Option (GIO)/Whole Life Purchase Option Option Amount: \$ _____
Accelerated Benefit Rider (EABR/ABR) (please complete required disclosure form)
10 Year Annually Renewable Term (RTR-10) Term Amount: \$ _____
Paid-Up Insurance Rider (for EMP, GIWL, SUPP only) Equivalent Annual Deposit, excluding Waiver \$ _____
Paid-Up Additions Rider (for EMP, GIWL, SUPP only) First Year Purchase Payment \$ _____
DuoGuard (List names & amounts for Designated Lives. Complete a separate application for each Designated Life.)
Exchange to Term Insurance Select Security Rider
Other \$ _____ Other \$ _____

Universal Life and Variable Life Riders

- Additional Sum Insured (Do NOT include this amount in Base Face Amount shown above) \$ _____
Secondary Guarantee Coverage Rider/Guaranteed Coverage Rider (for VUL GCR, elect coverage to age _____)
Accidental Death Benefit (ADB) ADB Face Amount: \$ _____
Waiver of Monthly Deductions
Disability Benefit Rider Monthly Specified Amount: \$ _____
Guaranteed Insurability Option Option Amount \$ _____
Adjustable Annual Renewable Term Term Amount: \$ _____ Select Security Rider
Other \$ _____ Other \$ _____

Riders for Survivorship Products (EstateGuard, SVUL, etc.)

- Survivorship Waiver of Premium (Death Waiver) (available on one or both of the base policy insureds) 10 Year 15 Year
Adjustable Annual Renewable Term (on both insureds) Term Amount: \$ _____
Single Life Term/RTR 85 (available on one or both of the base policy insureds)
Second to Die DuoGuard (List names & amounts for Designated Lives. Complete a separate application for each Designated Life.)
First To Die DuoGuard (available on one or both of the base policy insureds)
Split Dollar Protector (available on one or both of the base policy insureds)
Other \$ _____ Other \$ _____

8. Premiums

- a. 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 _____
- b. Who is to pay premiums? _____
- c. Send premium notices to:
 - Residence Business Owner's address Other _____
 - List Bill
 - New – Billing Name _____ Common billing date _____
 - Existing account # _____
- d. Automatic Premium Loan (if available) Yes No *(if left blank, default will be Yes)*
- e. Complete for VUL/UL policies:
 - Initial Premium \$ _____ Planned Premium (at the mode indicated above) \$ _____
- f. Complete for Variable Whole Life (PAL) policies:
 - Initial Premium \$ _____ Planned Modal Unscheduled Payment \$ _____
- g. Prepayment of Premium
 - No money is being submitted with this application.
 - Money is being submitted with this application, in the amount of \$ _____ for proposed life insurance in the amount of \$ _____ in exchange for the Conditional Receipt providing proposed conditional coverage for this amount of insurance only. Please see the Conditional Receipt for the circumstances under which money can be paid with this application, and Item (3) under "Conditions" in the Receipt for rules pertaining to the amount of life insurance that can be entered above.

9. Dividends (for participating policies only)

- A-Paid in cash
- B-Reduce premiums
- C-Left at interest *(Complete W-9 form if elected)*
- D-Paid-Up Additional Insurance *(Option D will be the default option if no other is elected)*
- 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
- K-Deferred Additional Insurance (EMP plans only)
- L- Term Insurance face amount not in excess of twice face amount of basic policy/Balance to purchase paid-up additional insurance
- P- Term Insurance face amount not in excess of twice 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)* 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.

10. Additional Information for VUL/UL Policies

- a. **Death Benefit Option** *(Note, not all options may be available with all policies)*
 - Option 1 Option 2 Option 3 Other _____
- b. **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 are excludible 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

I. Replacement/Existing Insurance

Does the owner/applicant have any existing individual life insurance policies or annuity contracts (including those in the process of being lapsed or surrendered)? Yes No (If "Yes", please complete appropriate state replacement forms.)

12. Existing Insurance on Proposed Insured

Are there any existing life insurance policies or annuity contracts in force on the proposed insured? Yes (please list below) No

A. Life insurance policies

Name of Company	Year Issued	Amount	Personal or Business	Accidental Death Amt	Waiver of Premium	GIO Amt
_____	_____	_____	<input type="checkbox"/> Per. <input type="checkbox"/> Bus	_____	_____	_____
_____	_____	_____	<input type="checkbox"/> Per. <input type="checkbox"/> Bus	_____	_____	_____
_____	_____	_____	<input type="checkbox"/> Per. <input type="checkbox"/> Bus	_____	_____	_____

B. Annuity contracts

Name of Company	Year Issued	Waiver of Premium
_____	_____	_____
_____	_____	_____
_____	_____	_____

13. Personal History of the Proposed Insured

(These questions apply to the Proposed Insured. Please provide details in Remarks section for any "yes" answers to the following questions, except for 13c.)

- | | Yes | No |
|--|--------------------------|--------------------------|
| a. Do you intend to change your occupation?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Do you intend to reside or travel outside of the U.S.?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Do you drive a motor vehicle? | <input type="checkbox"/> | <input type="checkbox"/> |
| Driver's License State _____ Driver's License # _____ | | |
| d. Within the past five years, have you been charged with and/or convicted of any motor vehicle moving violations or had your driver's license suspended or revoked? (If yes, details must include date of violation, description of violation and penalty.)..... | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Within the last ten years, have you been convicted of a felony, or is such a charge pending against you?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Within the last three years have you participated in, or do you intend to participate in, any of the following: piloting any type of aircraft; mountain climbing or rock climbing; scuba diving; hang gliding; parachuting or skydiving; or motor vehicle racing? (If yes to any, complete Aviation and/or Avocation Supplement.) | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Have you ever filed for personal or business bankruptcy? (If yes, give full details and date of discharge in Remarks section.) | <input type="checkbox"/> | <input type="checkbox"/> |
| h. Within the past five years, have you had disability, accident, medical or life insurance declined, postponed, modified, rated, cancelled or withdrawn a pending application, or had a renewal or reinstatement refused? | <input type="checkbox"/> | <input type="checkbox"/> |
| i. Have you smoked cigarettes in the past 24 months?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| (If you have quit, date last used: _____) | | |
| j. Have you used tobacco in any form in the last 12 months?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| If "No", have you used tobacco in any form in the last 24 months?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| If "No", have you used tobacco in any form in the last 48 months?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| (If you have quit, date last used: _____) | | |
| k. Do you currently use a nicotine patch or nicotine gum?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| l. Do you plan to apply for or are you currently applying for any other life, disability or accident insurance? (In details, include amount and company applied with, and whether this other insurance will be in addition to or in lieu of insurance with Guardian/GIAC/Berkshire.) | <input type="checkbox"/> | <input type="checkbox"/> |

14. Remarks Section

15. Alternate/Additional Life Policy

*Note: This section may only be used if **no** cash is being paid with the application. If cash is being paid, a separate application is needed for the alternate or additional plan.*

Please indicate: Alternate Policy Additional Policy

Plan of Insurance: _____ Face Amount: _____

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

16. Amendments or Corrections (For Home Office Or Customer Service Office Use Only)

Application For Life Insurance – Part I (continued)

Representations of the Proposed Insured and Owner

Those parties who sign below, agree that:

1. This application, (Part 1, Part 2, the Authorization, the Variable Life Supplement, if applicable, and any other supplements to the application) will form the basis for, and become part of and attached to, any policy issued.
2. 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.
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. 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.
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 that is issued based on this application.
5. 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 the first premium is paid. Except as provided in the Conditional Receipt (if an advance payment has been made and acknowledged and such Receipt issued) coverage does not begin until the effective date assuming the first premium is paid during the lifetime and prior to any change in the health of the Proposed Insured.
6. 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. In those states where written consent is required by statute or State Insurance Department regulation for amendments as to plan, amount, classification, age at issue, or benefits, such changes will be made only with the Owner's written consent.
7. 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.
8. 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, 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 may also be subject to civil penalties.

Signed at: _____ on _____
City and State mm/dd/yyyy

Signature of Proposed Insured Signature of Applicant/Owner if Other than Proposed Insured

Signature of Additional Owner Witness (for applications taken by mail)

- Check here if this application was taken by mail. If application is taken by mail, the signature of the agent does not attest to the signature of the Proposed Insured or Owner if Other than the Proposed Insured.
- Check here if this application was taken in person. I certify that I have taken this application in the presence of the Proposed Insured and Owner (if Other than the Proposed Insured), and that I have truly and accurately recorded on this application the information supplied by the Proposed Insured and Owner (if Other than the Proposed Insured).

Signature of Licensed Agent License Number(s)

Agent's Name State(s) where licensed



Customer Service Office
3900 Burgess Place
Bethlehem, PA 18017

THE GUARDIAN LIFE INSURANCE COMPANY OF AMERICA
THE GUARDIAN INSURANCE & ANNUITY COMPANY, INC.
(Please check appropriate company. In this application, "the Company" is the insurer checked above.)

APPLICATION FOR LIFE INSURANCE ON JUVENILE - Part 1

Please print

(Page 1 of 7)

I. Proposed Insured Information

a. First Name MI Last Name
b. Social Security # c. Sex Male Female
d. Date of Birth (mm/dd/yyyy) e. Place of Birth
f. Address
City State Zip

2. Adult Applicant Information

a. First Name MI Last Name
b. Social Security # c. Sex Male Female
d. Date of Birth (mm/dd/yyyy) e. Place of Birth
f. Relationship to Proposed Insured
g. Total Amount of Life Insurance In Force on Life of Applicant
h. Are you a U.S. citizen? Yes No
i. Marital Status Married Single Separated Widowed Divorced
j. Address
City State Zip
k. How long at this address?
l. Home phone m. e-mail address
n. If less than 2 years at current address, please furnish previous address:
Address
City State Zip
o. 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 Time a.m. p.m.

3. Policy Owner Information

a. The owner of the policy shall be the adult applicant, if living. Otherwise, it shall be:
the Proposed Insured, if living; otherwise the Proposed Insured.
Indicate name and relationship to insured
You can indicate in the Remarks section of this application if ownership of this policy is to revert to the Proposed Insured upon the Proposed Insured's 21st birthday. You can also make this ownership change after the policy is issued.
b. Send premium notices to owner's: Home Business
c. Complete if Policy is Trust Owned:
Date of Trust
Complete Names of Trustees:



4. Employment Information of Adult Applicant

- a. Name of Employer _____
- b. Address _____
 City _____ State _____ Zip _____
 Business Phone _____ Business Web Site _____
- c. If address is PO Box, include street address as well:
 Address _____
 City _____ State _____ Zip _____
- d. Occupation _____ e. Job Title _____
- f. Nature of Business _____
- g. How many years employed? _____ (If less than 2 years please furnish previous employer below)
- h. Former Employer _____
 Address _____
 City _____ State _____ Zip _____
- i. Occupation _____ j. Job Title _____
- k. Nature of Business _____

5. Beneficiary Information

Print full name and relationship to Proposed Insured. (Unless otherwise indicated, 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., if surviving the Insured, unless otherwise specified).

- a. Primary Beneficiary _____

- b. Contingent Beneficiary _____

- c. Tertiary Beneficiary _____

6. Plan Information

a. Plan of Insurance _____ Base Face Amount \$ _____

b. Riders

- Accidental Death Benefit (ADB) ADB Face Amount \$ _____
- Combined Waiver Benefit Applicant's Waiver of Premium
- Scheduled/Unscheduled Paid-Up Additions (EPUA) 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)\$ _____
- Accelerated Benefit Rider (EABR/ABR) (please complete required disclosure form)
- Guaranteed Purchase Option/Guaranteed Insurability Option Option Amount \$ _____
- Additional Sum Insured (for VUL. Do NOT include this amount in Base Face Amount shown above) \$ _____
- Guaranteed Coverage Rider (for VUL) Expiry Age _____
- Other _____ \$ _____ Other _____ \$ _____
- Other _____ \$ _____ Other _____ \$ _____

11. Existing Insurance on Proposed Insured

Are there any existing life insurance policies or annuity contracts in force on the proposed insured? Yes (please list below) No

A. Life insurance policies

<u>Name of Company</u>	<u>Year Issued</u>	<u>Amount</u>	<u>Accidental Death Amt</u>	<u>GIO Amt</u>
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

B. Annuity contracts

<u>Name of Company</u>	<u>Year Issued</u>	<u>Waiver of Premium</u>
_____	_____	_____
_____	_____	_____

12. Personal History of the Proposed Insured (These questions apply to the Proposed Insured)

1. a. Name and Address of Proposed Insured's personal physician (if none, so state).

b. Date and reason last consulted? _____

c. What treatment or medication was given or recommended? _____

2. Height: _____ feet _____ inches Weight: _____ lbs.

3. Weight change past year: _____ lbs. Gained Lost

Reason for change: _____

Please provide details in Remarks section for any "yes" answers to questions 4 through 12. To the best of your knowledge and belief:

	Yes	No
4. Was the Proposed Insured born prematurely? (If "Yes" and child is under age 2, please give duration of pregnancy, birth weight and current weight in Remarks Section.)	<input type="checkbox"/>	<input type="checkbox"/>
5. Has Proposed Insured had or been treated for fits or convulsions, rheumatism, scarlet fever, any accident or injury, or any other sickness or disease?	<input type="checkbox"/>	<input type="checkbox"/>
6. During the past 10 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 disorder of the immune system such as Human Immunodeficiency Virus?	<input type="checkbox"/>	<input type="checkbox"/>
7. Does the Proposed Insured have any physical deformity or mental abnormality?	<input type="checkbox"/>	<input type="checkbox"/>
8. Does the Proposed Insured have regular medical examinations?	<input type="checkbox"/>	<input type="checkbox"/>
9. Within the past five years, has any application for life or health insurance on the Proposed Insured been declined, postponed, rated, or in any way modified?	<input type="checkbox"/>	<input type="checkbox"/>
10. Is an application for other life insurance or health insurance now pending or planned for on the Proposed Insured? (In details, include amount and company applied with, and whether this other insurance will be in addition to or in lieu of insurance with Guardian/GIAC.)	<input type="checkbox"/>	<input type="checkbox"/>
11. Does Proposed Insured have a family history of diabetes, cancer, high blood pressure, heart disease, mental illness or suicide?	<input type="checkbox"/>	<input type="checkbox"/>

Proposed Insured's Family Record

	<u>Age if Living</u>	<u>Cause of Death</u>	<u>Age at Death</u>
Father			
Mother			
Brothers and Sisters			
No. Living _____			
No. Dead _____			

13. Personal History of the Applicant

Complete this section **only** if applying for the Combined Waiver of Premium rider or the Applicant's Waiver of Premium rider. All questions apply to the adult applicant.

- 1. a. Name and Address of applicant's personal physician (if none, so state)

- b. Date and reason last consulted? _____
- c. What treatment or medication was given or recommended? _____

- 2. Height: _____ feet _____ inches Weight: _____ lbs.
- 3. Weight change past year: _____ lbs. Gained Lost
 Reason for change: _____

Please provide details in Remarks section for any "yes" answers to questions 5 through 12.

- | | Yes | No |
|---|--------------------------|--------------------------|
| 4. Do you drive a motor vehicle?
Driver's License State _____ Driver's License # _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Within the past five years, have you been charged with and/or convicted of any motor vehicle moving violations or had your driver's license suspended or revoked? (If yes, details must include date of violation, description of violation and penalty). | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Within the last three years have you participated in any of the following: piloting any type of aircraft; mountain climbing or rock climbing; scuba diving; hang gliding; parachuting or skydiving; or motor vehicle racing? (If yes to any, complete Aviation and/or Avocation Supplement.) | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Within the past five years, have you had disability, accident, medical or life insurance declined, postponed, modified, rated, cancelled or withdrawn a pending application, or had a renewal or reinstatement refused? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Within the last ten years, have you been convicted of a felony, or is such a charge pending against you? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Do you have any loss of hearing or sight, an amputation of any kind, or any physical deformity, impairment or handicap? | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. 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? | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. During the past 10 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 disorder of the immune system such as Human Immunodeficiency Virus? | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Within the past 12 months, have you experienced or are you experiencing any symptoms for which you are considering seeking medical attention or advice? | <input type="checkbox"/> | <input type="checkbox"/> |

14. Remarks Section

(Please provide details of "yes" answers. Identify questions by number.)

15. Alternate/Additional Life Policy

Alternate Policy Additional Policy

Please indicate:

Plan of Insurance: _____ Face Amount: _____

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

16. Amendments or Corrections (For Home Office Or Customer Service Office Use Only)

Application For Life Insurance – Part I (continued)

Representations of the Applicant/Owner

Those parties who sign below, agree that:

1. This application, (Part 1, Part 2, the Authorization, the Variable Life Supplement, if applicable, and any other supplements to the application) will form the basis for, and become part of and attached to, any policy issued.
2. 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.
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. 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.
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 that is issued based on this application.
5. 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 the first premium is paid. Except as provided in the Conditional Receipt (if an advance payment has been made and acknowledged and such Receipt issued) coverage does not begin until the effective date assuming the first premium is paid during the lifetime and prior to any change in the health of the Proposed Insured and/or the adult applicant if an Applicant's Waiver of Premium or Combined Waiver benefit rider is being issued.
6. 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. In those states where written consent is required by statute or State Insurance Department regulation for amendments as to plan, amount, classification, age at issue, or benefits, such changes will be made only with the Owner's written consent.
7. 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.
8. 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, 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 may also be subject to civil penalties.

Signed at: _____ on _____
City and State mm/dd/yyyy

Signature of Applicant

Signature of Additional Owner

Witness (for applications taken by mail)

-
- Check here if this application was taken by mail. If application is taken by mail, the signature of the agent does not attest to the signature of the Applicant or other Owner.
- Check here if this application was taken in person. I certify that I have taken this application in the presence of the Proposed Insured and the Applicant, and that I have truly and accurately recorded on this application the information supplied by the Applicant.

Signature of Licensed Agent

License Number(s)

Agent's Name

State(s) where licensed



Customer Service Office
3900 Burgess Place
Bethlehem, PA 18017

- THE GUARDIAN LIFE INSURANCE COMPANY OF AMERICA
 - THE GUARDIAN INSURANCE & ANNUITY COMPANY, INC.
 - BERKSHIRE LIFE INSURANCE COMPANY OF AMERICA
- (Please check appropriate company. In this form, "the Company" is the insurer checked above.)

LIFE INSURANCE CHANGE REQUEST FORM

Please print

(Page 1 of 5)

I. General Information (Complete in ALL cases)

Name of Insured: _____ Insured's Date of Birth _____
 Policy Owner's Name _____
 Agency Name/Code: _____

Please complete Agent's Certification to provide Agent information and other information.

2. Conversions & Exchanges

Instructions:

- Most simple term conversions and LifeSpan exchanges can be requested on the "Term Conversion/ Exchange Express Request Form", form L-AP-CONV-2001. Please refer to the Instructions printed on form L-AP-CONV-2001 for further information. This Change form should only be used for those situations that do not meet the criteria for express handling.
- If this Change form must be used for the requested transaction, please complete Sections 1, 2, 4, and 12 of this form. If the conversion involves underwriting (e.g., conversion to a higher face amount, or the addition of a rider or benefit), please also complete Section 7 of this form, the Authorization and any required medical Part II. If the new policy is to be variable life, please also complete a Variable Life Supplement and any other forms required for a new variable life product (e.g., the Non-Brokerage Account Application and Explanation of Investment forms).

a) Is the Insured currently totally disabled as defined in the Waiver of Premium Rider included in the policy? Yes No (If yes, give details in Remarks Section)

b) Policies/Riders to be converted/exchanged:

Description of Original Coverage	Policy Number	Full/Partial *	Amount remaining in force <i>(for partial conversion only)</i>
_____	_____	<input type="checkbox"/> Full <input type="checkbox"/> Partial	_____
_____	_____	<input type="checkbox"/> Full <input type="checkbox"/> Partial	_____
_____	_____	<input type="checkbox"/> Full <input type="checkbox"/> Partial	_____
_____	_____	<input type="checkbox"/> Full <input type="checkbox"/> Partial	_____

* If a partial exchange of a VUL or PAL policy is being requested, the Owner agrees that the Company may split the policy into 2 policies. One of the new policies will be exchanged in accordance with the Owner's request and the other policy will remain in force as a new VUL or PAL policy (depending on whether the original policy was VUL or PAL.)

c) Effective date of Conversion or Exchange: _____

3. Guaranteed Purchase Option/Guaranteed Insurability Option

Instructions:

- If the original policy is other than a UL or VUL policy, complete Sections 1, 3, 4, 8 and 12 of this form.
- If the original policy is a UL or VUL policy, then complete Sections 1, 3, and 12 of this form. Since the amount exercised under the rider will be treated as a face amount increase under the base policy, please indicate in Section 5d if any change is being made to the Planned Premium as a result of the GIO exercise.
- If the new policy is to include riders, then please also complete Section 7, the Authorization and any required medical Part II.

Policy Number(s)	Type of Option Date	Amount Exercised
_____	<input type="checkbox"/> Regular <input type="checkbox"/> Alternate *	\$ _____
_____	<input type="checkbox"/> Regular <input type="checkbox"/> Alternate *	\$ _____
_____	<input type="checkbox"/> Regular <input type="checkbox"/> Alternate *	\$ _____

* For Alternate Option Date, please indicate: date of applicable event: _____ and reason

- Marriage Birth of Child(ren) Adoption of Child(ren) Other (please identify) _____



4. New Policy Information (for conversions, exchanges, GIO, etc)

Instructions:

When making a conversion, exchange, exercising a GIO option, or any other situation where a new policy is to be issued, use this Section to provide details about the new policy.

New Policy Plan _____ **Face Amount** _____

Riders (give type and, if applicable, amount) _____

Dividend Option _____ **Premium Mode *** _____ **APL?** Yes No (Default is Yes)

Death Benefit Option _____ **Planned Premium (UL/VUL)** _____ **7702 Test** _____

Owner _____

Beneficiary _____

Other Information _____

[* If adding this policy to an existing G-O-M arrangement, please provide existing policy number in "Other information".

5. Universal Life/Variable Universal Life Changes

Instructions:

- For face amount increases (not due to exercise of GIO), please complete Sections 1, 5, 7, 12, the Authorization, and any required medical Part II. If the product allows face increases to be specifically allocated to Basic Sum Insured and Additional Sum Insured, please indicate how the face increase is to be issued in Section 10, Remarks.
- For face amount decreases, complete Sections 1, 5 and 12 of this form.
- For changes in Death Benefit Option, please complete Sections 1, 5 and 12 of this form. However, for changes from Option 1 to Option 2, underwriting may be required (depending on the product). If so, you must also complete Section 7, the Authorization and any required medical Part II.

(a) Face Amount Changes

Policy Number	Type of Change	Amount of Face Change (do not enter resulting face amount)
_____	<input type="checkbox"/> Increase <input type="checkbox"/> Decrease	\$ _____
_____	<input type="checkbox"/> Increase <input type="checkbox"/> Decrease	\$ _____
_____	<input type="checkbox"/> Increase <input type="checkbox"/> Decrease	\$ _____

(b) Is the Insured currently totally disabled as defined in a disability Waiver benefit included in the policy? Yes No
 If Yes, please give details in Remarks section, and also indicate which type of Waiver rider (e.g., Waiver of Monthly Deductions, Disability Benefit Rider, or both).

(c) If increasing the face amount, are you also requesting an increase in the Specified Amount under a Disability Benefit Rider?
 Yes Amount of Increase \$ _____ No

(d) Change in Planned Premium (can be done in conjunction with a face amount change, or separately)

New Planned Premium: _____ New Premium Mode, if applicable _____

(e) Change in Death Benefit Option

Change From: Option 1 To: Option 1
 Option 2 Option 2
 Option 3

6. Other Policy Changes

Change applies to Policy Number(s) _____

- Plan changes* to: _____
- Redate* to: _____
- Add rider/benefit* _____
- Cancel rider/benefit _____
- Rating improvement request* _____
- Exercise Simplified Insurability Option* _____
- Increase Coverage* to: _____
- Reduce Coverage ** to: _____
- Correction of Age _____ (provide birth certificate)
- Change Premium Mode _____
- Change Dividend Option * to _____ (effective on next anniversary)
- Place Policy on Nonforfeiture Option _____
- Other* (explain below)

Instructions:

* Some policy changes involve additional underwriting. For these changes, please complete Sections 1, 6, 7 and 12 of this form, the Authorization and any required medical Part II. If the change being made does not require additional underwriting, then please complete Sections 1, 6 and 12 of this form only.

** (Note: for reductions in face amount, include instruction on how any release of cash value is to be handled. If not specific, release of cash value will be used to Purchase Paid-Up Additions.)

7. Personal History of the Insured

- | | Yes | No |
|--|--------------------------|--------------------------|
| a. Since the coverage was originally issued: | | |
| (i) have you changed your occupation or do you intend to do so?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| (ii) has there been any illness, injury, or surgical operation?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| (iii) have you consulted a physician or other practitioner, or have you had any lab, x-ray or other diagnostic test?.... | <input type="checkbox"/> | <input type="checkbox"/> |
| (iv) have you flown, or do you contemplate flying, as a pilot or crew member?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| (v) have you had disability, accident, medical or life insurance declined, postponed, modified, rated, cancelled or withdrawn a pending application, or had a renewal or reinstatement refused?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Are you aware of any impairment in your health?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Have you smoked cigarettes in the past 24 months?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| (If you have quit, date last used: _____) | | |
| d. Have you used tobacco in any form in the last 12 months?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| If "No", have you used tobacco in any form in the last 24 months?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| If "No", have you used tobacco in any form in the last 48 months?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| (If you have quit, date last used: _____) | | |
| e. Do you currently use a nicotine patch or nicotine gum?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Please indicate the name(s) and address(es) of your physician(s). | | |
| Name _____ | | |
| Address _____ | | |
| g. Please provide information regarding the last time you consulted with each of the listed physicians. | | |
| Date _____ | | |
| Reason _____ | | |
| Results _____ | | |

8. Replacement/Existing Coverage

Does the owner/applicant have any existing individual life insurance policies or annuity contracts (including those in the process of being lapsed or surrendered)? Yes No (If "Yes", please complete appropriate state replacement forms.)

9. Reinstatement

Reinstatement of policy number _____ which lapsed for non-payment of premium due on _____
 The following amount is enclosed in payment of the costs to reinstate the policy \$_____.

Instructions: Question a is asked of the policyowner. The remainder of the questions are asked of the person to be insured under the reinstated policy. If there are other persons to be insured under the reinstated policy (e.g., a Survivorship policy or a Beneficiary Insurance Option rider), a separate Change form for each such person is required. Please provide full details in Remarks section (Section 10) for any "yes" answers to the following questions. In addition to this Section, please also complete Sections 1 and 12, the Authorization, and any required medical Part II.

- | | Yes | No |
|--|--------------------------|--------------------------|
| a. Has any person died who was ever insured under this policy or any rider attached to this policy?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Within the past 5 years, have you: | | |
| (i) Had any medical or surgical treatment, observation or consultation?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| (ii) Had disability, accident, medical or life insurance declined, postponed, modified, rated, cancelled or withdrawn a pending application, or had a renewal or reinstatement refused?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| (iii) Made claims for or received benefits under any life or health insurance policy or prepayment plan, workmen's compensation or state or federal disability law, any pension or other allowance governmental or otherwise?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| (iv) Made any aerial flights, except as a fare-paying passenger?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| c. To the best of your knowledge and belief, are you now in good health other than as noted in question b, above?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| d. What is your current occupation? _____ | | |
| e. How much life insurance is in force or applied for on your life (not including this policy)? _____ | | |

10. Remarks

11. Amendments or Corrections (For Home Office Or Customer Service Office Use Only)

12. Representations (Complete in ALL cases)

Those parties who sign below, agree that:

1. Approval by the Company of the changes requested shall be based upon this Life Insurance Change Request form, and on the statements and representations made herein and in any required Part II or other supplement forms, all of which shall be attached to the policy.
2. 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.
3. For any new insurance: 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.
4. 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.
5. Changes or corrections made by the Company and noted in Section 11 of this form are ratified by the undersigned upon acceptance of the new policy or policy change. In those states where written consent is required by statute or State Insurance Department regulation for amendments as to plan, amount, classification, age at issue, or benefits, such changes will be made only with the Owner's written consent.
6. When a new policy is to be issued as a result of the requested policy change and no underwriting is required for the transaction, the new policy will take effect on the later of the policy date of the new policy or the date the first premium is paid. If the transaction does involve underwriting, then the portion of the new policy that was subject to underwriting will not take effect until the later of the policy date or the date the first premium is paid during the lifetime and prior to any change in health of the Proposed Insured. The policy date is the date from which premiums are calculated and become due.
7. For any new policy issued as a result of the requested change, 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.
8. In the case of reinstatement: (a) that the reinstatement, if approved by the Company, shall be contestable to the same extent and for the same period of time as was the original policy, beginning from the effective date of this reinstatement; (b) that no reinstatement shall take effect unless and until this application is approved by the Company and payment of any overdue premiums have been made during the lifetime of any insureds covered under the reinstated policy; (c) that any payment taken in connection with this application shall be collected at the risk of and for the account of the payor. Any payment made shall remain the payor's property until the Company approves this application. If it is not approved, any payment made shall be returned to and accepted by the payor, without interest; and (d) upon reinstatement, no benefit shall be paid if the death of any insured occurred between the date of default of this policy and the effective date of reinstatement.

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 may also be subject to civil penalties.

Signed at: _____ on _____
City and State mm/dd/yyyy

Signature of Proposed Insured Signature of Applicant/Owner if Other than Proposed Insured

Signature of Additional Owner Witness (for applications taken by mail)

- Check here if this form was taken by mail. If application is taken by mail, the signature of the agent does not attest to the signature of the Proposed Insured or Owner if Other than the Proposed Insured.
- Check here if this form was taken in person. I certify that I have taken this application in the presence of the Proposed Insured and Owner (if Other than the Proposed Insured), and that I have truly and accurately recorded on this application the information supplied by the Proposed Insured and Owner (if Other than the Proposed Insured).

Signature of Licensed Agent License Number(s)

Agent's Name State(s) where licensed



Customer Service Office
3900 Burgess Place
Bethlehem, PA 18017

The Guardian Life Insurance Company of America
 The Guardian Insurance & Annuity Company, Inc.
(Please check appropriate Company)

APPLICATION FOR LIFE INSURANCE Simplified Issue/Guaranteed Issue

Please print

(Page 1 of 6)

1. Owner Information

- a. Owner (check one only): Employer Proposed Insured Trust Other _____
- b. Owner name _____
- c. Social Security No./Tax ID No. _____ d. Relationship to proposed insured _____
- e. Street Address _____
- f. Telephone Number _____ g. Tax Qualified Plan? Yes No
- h. Check here if you wish all policyowner communications to be sent to the address shown above in 1.e., or please designate a different address: _____
- i. Complete if Policy is Employer Owned: Primary Contact _____ Title _____
- j. Complete if Policy is **Trust Owned**: Date of Trust _____
Complete Names of Authorized Trustees _____

2. Proposed Insured Information

- a. Individual Insured information below Census Data Attached
- b. First Name _____ MI _____ Last Name _____
- c. Social Security # _____ d. Sex Male Female
- e. Date of Birth (mm/dd/yyyy) _____ f. Place of Birth _____
- g. Are you a U.S. citizen? Yes No
If no, give: Visa Type _____
Visa Duration _____
Other _____
- h. Marital Status
 Married Single Separated
 Widowed Divorced
- i. Address _____
City _____ State _____ Zip _____
- j. How long at this address? _____ k. Home phone _____

3. Employment Information

- a. Name of Employer (if employer information is provided above, check here and proceed to question 3(c).

- b. Street Address _____
City _____ State _____ Zip _____
Business Phone _____
- c. How many years employed? _____
- d. Occupation _____ e. Job Title _____
- f. Nature of Business _____



4. Beneficiary Information

Check here if Beneficiary is the same as the Owner (if checked, skip this section).

Print full name and relationship to Proposed Insured. (Unless otherwise indicated, 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., if surviving the Insured, unless otherwise specified).

5. Purpose of Insurance

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

- | | | | | |
|--|--|--|--|---|
| <input type="checkbox"/> Buy-Sell | <input type="checkbox"/> Deferred Compensation | <input type="checkbox"/> Charitable Planning | <input type="checkbox"/> Family Income | <input type="checkbox"/> Mortgage |
| <input type="checkbox"/> Key Person | <input type="checkbox"/> Split Dollar | <input type="checkbox"/> Estate Planning | <input type="checkbox"/> Retirement | <input type="checkbox"/> Spouse/Child Insurance |
| <input type="checkbox"/> Executive Bonus | <input type="checkbox"/> Collateral for Debt | <input type="checkbox"/> Wealth Accumulation | <input type="checkbox"/> Education | <input type="checkbox"/> Other _____ |

6. Proposed Insurance

a. Plan of Insurance _____ **Base Policy Face Amount \$** _____

b. Riders

Traditional Life/Term Riders (Note: Option Q and R riders are elected in the Dividends Section)

- Accidental Death Benefit (ADB) ADB Face Amount: \$ _____
- Waiver of Premium (WP) Initial Period Waiver of Premium (For LifeSpan only)
- Scheduled/Unscheduled Paid-Up Additions (EPUA) Rider Unscheduled Only Paid-Up Additions (EPUA) 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) Option Amount: \$ _____
- Accelerated Benefit Rider (EABR/ABR) (please complete required disclosure form)
- 10 Year Annually Renewable Term (RTR-10) Term Amount: \$ _____
- DuoGuard (List names & amounts for Designated Lives. Complete a separate application for each Designated Life.)

<u>Name of Designated Life</u>	<u>Amount</u>	<u>Name of Designated Life</u>	<u>Amount</u>
_____	\$ _____	_____	\$ _____
_____	\$ _____	_____	\$ _____
_____	\$ _____		
- Other _____ \$ _____ Select Security Rider
- Other _____ \$ _____ Other _____ \$ _____

Universal Life and Variable Life Riders

- Additional Sum Insured (Do NOT include this amount in Base Face Amount shown above) \$ _____
- Secondary Guarantee Coverage Rider/Guaranteed Coverage Rider (for VUL GCR, elect coverage to age _____)
- Accidental Death Benefit (ADB) ADB Face Amount: \$ _____
- Waiver of Monthly Deductions
- Disability Benefit Rider Monthly Specified Amount: \$ _____
- Guaranteed Insurability Option Option Amount \$ _____
- Term Rider Term Amount: \$ _____ Select Security Rider
- Other _____ \$ _____ Other _____ \$ _____

7. Premiums

- a. 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 _____
- b. Who is to pay premiums? _____
- c. Send premium notices to:
 - Residence Business Owner's address Other _____
 - List Bill
 - New – Billing Name _____ Common billing date _____
 - Existing List Bill # _____
- d. Automatic Premium Loan (if available) Yes No *(if left blank, default will be Yes)*
- e. Complete for VUL/UL policies:
 - Initial Premium \$ _____ Planned Premium (at the mode indicated above) \$ _____
- f. Prepayment of Premium
 - No money is being submitted with this application.
 - Money is being submitted with this application, in the amount of \$ _____ for proposed life insurance in the amount of \$ _____ in exchange for the Conditional Receipt providing proposed conditional coverage for this amount of insurance only. Please see the Conditional Receipt for the circumstances under which money can be paid with this application, and Item (3) under "Conditions" in the Receipt for rules pertaining to the amount of life insurance that can be entered above.

8. Dividends (for participating policies only)

- A- Paid in cash
- B- Reduce premiums
- C- Left at interest *(Complete W-9 form if elected)*
- D- Paid-Up Additional Insurance *(Option D will be the default option if no other is elected)*
- 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)* 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.

9. Additional Information for VUL/UL Policies

- a. **Death Benefit Option** *(Note, not all options may be available with all policies)*
 - Option 1 Option 2 Option 3 Other _____
- b. **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 are excludible 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

10. Existing Insurance on Proposed Insured

Does the owner have any existing life insurance policies or annuity contracts in force on any of the proposed insureds?
 Yes (please list below) No

A. Life insurance policies/Annuity Contracts

Name of Insured	Name of Company	Year Issued	Amount	Guaranteed Issue?	Accidental Death	Waiver of Premium
_____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
_____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
_____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
_____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____

11. Actively At Work

- a. Is the Proposed Insured currently employed by the Employer named above and currently engaged in active, full-time work (of at least 30 hours per week) in a normal capacity, at his/her customary place of employment?
 Yes No (Please provide details of any "no" answer)
- b. During the 90 days preceding the date of this application, has the Proposed Insured been absent from work due to illness or injury (not including vacation, normal non-working days, or holidays) for either more than 3 consecutive days or more than a total of 5 days?
 Yes No (Please provide details of any "yes" answer)

12. Personal History of the Proposed Insured (Do not complete if applying for Guaranteed Issue)

These questions apply to the Proposed Insured. Please provide details in Remarks section for any "yes" answers.

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

Yes	No
<input type="checkbox"/>	<input type="checkbox"/>
- c. Have you ever had, been treated for or received a consultation or counseling for:
 - i. Heart disease, stroke, chest pain, elevated blood pressure, heart murmur or any other disease or disorder of the heart or blood vessels?.....

<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------
 - ii. Respiratory disorder, kidney disorder, diabetes, mental or emotional problems, disorder of the liver or other gastrointestinal organs, cancer or tumor of any kind, anemia or other disorder of the blood, disorder of the nervous systems or disorder of the reproductive organs?.....

<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------
 - iii. Any condition not covered in (i) or (ii)?

<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------
- d. Are you currently receiving medical care or taking medication?

<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------
- e. Have you been advised within the past 5 years to have any diagnostic test, hospitalization, or surgery which has not been completed?.....

<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------
- f. Have you ever used drugs other than as prescribed by a physician or had or been advised to have counseling or treatment for alcohol or drug use?

<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------

Application For Life Insurance (continued)
Representations of the Proposed Insured and Owner

Those parties who sign below, agree that:

1. This application, (Part 1, Part 2, the Authorization, any Consent to Insurance, and any other supplements to the application) will form the basis for, and become part of and attached to, any policy issued.
2. 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.
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. 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
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 that is issued based on this application.
5. 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 the first premium is paid. Except as provided in the Conditional Receipt (if an advance payment has been made and acknowledged and such Receipt issued) coverage does not begin until the effective date assuming the first premium is paid during the lifetime and prior to any change in the health of the Proposed Insured.
6. 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. In those states where written consent is required by statute or State Insurance Department regulation for amendments as to plan, amount, classification, age at issue, or benefits, such changes will be made only with the Owner's written consent.
7. 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.
8. 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, and with intent to defraud any insurance company or other person, files an application of insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and may also be subject to civil penalties.

Signed at: _____
City and State

on _____
mm/dd/yyyy

Signature of Proposed Insured

Signature of Applicant/Owner if Other than Proposed Insured

Signature of Additional Owner

Witness (for applications taken by mail)

-
-
- Check here if this application was taken by mail. If application is taken by mail, the signature of the agent does not attest to the signature of the Proposed Insured or Owner if Other than the Proposed Insured.
- Check here if this application was taken in person. I certify that I have taken this application in the presence of the Proposed Insured and Owner (if Other than the Proposed Insured), and that I have truly and accurately recorded on this application the information supplied by the Proposed Insured and Owner (if Other than the Proposed Insured).

Signature of Licensed Agent

License Number(s)

Agent's Name

State(s) where licensed

SERFF Tracking Number: GARD-126407940 State: Arkansas
 Filing Company: The Guardian Insurance & Annuity Company State Tracking Number: 44282
 Inc.
 Company Tracking Number: L-AP-2004
 TOI: L06I Individual Life - Variable Sub-TOI: L06I.003 Single Life - Single Premium
 Product Name: Life App04 GIAC
 Project Name/Number: Life App04 GIAC (Refile AR only)/L-AP-2004

Supporting Document Schedules

Item Status: **Status Date:**

Satisfied - Item: Flesch Certification

Comments:

Attachments:

Readabiity GIAC.pdf

Certif of Compliance with Rule 19 GIAC.pdf

Item Status: **Status Date:**

Satisfied - Item: Application

Comments:

Application filing forms are on the Forms Schedule

Item Status: **Status Date:**

Satisfied - Item: Agent's Cert

Comments:

Attachment:

Agent's Certification.pdf

Item Status: **Status Date:**

Satisfied - Item: Juvenile Agent's Cert

Comments:

Attachment:

Agents Cert for Juvenile App.pdf



STATE OF ARKANSAS
READABILITY CERTIFICATION

COMPANY NAME: The Guardian Insurance & Annuity Company, Inc.

This is to certify that the form(s) referenced below has achieved a Flesch Reading Ease Score as indicated below and complies with the requirements of Ark. Stat. Ann. Section 66-3251 through 66-3258, cited as the Life and Disability Insurance Policy Language Simplification Act.

Form Title	Form Number	Flesch Score
Life Insurance Application Part 1	L-AP-2004 AR	51.6
Juvenile Life Insurance Application	JUV-AP-2006 AR	46.9
Life Insurance Change Request Form	L-AP-CHG-2005 AR	45.6
Simplified Issue/ Guaranteed Issue Insurance Application	L-AP-SIGI-2008 AR	46.1

Name: John J. Monahan
Title: Director, Individual Markets Compliance
Date: December 4, 2009



**Certificate of Compliance with
Arkansas Rule and Regulation 19 and 49**

Insurer: **The Guardian Insurance and Annuity Company , Inc.**

Form Number(s): **L-AP-2004 AR
JUV-AP-2006 AR
L-AP-CHG-2005 AR
L-AP-SIGI-2008 AR**

I hereby certify that the filing above meets all applicable Arkansas requirements including the requirements of Rule and Regulation 19 and 49.

Signature of Company Officer

John J. Monahan

Name

Director

Title

December 4, 2009

Date :

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. How long have you known the Proposed Insured? _____ Years; Proposed Owner? _____ Years
2. If Proposed Insured is not gainfully employed, indicate amount of insurance on premium payor's life and relationship to Proposed Insured. _____
3. If beneficiary is estate, explain in Remarks why, and who will ultimately receive the proceeds of the policy?
4. 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
5. Do you have knowledge of any existing life insurance policy or annuity contract in force on the Proposed Insured? Yes No
6. 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 6b, 6c, and 6d)
- 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: _____
7. **Complete if Medical Examination necessary.** Medical Requirements being submitted:
 Chest X-ray EKG Stress EKG Full Blood Saliva Urine
 Paramedical Exam Medical Exam Other _____
8. Is the proposed life policy associated with a specific corporate initiative (e.g., executive benefit, retirement, etc.). If so, please indicate: _____
9. Remarks (and additional instructions):

10. Commissions

Producer's Name	Producer's Code	Servicing Agent (Check 1)	Producer's Social Security Number	Percentage
_____	<input type="text"/>	<input type="checkbox"/>	_____	<input type="text"/> % <input type="text"/>
_____	<input type="text"/>	<input type="checkbox"/>	_____	<input type="text"/> % <input type="text"/>
_____	<input type="text"/>	<input type="checkbox"/>	_____	<input type="text"/> % <input type="text"/>
_____	<input type="text"/>	<input type="checkbox"/>	_____	<input type="text"/> % <input type="text"/>
_____	<input type="text"/>	<input type="checkbox"/>	_____	<input type="text"/> % <input type="text"/>

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.

Dated at _____, this _____ day of _____, _____.
City and State (month) (year)

 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



IMNB0000000120201

AGENT'S CERTIFICATION (Juvenile App) (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):

- | | |
|---|---|
| <input type="checkbox"/> No Marketing Initiative | <input type="checkbox"/> DI to Life Program |
| <input type="checkbox"/> Business Resource Center | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Take Advantage/Rapid App | |

2. How long have you known the Applicant? _____ Years

3. How much do you think the Applicant is worth?_____. What do you believe the Applicant's annual income to be? _____ .

4. How long have you know the proposed insured?_____Years.

5. Did you see the Proposed Insured at the time this application was completed? Yes No

a. Did he/she appear to be in good health at the time? Yes No

b. Did he/she appear to have any kind of physical disability? Yes No

6. Do you know anything unfavorable about the health, habits, character, occupation, family history, pursuits, residence or mode of living of the Proposed Insured or Applicant? Yes No (If yes, give full details under remarks.)

7. Do you have any reasons whatsoever to believe any of the answers in this application regarding the Proposed Insured or Applicant are untrue or incomplete in any manner? Yes No If yes, give full details under remarks.

8. 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

9. Do you have knowledge that the proposed owner of this policy also owns any other existing life insurance policy or annuity contract on the Proposed Insured? Yes No

10. 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.)

11.a. Did every person signing this application communicate in English well enough to understand and answer each question in English? Yes No (If no, Who acted as interpreter)? _____

b. If English was not used as the primary language, which language was the sales interview conducted in? _____

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

13. 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.

14. 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)

15. Give names of brothers and sisters of Proposed Insured who are under the age of 18, and date of birth and insurance in force and applied for on each.

Name	Date of Birth	Insurance Inforce/Applied For
------	---------------	-------------------------------



I M N B 0 0 0 8 1 0 0 1 2 0 3 0 2

