

SERFF Tracking Number: GARD-126259672 State: Arkansas  
Filing Company: The Guardian Life Insurance Company of America State Tracking Number: 43523  
Company Tracking Number: DI-2009  
TOI: H111 Individual Health - Disability Income Sub-TOI: H111.005 Business Overhead Expense - Related to marketing with employer or association groups  
Product Name: DI-2009  
Project Name/Number: /

## Filing at a Glance

Company: The Guardian Life Insurance Company of America

Product Name: DI-2009

SERFF Tr Num: GARD-126259672 State: Arkansas

TOI: H111 Individual Health - Disability Income

SERFF Status: Closed-Approved-Closed  
State Tr Num: 43523

Sub-TOI: H111.005 Business Overhead Expense - Related to marketing with employer or association groups

Co Tr Num: DI-2009

State Status: Approved-Closed

Filing Type: Form

Author: Cindy Ego

Reviewer(s): Rosalind Minor

Date Submitted: 09/16/2009

Disposition Date: 09/17/2009

Disposition Status: Approved-Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

## General Information

Project Name:

Status of Filing in Domicile: Pending

Project Number:

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: 09/17/2009

Explanation for Other Group Market Type:

State Status Changed: 09/17/2009

Deemer Date:

Created By: Cindy Ego

Submitted By: Cindy Ego

Corresponding Filing Tracking Number: GARD-126059672

Filing Description:

The Guardian Life Insurance Company of America is submitting applications DI-2009, Application for Insurance, and DI-NM-2009, Application for Insurance Part 2 Non-Medical, for your review and approval. They replace DI-2007 and DI-NM-2007 which were approved in your state on 08/29/2007. The submitted forms are filed in our state of domicile, New

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York, concurrently. If the forms submitted in your state contain a state suffix, all references in this letter to such form number without a state suffix apply to the suffixed version submitted.

The submitted applications, DI-2009 and DI-NM-2009, will be used to apply for individual disability income insurance by both The Guardian Life Insurance Company of America (Guardian) and Berkshire Life Insurance Company of America (Berkshire Life). Berkshire Life is a wholly owned subsidiary of Guardian. A separate filing will be submitted on behalf of Berkshire. We would appreciate any efforts you can make to coordinate the review of these forms for the two companies. The Producer's Certification, form DI-PC-2009, is not considered part of the application, however, we are including this form for your Department's information because it contains the required insurance replacement question.

Policy Numbers with which these applications will be used  
AH55A 7/99 Business Reducing Term Disability Income Policy (Guardian)  
NC56-A 7/99 Personal Reducing Term Disability Income Policy (Guardian)  
4200 (01/10) Overhead Expense Disability Income Policy (Berkshire Life)  
1200 (09/04) Disability Income Policy (Berkshire Life)  
1400 (03/07) Disability Income Policy (Berkshire Life)  
1500 (03/07) Disability Income Policy (Berkshire Life)

The following forms that were approved in your state for both Berkshire Life and Guardian on 05/22/2003 will be used in conjunction with application DI--2009:

Form Number	Description
C-ADU-SUPP-2003	Alcohol and Drug Usage Supplement
C-AVIA-SUPP-2003	Aviation Supplement
C-AVOC-SUPP-2003	Avocations Supplement
C-AP-SUPP-2003	Supplement to Application for Insurance
C-UNDINQ-2003	Underwriting Inquiry Form
C-NIIP-2003	Insurance Information Practices
C-AUTH-2003	Authorization to Obtain and Release Information
C-MED-2003	Representations to the Medical Examiner (Part 2)

Form DI-CR-2007, Conditional Receipt for Disability which was approved on 08/29/2007 will be used in conjunction with the submitted application.

We will also use Special Exceptions Agreement, form 71-SE (06/01) and Amendment to the Application, form 71-A

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(06/01), which were approved on 03/26/2001 with DI-2009 and the Declaration of Insurability, form 2986-6-2001 which was approved on 08/16/2001.

In addition to using this application in the traditional paper situation, we also plan to use this application to take applications electronically using a computer. Please note that we are not referring to direct solicitation through the internet or other means. The sale of individual disability income insurance using this application will always involve a licensed agent. When the application is completed in this manner the application and all required forms will be printed at the end of the process and signed by the applicant. Under the electronic application procedure described above, the completed application at the end of the process will be an exact copy of the application forms as approved by your Department.

#### Marketing

Our policies are marketed in an individual basis through our agency distribution system. Our products are mainly marketed to professionals such as physicians, attorneys and small business owners. Our policies are underwritten on an individual basis using information supplied or authorized by the applicant.

## Company and Contact

### Filing Contact Information

Cindy Ego, Compliance Specialist

700 South Street

413-395-4319 [Phone]

Pittsfield, MA 01201

### Filing Company Information

The Guardian Life Insurance Company of America

CoCode: 64246

State of Domicile: New York

7 Hanover Square

Group Code: 429

Company Type: Life

New York, NY 10004

Group Name:

State ID Number:

(212) 598-8704 ext. [Phone]

FEIN Number: 13-5123390

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## Filing Fees

SERFF Tracking Number: GARD-126259672 State: Arkansas  
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Fee Required? Yes  
Fee Amount: \$40.00  
Retaliatory? No  
Fee Explanation: 2 forms @ \$20  
Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
The Guardian Life Insurance Company of America	\$40.00	09/16/2009	30602447

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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	09/17/2009	09/17/2009

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to marketing with employer or association  
groups  
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## Disposition

Disposition Date: 09/17/2009

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	Yes
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Supporting Document	John Doe Applications	Approved-Closed	Yes
Supporting Document	Producer Certification	Approved-Closed	Yes
Form	Application for Insurance	Approved-Closed	Yes
Form	Application for Insurance - Part 2 Non-Medical	Approved-Closed	Yes

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## Form Schedule

### Lead Form Number: DI-2009

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 09/17/2009	DI-2009	Application/Enrollment Form	Application for Insurance	Initial		50.100	DI-2009.pdf
Approved-Closed 09/17/2009	DI-NM-2009	Application/Enrollment Form	Application for Insurance - Part 2 Non-Medical	Initial		53.500	DI-NM-2009.pdf



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

## Application for Insurance | Part I

Please indicate all insurance applied for with this Part 1 Application and include the appropriate application supplement for each product selected to right.

- Individual Disability Insurance
- Individual Disability Insurance – Retirement Protection Plus Program
- Overhead Expense     Disability Buy-Out
- Business Reducing Term/PayGuard

### I. Proposed Insured Information

a. Proposed Insured

\_\_\_\_\_  
First                                      Middle Initial                                      Last Name

\_\_\_\_\_  
Suffix                                      Previous Last Name

b. Gender

Male     Female

c. Social Security Number

\_\_\_\_\_

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

\_\_\_\_\_

e. Place of Birth

\_\_\_\_\_

f. Are you a U.S. citizen?

Yes     No    (If no, answer the following questions)

\_\_\_\_\_  
Visa Type                                      Visa Duration

*How long have you lived in the U.S. on a full-time basis?*

\_\_\_\_\_  
(If residence has not been continuous, give dates, and explain in Remarks and Special Requests.)

*Do you expect to remain in the U.S. permanently?*

Yes     No    If no, include details:

*When do you expect to obtain U.S. citizenship or permanent residency?*

\_\_\_\_\_

g. Home Address

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

\_\_\_\_\_  
City                                      State                                      ZIP

h. How long at this address?

\_\_\_\_\_

i. Telephone Number

\_\_\_\_\_  
Home Phone Number                                      Cell Phone Number

j. E-mail Address

\_\_\_\_\_

k. If less than 2 years at current address, please furnish previous address:

\_\_\_\_\_  
Address

\_\_\_\_\_  
City                                      State                                      ZIP

**2. Business Information**

a. Name of Current Employer \_\_\_\_\_

b. Business Address \_\_\_\_\_  
(If mailing address is PO Box, include street address as well.)

\_\_\_\_\_  
City State ZIP

*Business Phone* \_\_\_\_\_

*Business Website* \_\_\_\_\_

c. Occupation \_\_\_\_\_

d. Job Title \_\_\_\_\_

e. Nature of Business \_\_\_\_\_

f. How many years employed with your current employer? \_\_\_\_\_  
(If less than 2 years, please furnish previous employer below.)

g. Former Employer \_\_\_\_\_

\_\_\_\_\_  
Address

\_\_\_\_\_  
City State ZIP

h. Occupation \_\_\_\_\_

i. Job Title \_\_\_\_\_

j. Nature of Business \_\_\_\_\_

**3. Occupational Information**

a. Describe, in order of importance, all duties of your occupation. Include all activities that are performed in connection with the duties of your occupation, including but not limited to travel, sales and supervisory.

Description of Specific Duties	% of Time Devoted to Each Duty

b. Describe exact physical duties of your occupation (lifting, climbing, driving, etc.). If none, so state. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

c. Describe any tools or equipment you use to perform the duties of your occupation. If none, so state. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

- d. If you are a medical doctor or dentist, what percent of your gross income is derived from surgical procedures, such as catheterization, angioplasty, stent placement, pacemaker implant, endoscopy, or other surgical procedure? \_\_\_\_\_ %
- e. Is this a home-based occupation?  Yes  No  
If yes, what percentage of time do you spend working at home? \_\_\_\_\_ %
- f. Number of years in this occupation \_\_\_\_\_
- g. How many hours per week are you at work in this occupation? \_\_\_\_\_ hours
- h. Have you been continuously at work full time performing the usual duties of your occupation for the past six months?  Yes  No If no, explain: \_\_\_\_\_
- i. Do you supervise any employees?  Yes  No If yes, how many? \_\_\_\_\_
- j. Are you a business owner?  Yes  No
- k. What percentage of the business do you own? \_\_\_\_\_ %
- l. What type of business do you own?  Sole Proprietorship  Partnership  "S" Corporation  
 Limited Liability Company (LLC)  "C" Corporation  
 Limited Liability Partnership (LLP)  
 Other: \_\_\_\_\_
- m. Do you plan to change any occupation or employment within the next six months?  Yes  No If yes, provide details: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
- n. Do you have any other part- or full-time jobs, occupations or employment?  Yes  No If yes, provide details: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**4. The Following Questions Apply to the Proposed Insured**

(Please provide details in Section 8 Remarks and Special Requests to all "Yes" answers.)

- a. Do you plan to reside or travel outside of the U.S.?  Yes  No  
(If yes, indicate location, frequency, for work or pleasure, date of departure, length of stay.) \_\_\_\_\_
- b. Do you drive a motor vehicle? \_\_\_\_\_ Driver's License State \_\_\_\_\_ Driver's License # \_\_\_\_\_  Yes  No
- c. 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.)  Yes  No
- d. Within the last 10 years, have you been convicted of a felony, or is such a charge pending against you?  Yes  No
- e. Have you ever had a professional license suspended or revoked, or is such license under review, or have you ever been disbarred?  Yes  No

- f. Within the last three years, have you participated in any of the following, or do you plan in the future to participate in any of the following: piloting any type of aircraft; mountain climbing or rock climbing; scuba diving; hang gliding; parachuting or skydiving; motor vehicle racing; or other hazardous activity? (If yes to any, complete Aviation and/or Avocation Supplement.)  Yes  No
- g. Within the past five years, have you had disability, accident, medical, life or health insurance declined, postponed, modified, rated, cancelled, rescinded, or have you withdrawn a pending application, or had a renewal or reinstatement refused?  Yes  No
- h. Have you used tobacco, nicotine, or any nicotine delivery system in any form in the last 12 months? (If you have quit, date last used: \_\_\_\_\_)  Yes  No
- i. Do you plan to apply for or are you currently applying for any other life, long-term care, disability or accident insurance? (In Section 8 Remarks and Special Requests, include amount applying for and company applying with, and whether this other insurance will be in addition to or in lieu of insurance with Berkshire or Guardian.)  Yes  No
- j. Are you currently a member of, or do you plan on joining, any branch of the United States Military, including the Army, Navy, Air Force, Marine Corps, Coast Guard, National Guard, or any reserve military unit?  Yes  No
- k. Are you currently employed by, or seeking employment with, any company or entity which provides military, paramilitary, or security services outside of the United States?  Yes  No
- l. Have you been alerted to, received orders for, or had any indication of an overseas assignment or active service with any branch of the United States Military, including the Army, Navy, Air Force, Marine Corps, Coast Guard, National Guard, or any reserve military unit?  Yes  No
- m. Have you ever had or been treated for cancer, heart attack, stroke, diabetes, or any disease of the liver, lungs, kidneys, or heart, or any disorder of the back or spine?  Yes  No
- n. Are you currently receiving any medical advice, counseling or treatment for any medical, surgical or psychiatric condition?  Yes  No

If questions 4m or 4n are left blank or answered "Yes," no prepayment should be taken and no Conditional Receipt issued.

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

- o. Have you ever had an injury or sickness that caused a loss of: sight in both eyes; hearing in both ears; speech; or the use of two arms or two legs?  Yes  No
- p. Do you need human assistance of any kind to perform everyday activities such as bathing, continence, dressing, eating, using the toilet or transferring (for example, from the chair to your bed)?  Yes  No
- q. Do you use any special medical equipment or appliances, including but not limited to, a wheelchair, pacemaker, oxygen tank, cane, catheter, or artificial limb?  Yes  No
- r. Have you ever received treatment, attention or advice for memory loss or confusion, Alzheimer's disease, stroke, senility, dementia, loss of speech or comprehension of spoken language?  Yes  No

If any question listed in 4o through 4r is answered "Yes," no prepayment should be taken and no Conditional Receipt issued.

**5. Other Disability Insurance Coverage of the Proposed Insured**

a. Do you have disability insurance in force or applied for, or are you eligible for disability insurance within the next 12 months with any company, including Guardian or Berkshire?  Yes  No

**Type of Insurance**

**DI** = Disability Income Insurance  
**OE** = Overhead Expense  
**RP** = Retirement Protection

**DBO** = Buy-Out  
**KEY** = Key Person  
**RT** = Reducing Term

**Category**

**IDI** = Individual  
**STD** = Group STD  
**LTD** = Group LTD  
**A** = Association

**Status**

**I** = In Force  
**P** = Pending  
**E** = Eligible For

i. Company Name:			
ii. Type of Insurance:			
iii. Category:			
iv. Status:			
v. Date insurance applied for, issued, or eligible for (if known):			
vi. Policy Number (if known):			
vii. Benefit Amount:	\$	\$	\$
viii. Benefit Period:			
ix. Social Insurance Benefit:	\$	\$	\$
x. Automatic Increase Option:		%	%
xi. Future Increase Option (amount remaining):	\$	\$	\$
xii. Catastrophic Benefit:	\$	\$	\$
xiii. Retirement Benefit:	\$	\$	\$
xiv. Does employer pay premium and not include it as taxable income to you?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
xv. If group coverage, is it convertible?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

b. Replacement

Is the insurance being applied for replacing this coverage?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, amount to be replaced?*	\$	\$	\$
Date for coverage to be replaced			

*\*When issuing any insurance as a result of this application, the Company will rely on the fact that you can and will permanently terminate the coverage as specified above following the delivery of the policy and will not at any time reinstate the coverage. If the coverage is not terminated, benefits under any policy issued based upon this application may be reduced by the amount payable under such existing policies. Further, if the coverage is not terminated, the Company reserves all rights outlined in any policy issued.*

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

a. **Earned Income.** Fill in the amounts requested for last year and two years ago using your individual and/or business income tax returns and supporting schedules. **Note:** Do not list income that is not reported to the IRS. Explain in Section 8 Remarks and Special Requests, any significant fluctuations between years. Describe any changes since the end of the most recent calendar year. Put loss amounts in parentheses.

	Column A Year-To-Date This Calendar Year	Column B Actual Filed Last Calendar Year	Column C Actual Filed Two Calendar Years Ago
1. Non-owner employee salary, wages and bonus from Form W-2	\$	\$	\$
2. Business owner salary, wages, and bonus from Form W-2	\$	\$	\$
3. Sole Proprietor net income (after business expenses) from Form 1040, Schedule C	\$	\$	\$
4. Share of Partnership or Sub-Chapter "S" corporation income (after business expenses) shown on Form 1040 or 1120 "S", Schedule K-1	\$	\$	\$
5. Other earned income (explain source)	\$	\$	\$
<b>6. Total Earned Income (add lines 1-5)</b>	\$	\$	\$

b. **Unearned Income.** Unearned income or passive income includes, but is not limited to, income from dividends, capital gains, interest (including tax exempt interest), rentals, royalties, pension plans, retirement plans, alimony, investments, and business interests as an inactive owner.

*Is your unearned income more than 10% of total earned income (line 6 above)?*

Yes

No

	Column A	Column B	Column C
If yes, indicate the unearned income amounts.	\$	\$	\$

Sources: \_\_\_\_\_

c. **Retirement Contributions**

1. Do you participate in a qualified retirement plan such as a 401(k), 403(b), SIMPLE, IRA or profit sharing?

Yes

No

	Column A	Column B	Column C
2. Total Annual Contribution (including your contribution and employer contributions)	\$	\$	\$

3. Do you wish to have this retirement contribution considered as part of your earned income?

Yes

No

d. **Net Worth** Does your net worth exceed \$6 million?  Yes  No If yes, itemize net worth below.

Cash, Savings, Stocks, Bonds \$ \_\_\_\_\_

Fair Market Value of your business (excluding good will) \$ \_\_\_\_\_

Personal Property \$ \_\_\_\_\_

Real Estate (excluding primary residence) \$ \_\_\_\_\_

Other \$ \_\_\_\_\_ Explain: \_\_\_\_\_

e. **Bankruptcy**

Have you ever filed bankruptcy?  Yes  No  Personal  Business

If yes, answer the following questions:

(a) Date bankruptcy filed? \_\_\_\_\_

(b) Date bankruptcy discharged? \_\_\_\_\_

**7. Premiums**

a. Mode  Annual  Semiannual  Quarterly  
 Automatic payment plan  
(Complete the Request for Guard-O-Matic Arrangement form.)  
 New Service  Add to My Existing Service  
 Monthly (list bill only – not available for all products)  
 Other: \_\_\_\_\_

b. What percentage of premium will be paid by your employer?  None  100% Other: \_\_\_\_\_ %

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

d. If paid by the proposed insured, is it paid with:  Pre-tax dollars or  After-tax dollars

e. Send premium notices to:  Residence  Owner's Address  Business  
 Other: \_\_\_\_\_  
 List Bill  
 New – Billing Name \_\_\_\_\_  
Common Billing Date \_\_\_\_\_  
 Existing Account # \_\_\_\_\_

f. Prepayment of Premium  No money has been submitted with this application for proposed insurance.  
 \$ \_\_\_\_\_ has been submitted with this application for proposed insurance. *If money is submitted when this application is signed, the terms of the Conditional Receipt shall apply if conditions are met.*

g. Is the policy being applied for through an association of which you are a member? *Proof of membership may be required.*  Yes  No  
Association Name \_\_\_\_\_

### **8. Remarks and Special Requests**

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Provide all details to any "yes" answers, identifying each detail by question number. Include, if applicable, diagnosis or symptoms, tests performed, dates, types and amounts of medication, length of disability, degree of recovery, and names and addresses of all physicians, medical or mental health professionals, counselors, psychotherapists, chiropractors, practitioners or hospitals. Also include in this section any special policy requests such as specific policy date other than as provided by the terms of this application.

### **9. Amendments or Corrections** (For Home Office Use Only)

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

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## Representations of the Proposed Insured and Owner

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Those parties who sign below, agree that:

1. This Application for Insurance (Part 1), Application for Insurance (Part 2 Non-Medical), any required Representations to the Medical Examiner, and any other supplements or amendments to this Application for Insurance will form the basis for, and become part of and attached to any policy or coverage issued and is herein referred to as the "Application."
2. All of the statements that are part of this 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 that is issued based on this Application.
5. All coverage shown to be discontinued in answer to Question 5b of this application will be permanently terminated on or before the date(s) indicated. If not, it is understood and agreed that the Company reserves all rights outlined in any policy issued. Further, benefits under any policy or coverage issued based on this application may be reduced by the amount payable under such existing policies.
6. The policy date is the date from which premiums are calculated and become due. Except as provided in the Conditional Receipt (if an advance payment has been made and acknowledged and such Receipt issued), no insurance shall take effect unless and until the policy is delivered, the first premium is paid, and there has been no change in the health, the income level, status of employment or occupation of the proposed insured. If disability insurance becomes effective in the manner stated in the Conditional Receipt, the amount of such insurance shall not exceed the limits set forth in such Receipt. If a request is made for coverage to commence as of a specified date, it is understood and agreed that certain rights under the conditional receipt may be waived.
7. 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.
8. 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.
9. If applying for Disability Buy-Out insurance, if no written buy-sell agreement is in place, one must be executed before a disability occurs that would qualify for benefits under the policy. Otherwise, the Company will have no liability other than to refund premiums. We will require a written assurance within one year of the policy date that an agreement is in place. If no assurance is received, the policy will be voided and the premiums refunded.

**Any person who knowingly, and with intent to defraud any insurance company or other person, files an application of insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and may also be subject to civil penalties.**

Signed at \_\_\_\_\_ this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_  
City and State Day Month Year

\_\_\_\_\_  
Signature of Proposed Insured

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

\_\_\_\_\_  
Witness



Individual Disability Insurance Supplement
to the Application for Insurance

I. Proposed Insured Information

a. Proposed Insured
b. Social Security Number
c. Date of Birth (mm/dd/yyyy)

2. Premium Structure

Level Graded Step Rate

3. Personal Disability Insurance

a. Policy Form No.
Monthly Indemnity
Elimination Period
Benefit Period
Occupational Class

b. Supplemental Benefits

3% Compound Cost of Living Adjustment
6% Maximum Cost of Living Adjustment
Four-Year Delayed Cost of Living Adjustment
Unemployment Waiver of Premium
Catastrophic Disability Benefit
Future Increase Option
Social Insurance Substitute
Retirement Protection Plus
Residual Disability Benefit
Partial Disability Benefit
Graded Lifetime Indemnity for Total Disability
Monthly Indemnity
Elimination Period
Benefit Period
Other



**BERKSHIRE LIFE INSURANCE COMPANY OF AMERICA**

Home Office: 700 South Street, Pittsfield, MA 01201

Berkshire Life Insurance Company of America is a wholly owned stock subsidiary of

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

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## Retirement Protection Plus Program Individual Disability Insurance Supplement to the Application for Insurance

---

### I. Proposed Insured Information

---

a. Proposed Insured

\_\_\_\_\_  
First Middle Initial Last Name

b. Social Security Number

\_\_\_\_\_

c. Date of Birth (mm/dd/yyyy)

\_\_\_\_\_

### 2. Premium Structure

---

Level  Graded  Step Rate

### 3. Disability Insurance As Part Of The Retirement Protection Plus Program

---

a. **Case No.**

*(Applicable with Income ProVider Only)*

\_\_\_\_\_

b. **Policy Form No.**

\_\_\_\_\_

*Monthly Indemnity*

\$ \_\_\_\_\_

*Elimination Period*

180 days  360 days

*Benefit Period*

To Age 65

*Occupational Class*

\_\_\_\_\_

c. **Supplemental Benefits**

3% Compound Cost of Living Adjustment

6% Maximum Cost of Living Adjustment

Modified Own Occupation  
*(Applicable with Income ProVider Only)*

Future Increase Option

\$ \_\_\_\_\_

Other

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



Income ProVider Disability Insurance Supplement
to the Application for Insurance

I. Proposed Insured Information

a. Proposed Insured
First Middle Initial Last Name
b. Social Security Number
c. Date of Birth (mm/dd/yyyy)

2. Personal Disability Insurance

a. Case No.
b. Policy Form No.
Monthly Indemnity \$
Elimination Period
Benefit Period
Occupational Class

c. Supplemental Benefits

Basic Residual Disability Enhanced Residual Disability
Modified Own Occupation True Own Occupation
3% Compound Cost of Living Adjustment 6% Maximum Cost of Living Adjustment
Catastrophic Disability Benefit \$
Additional Monthly Benefit
Monthly Indemnity \$
Elimination Period
Benefit Period
Retirement Protection Plus
Monthly Indemnity \$
Elimination Period 180 days 360 days
Benefit Period To Age 65
Other



Overhead Expense Insurance Supplement
to the Application for Insurance

I. Proposed Insured Information

a. Proposed Insured
b. Social Security Number
c. Date of Birth (mm/dd/yyyy)

2. Overhead Expense Insurance

a. Monthly Benefit
Benefit Period
Elimination Period
Occupational Class

b. Supplemental Benefits

Supplemental Overhead Expense Benefit
Future Increase Option

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

d. Are there other employees in the firm who generate revenue?
If yes, what is the compensation for these employees, their title(s) and the percentage of gross revenue they generate?

e. Owner Information (if other than the proposed insured)

Name of Owner
Address
City State ZIP
Social Security #/Tax ID #
Relationship to Proposed Insured

**f. Monthly Expenses of the Business Entity**

What are the current average monthly overhead expenses incurred for the items shown?  
 (If responsibility for expenses shared jointly with others, include only the portion for which the proposed insured is responsible.)

Advertising	\$	_____
Car and Truck Expenses		_____
Commissions and Fees		_____
Contract Labor		_____
Depreciation and Section 179 Expense Deduction		_____
Employee Benefit Programs		_____
Insurance		_____
Interest:		
Mortgage (Paid to Banks, etc.)		_____
Other		_____
Legal and Professional Services		_____
Office Expenses		_____
Pension and Profit Sharing Plans		_____
Rent or Lease (Other Business Property)		_____
Repairs and Maintenance		_____
Taxes and Licenses		_____
Utilities		_____
Employee Wages (excluding members of your profession)		_____
Other Expenses (itemized):		
_____	\$	_____
_____		_____
_____		_____
_____		_____
<b>TOTAL (Should agree with 2c.)</b>	\$	_____
Proposed Insured Monthly Earned Income*	\$	_____

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



---

## Disability Buy-Out Insurance Supplement to the Application for Insurance

---

### I. Proposed Insured Information

---

a. Proposed Insured

First Middle Initial Last Name

b. Social Security Number

c. Date of Birth (mm/dd/yyyy)

### 2. Disability Buy-Out Insurance

---

a. Funding

Lump Sum  Monthly  Down Payment

*Benefit Amount*

Monthly: \$ Lump Sum: \$

*Benefit Period*

*Elimination Period*

*Occupational Class*

b. Supplemental Benefits

Future Increase Option

Monthly: \$ Lump Sum: \$

c. Type of disability buy-sell agreement  
(in force or to be drafted):

Cross Purchase  Entity Purchase

Trusteed Cross Purchase

*Status of disability buy-sell agreement:*

In force and dated \_\_\_\_\_

Date to be executed \_\_\_\_\_

d. Owner Information

*Name of owner (first name, middle  
initial and last name) or name of  
trust, company or other owner:*

*Address*

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

City

State

ZIP

*Social Security #/Tax ID #*

*Owner's Relationship to  
Proposed Insured*

**Disability Buy-Out Insurance Supplement to the Application for Insurance | Continued**

Please complete the following if owner is a trust:

Date of Trust (mm/dd/yyyy) \_\_\_\_\_

Complete Names of Trustees \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

e. Give names of all other stockholders or partners. (If there are any on whom Disability Buy-Out (DBO) is not carried or proposed, explain in the *Application for Insurance, Part 1, Section 8 Remarks and Special Requests.*)

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

f. Does a familial relationship exist among any of the above stockholders or partners?

Yes  No If yes, describe: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

g. Indicate type of business organization:

Professional Corporation/Personal Service Partnership

Commercial Business/Other

h. Business Financial Information

		Column A	Column B	Column C
1. Total Assets	\$			
2. Total Liabilities	\$			
3. Business Net Worth (Total Assets minus Total Liabilities)	\$	Actual Filed Last Calendar Year	Actual Filed Two Calendar Years Ago	Actual Filed Three Calendar Years Ago
4. Gross Annual Sales	\$	\$	\$	\$
5. Net Profit After Taxes	\$	\$	\$	\$



---

## Reducing Term Insurance Supplement to the Application for Insurance

---

### I. Proposed Insured Information

---

a. Proposed Insured

First Middle Initial Last Name

b. Social Security Number

c. Date of Birth (mm/dd/yyyy)

### 2. Reducing Term Insurance

---

a.  Business Reducing Term  PayGuard

Monthly Benefit Amount \$

Elimination/Waiting Period

Benefit Term

Occupational Class

b. For Business Reducing Term

Loss Payee

(Loss payee must be the individual Tax ID  
or entity that the money is owed to.)

Owner

Tax ID

### Information About the Economic Need for this Insurance

c. Explain the reason that the obligation was incurred  Business Loan  Employment Contract  
 Purchase Agreement  
 Other (describe):

Details:

d. Names of all debtors or guarantors:

e. Name and address of creditor or person to whom guarantees have been given:

f. Date obligation took effect (mm/dd/yyyy):

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

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

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

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





- BERKSHIRE LIFE INSURANCE COMPANY OF AMERICA**  
Home Office: 700 South Street, Pittsfield, MA 01201  
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- THE GUARDIAN LIFE INSURANCE COMPANY OF AMERICA**  
Administrative Office: 700 South Street, Pittsfield, MA 01201  
*(Please check appropriate company(ies). Any insurer checked above is herein referred to as the "Company.")*

## Application for Insurance | Part 2 Non-Medical

### I. Proposed Insured Information

a. Proposed Insured

First	Middle Initial	Last Name
_____	_____	_____

b. Social Security Number

\_\_\_\_\_

c. Date of Birth (mm/dd/yyyy)

\_\_\_\_\_

d. Name of your primary care physician

\_\_\_\_\_

If none, check here

*Address of primary care physician*

\_\_\_\_\_

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

\_\_\_\_\_

*Primary care physician's telephone number*

City	State	ZIP
_____	_____	_____

e. Date and reason last consulted?

\_\_\_\_\_

\_\_\_\_\_

f. What treatment or medication was given or recommended?

\_\_\_\_\_

\_\_\_\_\_

g. Height

\_\_\_\_\_ feet \_\_\_\_\_ inches

Weight

\_\_\_\_\_ lbs.

h. Weight change past year:

Gain  Loss \_\_\_\_\_ lbs.  None

*Reason for change:*

\_\_\_\_\_

**(Please provide details in Remarks and Special Requests for any "Yes" answers.)**

i. Have you ever had or been treated for cancer or tumor?  Yes  No

j. In the last 10 years, have you had, been treated for or received a consultation or counseling for:

i. high blood pressure, chest pain or disorder of the heart or circulatory system?  Yes  No

ii. diabetes or disorder of the glands, bone, blood or skin?  Yes  No

iii. complications of pregnancy, infertility, or any disorder of the breasts, reproductive or genital organs, prostate, kidneys, or urinary systems?  Yes  No

iv. hernia, hepatitis, or disorder of the liver, gall bladder, esophagus, stomach, pancreas, spleen, intestines, colon or rectum?  Yes  No

v. arthritis, rheumatism, or disorder of the joints, limbs or muscles?  Yes  No

- vi. disorder or condition of the back, neck or spine?  Yes  No

---

- vii. allergy, asthma, sinusitis, emphysema, disorder of the lungs or respiratory system, or sleep apnea?  Yes  No

---

- viii. epilepsy, stroke, dizziness, headache, muscle weakness, or disorder of the brain or spinal cord?  Yes  No

---

- ix. disorder of the eyes, ears, nose or throat?  Yes  No

---

- x. anxiety, depression, nervousness, stress, mental or nervous disorder, or other emotional disorder?  Yes  No

---

- xi. Chronic Fatigue Syndrome, Fibromyalgia, Epstein Barr Virus or Lyme Disease?  Yes  No

---

- k. Do you have any loss of hearing or sight, an amputation of any kind, or any physical deformity, impairment or handicap?  Yes  No

---

- l. Within the past 10 years, have you been diagnosed by or received treatment from a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or any deficiency of the immune system such as Human Immunodeficiency Virus?  Yes  No

---

- m. i. Are you currently taking prescribed medication?  Yes  No

---

- ii. Are you currently taking non-prescription medication?  Yes  No

---

- n. i. Have you ever used stimulants, hallucinogens, narcotics or any other controlled substance? (If yes, complete the Alcohol and Drug Usage Supplement.)  Yes  No

---

- ii. Have you ever had or been advised to have counseling or treatment for alcohol or drug use? (If yes, complete the Alcohol and Drug Usage Supplement.)  Yes  No

---

- o. Are you now pregnant? If yes, expected delivery date: \_\_\_\_\_  Yes  No

---

- p. Within the past five years, have you had a sickness or injury for which you have made a benefits claim or for which you will make a benefits claim?  Yes  No

---

- q. Within the past five years, have you had a physical exam or check-up of any kind?  Yes  No

---

- r. Within the past five years, have you been advised to have surgery or any diagnostic tests that were not performed, except for HIV tests?  Yes  No

---

- s. Within the past 12 months, have you had symptoms of any condition listed in this Section 1, except those conditions listed in question 1.I., for which you have not sought medical attention or advice?  Yes  No

---

- t. Other than as previously stated on this application, in the last five years have you received medical advice or counseling from physicians, medical or mental health professionals, counselors, psychotherapists, chiropractors, or other practitioners, or have you been a patient in a hospital, clinic, sanatorium, or other medical facility?  Yes  No

---

- u. Do you have a family history of: diabetes, cancer, high blood pressure, heart disease, Huntington's Disease, mental illness or suicide?  Yes  No

	Age if Living	Cause of Death	Age at Death
FATHER			
MOTHER			
BROTHERS and SISTERS			
No. Living _____			
No. Dead _____			

## 2. Remarks and Special Requests

---

**DETAILS OF "YES" ANSWERS. IDENTIFY QUESTION & NUMBER.**

Give diagnosis or symptoms, tests performed, dates, types and amounts of medication, length of disability, degree of recovery, and names and addresses of all physicians, medical or mental health professionals, counselors, psychotherapists, practitioners or hospitals. Additional paper may be attached if necessary to explain details.

I understand and agree that the statements and answers in this Application for Insurance (Part 2 Non-Medical) are written as made by me; to the best of my knowledge and belief are full, complete and true; and that they shall be a part of the contract of insurance, if issued.

**Any person who knowingly, and with intent to defraud any insurance company or other person, files an application of insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and may also be subject to civil penalties.**

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

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Signature of Proposed Insured

SERFF Tracking Number: GARD-126259672 State: Arkansas  
 Filing Company: The Guardian Life Insurance Company of America State Tracking Number: 43523  
 Company Tracking Number: DI-2009  
 TOI: H111 Individual Health - Disability Income Sub-TOI: H111.005 Business Overhead Expense - Related to marketing with employer or association groups  
 Product Name: DI-2009  
 Project Name/Number: /

## Supporting Document Schedules

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Flesch Certification	Approved-Closed	09/17/2009
<b>Comments:</b>		
<b>Attachment:</b> Guardian Application FLESCH CERTIFICATION.pdf		

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Bypassed - Item:</b> Application	Approved-Closed	09/17/2009
<b>Bypass Reason:</b> This is an application filing. The application is attached to the form schedule.		
<b>Comments:</b>		

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Bypassed - Item:</b> Health - Actuarial Justification	Approved-Closed	09/17/2009
<b>Bypass Reason:</b> This an application form filing only. No rates submitted.		
<b>Comments:</b>		

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Bypassed - Item:</b> Outline of Coverage	Approved-Closed	09/17/2009
<b>Bypass Reason:</b> n/a - this is an application only filing.		
<b>Comments:</b>		

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> John Doe Applications	Approved-Closed	09/17/2009
<b>Comments:</b>		

SERFF Tracking Number: GARD-126259672 State: Arkansas  
Filing Company: The Guardian Life Insurance Company of America State Tracking Number: 43523  
Company Tracking Number: DI-2009  
TOI: H111 Individual Health - Disability Income Sub-TOI: H111.005 Business Overhead Expense - Related to marketing with employer or association groups

Product Name: DI-2009

Project Name/Number: /

John Doe Applications included for informational purposes.

**Attachments:**

DI-2009 John Doe.pdf

DI-NM-2009 John Doe.pdf

	<b>Item Status:</b>	<b>Status</b>
<b>Satisfied - Item:</b> Producer Certification	Approved-Closed	<b>Date:</b> 09/17/2009

**Comments:**

The Producer's Certification which includes the required replacement question is included for informational purposes only.

**Attachment:**

DI-PC-2009.pdf

The Guardian Life Insurance Company of America  
7 Hanover Square  
New York NY 10007

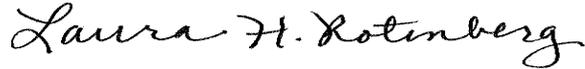
CERTIFICATION

This is to certify that the policy forms listed below comply with the readability ease standards of the Life and Health Policy Language Simplification Act, Section 5a.

<u>Form Number</u>	<u>Syllables</u>	<u>Words</u>	<u>Sentences</u>	<u>Flesch Score</u>
DI-2009	3,868	2,422	118	50.1

The following form was scored in combination with Application DI-2009 since it is always used with this form:

DI-NM-2009	2,760	1825	73	53.5
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Laura H. Rotenberg  
Counsel



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

## Application for Insurance | Part I

Please indicate all insurance applied for with this Part 1 Application and include the appropriate application supplement for each product selected to right.

- Individual Disability Insurance
- Individual Disability Insurance – Retirement Protection Plus Program
- Overhead Expense     Disability Buy-Out
- Business Reducing Term/PayGuard

### I. Proposed Insured Information

a. Proposed Insured

\_\_\_\_\_  
First                                      Middle Initial                                      Last Name

\_\_\_\_\_  
Suffix                                      Previous Last Name

b. Gender

Male     Female

c. Social Security Number

\_\_\_\_\_

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

\_\_\_\_\_

e. Place of Birth

\_\_\_\_\_

f. Are you a U.S. citizen?

Yes     No    (If no, answer the following questions)

\_\_\_\_\_  
Visa Type                                      Visa Duration

*How long have you lived in the U.S. on a full-time basis?*

\_\_\_\_\_  
(If residence has not been continuous, give dates, and explain in Remarks and Special Requests.)

*Do you expect to remain in the U.S. permanently?*

Yes     No    If no, include details:

*When do you expect to obtain U.S. citizenship or permanent residency?*

\_\_\_\_\_

g. Home Address

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

\_\_\_\_\_  
City                                      State                                      ZIP

h. How long at this address?

\_\_\_\_\_

i. Telephone Number

\_\_\_\_\_  
Home Phone Number                                      Cell Phone Number

j. E-mail Address

\_\_\_\_\_

k. If less than 2 years at current address, please furnish previous address:

\_\_\_\_\_  
Address

\_\_\_\_\_  
City                                      State                                      ZIP

**2. Business Information**

a. Name of Current Employer \_\_\_\_\_

b. Business Address \_\_\_\_\_  
(If mailing address is PO Box, include street address as well.)

\_\_\_\_\_  
City State ZIP

*Business Phone* \_\_\_\_\_

*Business Website* \_\_\_\_\_

c. Occupation \_\_\_\_\_

d. Job Title \_\_\_\_\_

e. Nature of Business \_\_\_\_\_

f. How many years employed with your current employer? \_\_\_\_\_  
(If less than 2 years, please furnish previous employer below.)

g. Former Employer \_\_\_\_\_

\_\_\_\_\_  
Address

\_\_\_\_\_  
City State ZIP

h. Occupation \_\_\_\_\_

i. Job Title \_\_\_\_\_

j. Nature of Business \_\_\_\_\_

**3. Occupational Information**

a. Describe, in order of importance, all duties of your occupation. Include all activities that are performed in connection with the duties of your occupation, including but not limited to travel, sales and supervisory.

Description of Specific Duties	% of Time Devoted to Each Duty

b. Describe exact physical duties of your occupation (lifting, climbing, driving, etc.). If none, so state. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

c. Describe any tools or equipment you use to perform the duties of your occupation. If none, so state. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

- d. If you are a medical doctor or dentist, what percent of your gross income is derived from surgical procedures, such as catheterization, angioplasty, stent placement, pacemaker implant, endoscopy, or other surgical procedure? \_\_\_\_\_ %
- e. Is this a home-based occupation?  Yes  No  
If yes, what percentage of time do you spend working at home?  
\_\_\_\_\_ %
- f. Number of years in this occupation \_\_\_\_\_
- g. How many hours per week are you at work in this occupation? \_\_\_\_\_ hours
- h. Have you been continuously at work full time performing the usual duties of your occupation for the past six months?  Yes  No If no, explain: \_\_\_\_\_
- i. Do you supervise any employees?  Yes  No If yes, how many? \_\_\_\_\_
- j. Are you a business owner?  Yes  No
- k. What percentage of the business do you own? \_\_\_\_\_ %
- l. What type of business do you own?  Sole Proprietorship  Partnership  "S" Corporation  
 Limited Liability Company (LLC)  "C" Corporation  
 Limited Liability Partnership (LLP)  
 Other: \_\_\_\_\_
- m. Do you plan to change any occupation or employment within the next six months?  Yes  No If yes, provide details: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
- n. Do you have any other part- or full-time jobs, occupations or employment?  Yes  No If yes, provide details: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**4. The Following Questions Apply to the Proposed Insured**

(Please provide details in Section 8 Remarks and Special Requests to all "Yes" answers.)

- a. Do you plan to reside or travel outside of the U.S.?  Yes  No  
(If yes, indicate location, frequency, for work or pleasure, date of departure, length of stay.) \_\_\_\_\_
- b. Do you drive a motor vehicle? \_\_\_\_\_ Driver's License State \_\_\_\_\_ Driver's License # \_\_\_\_\_  Yes  No
- c. 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.)  Yes  No
- d. Within the last 10 years, have you been convicted of a felony, or is such a charge pending against you?  Yes  No
- e. Have you ever had a professional license suspended or revoked, or is such license under review, or have you ever been disbarred?  Yes  No

- f. Within the last three years, have you participated in any of the following, or do you plan in the future to participate in any of the following: piloting any type of aircraft; mountain climbing or rock climbing; scuba diving; hang gliding; parachuting or skydiving; motor vehicle racing; or other hazardous activity? (If yes to any, complete Aviation and/or Avocation Supplement.)  Yes  No
- g. Within the past five years, have you had disability, accident, medical, life or health insurance declined, postponed, modified, rated, cancelled, rescinded, or have you withdrawn a pending application, or had a renewal or reinstatement refused?  Yes  No
- h. Have you used tobacco, nicotine, or any nicotine delivery system in any form in the last 12 months? (If you have quit, date last used: \_\_\_\_\_)  Yes  No
- i. Do you plan to apply for or are you currently applying for any other life, long-term care, disability or accident insurance? (In Section 8 Remarks and Special Requests, include amount applying for and company applying with, and whether this other insurance will be in addition to or in lieu of insurance with Berkshire or Guardian.)  Yes  No
- j. Are you currently a member of, or do you plan on joining, any branch of the United States Military, including the Army, Navy, Air Force, Marine Corps, Coast Guard, National Guard, or any reserve military unit?  Yes  No
- k. Are you currently employed by, or seeking employment with, any company or entity which provides military, paramilitary, or security services outside of the United States?  Yes  No
- l. Have you been alerted to, received orders for, or had any indication of an overseas assignment or active service with any branch of the United States Military, including the Army, Navy, Air Force, Marine Corps, Coast Guard, National Guard, or any reserve military unit?  Yes  No
- m. Have you ever had or been treated for cancer, heart attack, stroke, diabetes, or any disease of the liver, lungs, kidneys, or heart, or any disorder of the back or spine?  Yes  No
- n. Are you currently receiving any medical advice, counseling or treatment for any medical, surgical or psychiatric condition?  Yes  No

If questions 4m or 4n are left blank or answered "Yes," no prepayment should be taken and no Conditional Receipt issued.

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

- o. Have you ever had an injury or sickness that caused a loss of: sight in both eyes; hearing in both ears; speech; or the use of two arms or two legs?  Yes  No
- p. Do you need human assistance of any kind to perform everyday activities such as bathing, continence, dressing, eating, using the toilet or transferring (for example, from the chair to your bed)?  Yes  No
- q. Do you use any special medical equipment or appliances, including but not limited to, a wheelchair, pacemaker, oxygen tank, cane, catheter, or artificial limb?  Yes  No
- r. Have you ever received treatment, attention or advice for memory loss or confusion, Alzheimer's disease, stroke, senility, dementia, loss of speech or comprehension of spoken language?  Yes  No

If any question listed in 4o through 4r is answered "Yes," no prepayment should be taken and no Conditional Receipt issued.

**5. Other Disability Insurance Coverage of the Proposed Insured**

a. Do you have disability insurance in force or applied for, or are you eligible for disability insurance within the next 12 months with any company, including Guardian or Berkshire?  Yes  No

**Type of Insurance**

**DI** = Disability Income Insurance  
**OE** = Overhead Expense  
**RP** = Retirement Protection

**DBO** = Buy-Out  
**KEY** = Key Person  
**RT** = Reducing Term

**Category**

**IDI** = Individual  
**STD** = Group STD  
**LTD** = Group LTD  
**A** = Association

**Status**

**I** = In Force  
**P** = Pending  
**E** = Eligible For

i. Company Name:			
ii. Type of Insurance:			
iii. Category:			
iv. Status:			
v. Date insurance applied for, issued, or eligible for (if known):			
vi. Policy Number (if known):			
vii. Benefit Amount:	\$	\$	\$
viii. Benefit Period:			
ix. Social Insurance Benefit:	\$	\$	\$
x. Automatic Increase Option:		%	%
xi. Future Increase Option (amount remaining):	\$	\$	\$
xii. Catastrophic Benefit:	\$	\$	\$
xiii. Retirement Benefit:	\$	\$	\$
xiv. Does employer pay premium and not include it as taxable income to you?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
xv. If group coverage, is it convertible?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

b. Replacement

Is the insurance being applied for replacing this coverage?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, amount to be replaced?*	\$	\$	\$
Date for coverage to be replaced			

*\*When issuing any insurance as a result of this application, the Company will rely on the fact that you can and will permanently terminate the coverage as specified above following the delivery of the policy and will not at any time reinstate the coverage. If the coverage is not terminated, benefits under any policy issued based upon this application may be reduced by the amount payable under such existing policies. Further, if the coverage is not terminated, the Company reserves all rights outlined in any policy issued.*

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

a. **Earned Income.** Fill in the amounts requested for last year and two years ago using your individual and/or business income tax returns and supporting schedules. **Note:** Do not list income that is not reported to the IRS. Explain in Section 8 Remarks and Special Requests, any significant fluctuations between years. Describe any changes since the end of the most recent calendar year. Put loss amounts in parentheses.

	Column A Year-To-Date This Calendar Year	Column B Actual Filed Last Calendar Year	Column C Actual Filed Two Calendar Years Ago
1. Non-owner employee salary, wages and bonus from Form W-2	\$	\$	\$
2. Business owner salary, wages, and bonus from Form W-2	\$	\$	\$
3. Sole Proprietor net income (after business expenses) from Form 1040, Schedule C	\$	\$	\$
4. Share of Partnership or Sub-Chapter "S" corporation income (after business expenses) shown on Form 1040 or 1120 "S", Schedule K-1	\$	\$	\$
5. Other earned income (explain source)	\$	\$	\$
<b>6. Total Earned Income (add lines 1-5)</b>	\$	\$	\$

b. **Unearned Income.** Unearned income or passive income includes, but is not limited to, income from dividends, capital gains, interest (including tax exempt interest), rentals, royalties, pension plans, retirement plans, alimony, investments, and business interests as an inactive owner.

*Is your unearned income more than 10% of total earned income (line 6 above)?*

Yes

No

	Column A	Column B	Column C
If yes, indicate the unearned income amounts.	\$	\$	\$

Sources: \_\_\_\_\_

c. **Retirement Contributions**

1. Do you participate in a qualified retirement plan such as a 401(k), 403(b), SIMPLE, IRA or profit sharing?

Yes

No

	Column A	Column B	Column C
2. Total Annual Contribution (including your contribution and employer contributions)	\$	\$	\$

3. Do you wish to have this retirement contribution considered as part of your earned income?

Yes

No

d. **Net Worth** Does your net worth exceed \$6 million?  Yes  No If yes, itemize net worth below.

Cash, Savings, Stocks, Bonds \$ \_\_\_\_\_

Fair Market Value of your business (excluding good will) \$ \_\_\_\_\_

Personal Property \$ \_\_\_\_\_

Real Estate (excluding primary residence) \$ \_\_\_\_\_

Other \$ \_\_\_\_\_ Explain: \_\_\_\_\_

e. **Bankruptcy**

Have you ever filed bankruptcy?  Yes  No  Personal  Business

If yes, answer the following questions:

(a) Date bankruptcy filed? \_\_\_\_\_

(b) Date bankruptcy discharged? \_\_\_\_\_

**7. Premiums**

a. Mode  Annual  Semiannual  Quarterly  
 Automatic payment plan  
(Complete the Request for Guard-O-Matic Arrangement form.)  
 New Service  Add to My Existing Service  
 Monthly (list bill only – not available for all products)  
 Other: \_\_\_\_\_

b. What percentage of premium will be paid by your employer?  None  100% Other: \_\_\_\_\_ %

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

d. If paid by the proposed insured, is it paid with:  Pre-tax dollars or  After-tax dollars

e. Send premium notices to:  Residence  Owner's Address  Business  
 Other: \_\_\_\_\_  
 List Bill  
 New – Billing Name \_\_\_\_\_  
Common Billing Date \_\_\_\_\_  
 Existing Account # \_\_\_\_\_

f. Prepayment of Premium  No money has been submitted with this application for proposed insurance.  
 \$ \_\_\_\_\_ has been submitted with this application for proposed insurance. *If money is submitted when this application is signed, the terms of the Conditional Receipt shall apply if conditions are met.*

g. Is the policy being applied for through an association of which you are a member? *Proof of membership may be required.*  Yes  No  
Association Name \_\_\_\_\_

### **8. Remarks and Special Requests**

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Provide all details to any "yes" answers, identifying each detail by question number. Include, if applicable, diagnosis or symptoms, tests performed, dates, types and amounts of medication, length of disability, degree of recovery, and names and addresses of all physicians, medical or mental health professionals, counselors, psychotherapists, chiropractors, practitioners or hospitals. Also include in this section any special policy requests such as specific policy date other than as provided by the terms of this application.

### **9. Amendments or Corrections** (For Home Office Use Only)

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

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## Representations of the Proposed Insured and Owner

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Those parties who sign below, agree that:

1. This Application for Insurance (Part 1), Application for Insurance (Part 2 Non-Medical), any required Representations to the Medical Examiner, and any other supplements or amendments to this Application for Insurance will form the basis for, and become part of and attached to any policy or coverage issued and is herein referred to as the "Application."
2. All of the statements that are part of this 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 that is issued based on this Application.
5. All coverage shown to be discontinued in answer to Question 5b of this application will be permanently terminated on or before the date(s) indicated. If not, it is understood and agreed that the Company reserves all rights outlined in any policy issued. Further, benefits under any policy or coverage issued based on this application may be reduced by the amount payable under such existing policies.
6. The policy date is the date from which premiums are calculated and become due. Except as provided in the Conditional Receipt (if an advance payment has been made and acknowledged and such Receipt issued), no insurance shall take effect unless and until the policy is delivered, the first premium is paid, and there has been no change in the health, the income level, status of employment or occupation of the proposed insured. If disability insurance becomes effective in the manner stated in the Conditional Receipt, the amount of such insurance shall not exceed the limits set forth in such Receipt. If a request is made for coverage to commence as of a specified date, it is understood and agreed that certain rights under the conditional receipt may be waived.
7. 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.
8. 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.
9. If applying for Disability Buy-Out insurance, if no written buy-sell agreement is in place, one must be executed before a disability occurs that would qualify for benefits under the policy. Otherwise, the Company will have no liability other than to refund premiums. We will require a written assurance within one year of the policy date that an agreement is in place. If no assurance is received, the policy will be voided and the premiums refunded.

**Any person who knowingly, and with intent to defraud any insurance company or other person, files an application of insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and may also be subject to civil penalties.**

Signed at \_\_\_\_\_ this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_  
City and State Day Month Year

\_\_\_\_\_  
Signature of Proposed Insured

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

\_\_\_\_\_  
Witness





**BERKSHIRE LIFE INSURANCE COMPANY OF AMERICA**

Home Office: 700 South Street, Pittsfield, MA 01201

Berkshire Life Insurance Company of America is a wholly owned stock subsidiary of

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

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## Retirement Protection Plus Program Individual Disability Insurance Supplement to the Application for Insurance

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### I. Proposed Insured Information

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a. Proposed Insured

First Middle Initial Last Name

b. Social Security Number

\_\_\_\_\_

c. Date of Birth (mm/dd/yyyy)

\_\_\_\_\_

### 2. Premium Structure

---

Level  Graded  Step Rate

### 3. Disability Insurance As Part Of The Retirement Protection Plus Program

---

a. **Case No.**

*(Applicable with Income ProVider Only)*

\_\_\_\_\_

b. **Policy Form No.**

\_\_\_\_\_

*Monthly Indemnity*

\$ \_\_\_\_\_

*Elimination Period*

180 days  360 days

*Benefit Period*

To Age 65

*Occupational Class*

\_\_\_\_\_

c. **Supplemental Benefits**

3% Compound Cost of Living Adjustment

6% Maximum Cost of Living Adjustment

Modified Own Occupation  
*(Applicable with Income ProVider Only)*

Future Increase Option

\$ \_\_\_\_\_

Other

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



## Income ProVider Disability Insurance Supplement to the Application for Insurance

### I. Proposed Insured Information

a. Proposed Insured

	First	Middle Initial	Last Name
--	-------	----------------	-----------

b. Social Security Number \_\_\_\_\_

c. Date of Birth (mm/dd/yyyy) \_\_\_\_\_

### 2. Personal Disability Insurance

a. **Case No.** \_\_\_\_\_

b. **Policy Form No.** \_\_\_\_\_

*Monthly Indemnity* \$ \_\_\_\_\_

*Elimination Period* \_\_\_\_\_

*Benefit Period* \_\_\_\_\_

*Occupational Class* \_\_\_\_\_

### c. Supplemental Benefits

<input type="checkbox"/> <i>Basic Residual Disability</i>	<input type="checkbox"/> <i>Enhanced Residual Disability</i>
<input type="checkbox"/> <i>Modified Own Occupation</i>	<input type="checkbox"/> <i>True Own Occupation</i>
<input type="checkbox"/> <i>3% Compound Cost of Living Adjustment</i>	<input type="checkbox"/> <i>6% Maximum Cost of Living Adjustment</i>
<input type="checkbox"/> <i>Catastrophic Disability Benefit</i>	\$ _____
<input type="checkbox"/> <i>Additional Monthly Benefit</i>	
<i>Monthly Indemnity</i>	\$ _____
<i>Elimination Period</i>	_____
<i>Benefit Period</i>	_____
<input type="checkbox"/> <i>Retirement Protection Plus</i>	
<i>Monthly Indemnity</i>	\$ _____
<i>Elimination Period</i>	<input type="checkbox"/> 180 days <input type="checkbox"/> 360 days
<i>Benefit Period</i>	To Age 65
<input type="checkbox"/> <i>Other</i>	_____
	_____
	_____



Overhead Expense Insurance Supplement
to the Application for Insurance

I. Proposed Insured Information

a. Proposed Insured
First Middle Initial Last Name
b. Social Security Number
c. Date of Birth (mm/dd/yyyy)

2. Overhead Expense Insurance

a. Monthly Benefit \$
Benefit Period
Elimination Period
Occupational Class

b. Supplemental Benefits

Supplemental Overhead Expense Benefit

Future Increase Option \$

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

d. Are there other employees in the firm who generate revenue? Yes No

If yes, what is the compensation for these employees, their title(s) and the percentage of gross revenue they generate?

e. Owner Information (if other than the proposed insured)

Name of Owner

Address

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

City State ZIP

Social Security #/Tax ID #

Relationship to Proposed Insured

**f. Monthly Expenses of the Business Entity**

What are the current average monthly overhead expenses incurred for the items shown?  
 (If responsibility for expenses shared jointly with others, include only the portion for which the proposed insured is responsible.)

Advertising	\$	_____
Car and Truck Expenses		_____
Commissions and Fees		_____
Contract Labor		_____
Depreciation and Section 179 Expense Deduction		_____
Employee Benefit Programs		_____
Insurance		_____
Interest:		
Mortgage (Paid to Banks, etc.)		_____
Other		_____
Legal and Professional Services		_____
Office Expenses		_____
Pension and Profit Sharing Plans		_____
Rent or Lease (Other Business Property)		_____
Repairs and Maintenance		_____
Taxes and Licenses		_____
Utilities		_____
Employee Wages (excluding members of your profession)		_____
Other Expenses (itemized):		
_____	\$	_____
_____		_____
_____		_____
_____		_____
<b>TOTAL (Should agree with 2c.)</b>	\$	_____
Proposed Insured Monthly Earned Income*	\$	_____

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



Disability Buy-Out Insurance Supplement
to the Application for Insurance

I. Proposed Insured Information

a. Proposed Insured
b. Social Security Number
c. Date of Birth (mm/dd/yyyy)

2. Disability Buy-Out Insurance

a. Funding
Benefit Amount
Benefit Period
Elimination Period
Occupational Class

b. Supplemental Benefits
c. Type of disability buy-sell agreement
Status of disability buy-sell agreement:

d. Owner Information
Name of owner
Address
City State ZIP
Social Security #/Tax ID #
Owner's Relationship to Proposed Insured

**Disability Buy-Out Insurance Supplement to the Application for Insurance | Continued**

Please complete the following if owner is a trust:

Date of Trust (mm/dd/yyyy) \_\_\_\_\_

Complete Names of Trustees \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

e. Give names of all other stockholders or partners. (If there are any on whom Disability Buy-Out (DBO) is not carried or proposed, explain in the *Application for Insurance, Part 1, Section 8 Remarks and Special Requests.*)

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

f. Does a familial relationship exist among any of the above stockholders or partners?

Yes  No If yes, describe: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

g. Indicate type of business organization:

Professional Corporation/Personal Service Partnership

Commercial Business/Other

h. Business Financial Information

		Column A	Column B	Column C
1. Total Assets	\$			
2. Total Liabilities	\$	Actual Filed Last Calendar Year	Actual Filed Two Calendar Years Ago	Actual Filed Three Calendar Years Ago
3. Business Net Worth (Total Assets minus Total Liabilities)	\$			
4. Gross Annual Sales	\$	\$	\$	\$
5. Net Profit After Taxes	\$	\$	\$	\$



---

## Reducing Term Insurance Supplement to the Application for Insurance

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### I. Proposed Insured Information

---

a. Proposed Insured

First Middle Initial Last Name

b. Social Security Number

\_\_\_\_\_

c. Date of Birth (mm/dd/yyyy)

\_\_\_\_\_

### 2. Reducing Term Insurance

---

a.  Business Reducing Term  PayGuard

Monthly Benefit Amount \$ \_\_\_\_\_

Elimination/Waiting Period \_\_\_\_\_

Benefit Term \_\_\_\_\_

Occupational Class \_\_\_\_\_

b. For Business Reducing Term

Loss Payee \_\_\_\_\_

(Loss payee must be the individual Tax ID  
or entity that the money is owed to.)

Owner \_\_\_\_\_

Tax ID \_\_\_\_\_

### Information About the Economic Need for this Insurance

c. Explain the reason that the obligation  
was incurred

Business Loan  Employment Contract

Purchase Agreement

Other (describe): \_\_\_\_\_

Details: \_\_\_\_\_

d. Names of all debtors or guarantors:

\_\_\_\_\_

e. Name and address of creditor or  
person to whom guarantees have  
been given:

\_\_\_\_\_

\_\_\_\_\_

f. Date obligation took effect (mm/dd/yyyy):

\_\_\_\_\_

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

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

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

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





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

## Application for Insurance | Part 2 Non-Medical

### I. Proposed Insured Information

a. Proposed Insured

First	Middle Initial	Last Name
_____	_____	_____

b. Social Security Number

\_\_\_\_\_

c. Date of Birth (mm/dd/yyyy)

\_\_\_\_\_

d. Name of your primary care physician

\_\_\_\_\_

If none, check here

*Address of primary care physician*

\_\_\_\_\_

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

\_\_\_\_\_

*Primary care physician's telephone number*

City	State	ZIP
_____	_____	_____

e. Date and reason last consulted?

\_\_\_\_\_

f. What treatment or medication was given or recommended?

\_\_\_\_\_

g. Height

feet	inches
_____	_____

Weight

lbs.
_____

h. Weight change past year:

Gain  Loss \_\_\_\_\_ lbs.  None

*Reason for change:*

\_\_\_\_\_

**(Please provide details in Remarks and Special Requests for any "Yes" answers.)**

i. Have you ever had or been treated for cancer or tumor?  Yes  No

j. In the last 10 years, have you had, been treated for or received a consultation or counseling for:

i. high blood pressure, chest pain or disorder of the heart or circulatory system?  Yes  No

ii. diabetes or disorder of the glands, bone, blood or skin?  Yes  No

iii. complications of pregnancy, infertility, or any disorder of the breasts, reproductive or genital organs, prostate, kidneys, or urinary systems?  Yes  No

iv. hernia, hepatitis, or disorder of the liver, gall bladder, esophagus, stomach, pancreas, spleen, intestines, colon or rectum?  Yes  No

v. arthritis, rheumatism, or disorder of the joints, limbs or muscles?  Yes  No

- vi. disorder or condition of the back, neck or spine?  Yes  No

---

- vii. allergy, asthma, sinusitis, emphysema, disorder of the lungs or respiratory system, or sleep apnea?  Yes  No

---

- viii. epilepsy, stroke, dizziness, headache, muscle weakness, or disorder of the brain or spinal cord?  Yes  No

---

- ix. disorder of the eyes, ears, nose or throat?  Yes  No

---

- x. anxiety, depression, nervousness, stress, mental or nervous disorder, or other emotional disorder?  Yes  No

---

- xi. Chronic Fatigue Syndrome, Fibromyalgia, Epstein Barr Virus or Lyme Disease?  Yes  No

---

- k. Do you have any loss of hearing or sight, an amputation of any kind, or any physical deformity, impairment or handicap?  Yes  No

---

- l. Within the past 10 years, have you been diagnosed by or received treatment from a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or any deficiency of the immune system such as Human Immunodeficiency Virus?  Yes  No

---

- m. i. Are you currently taking prescribed medication?  Yes  No

---

- ii. Are you currently taking non-prescription medication?  Yes  No

---

- n. i. Have you ever used stimulants, hallucinogens, narcotics or any other controlled substance? (If yes, complete the Alcohol and Drug Usage Supplement.)  Yes  No

---

- ii. Have you ever had or been advised to have counseling or treatment for alcohol or drug use? (If yes, complete the Alcohol and Drug Usage Supplement.)  Yes  No

---

- o. Are you now pregnant? If yes, expected delivery date: \_\_\_\_\_  Yes  No

---

- p. Within the past five years, have you had a sickness or injury for which you have made a benefits claim or for which you will make a benefits claim?  Yes  No

---

- q. Within the past five years, have you had a physical exam or check-up of any kind?  Yes  No

---

- r. Within the past five years, have you been advised to have surgery or any diagnostic tests that were not performed, except for HIV tests?  Yes  No

---

- s. Within the past 12 months, have you had symptoms of any condition listed in this Section 1, except those conditions listed in question 1.I., for which you have not sought medical attention or advice?  Yes  No

---

- t. Other than as previously stated on this application, in the last five years have you received medical advice or counseling from physicians, medical or mental health professionals, counselors, psychotherapists, chiropractors, or other practitioners, or have you been a patient in a hospital, clinic, sanatorium, or other medical facility?  Yes  No

---

- u. Do you have a family history of: diabetes, cancer, high blood pressure, heart disease, Huntington's Disease, mental illness or suicide?  Yes  No

	Age if Living	Cause of Death	Age at Death
FATHER			
MOTHER			
BROTHERS and SISTERS			
No. Living _____			
No. Dead _____			

## 2. Remarks and Special Requests

### DETAILS OF "YES" ANSWERS. IDENTIFY QUESTION & NUMBER.

Give diagnosis or symptoms, tests performed, dates, types and amounts of medication, length of disability, degree of recovery, and names and addresses of all physicians, medical or mental health professionals, counselors, psychotherapists, practitioners or hospitals. Additional paper may be attached if necessary to explain details.

I understand and agree that the statements and answers in this Application for Insurance (Part 2 Non-Medical) are written as made by me; to the best of my knowledge and belief are full, complete and true; and that they shall be a part of the contract of insurance, if issued.

**Any person who knowingly, and with intent to defraud any insurance company or other person, files an application of insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and may also be subject to civil penalties.**

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

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Signature of Proposed Insured

