

SERFF Tracking Number: GARD-127178720 State: Arkansas  
Filing Company: The Guardian Life Insurance Company of America State Tracking Number: 48906  
Company Tracking Number: L-AP-2011  
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other  
Product Name: Life Application 2011 (GLIC)  
Project Name/Number: Life Application 2011/L-AP-2011

## Filing at a Glance

Company: The Guardian Life Insurance Company of America

Product Name: Life Application 2011 (GLIC) SERFF Tr Num: GARD-127178720 State: Arkansas  
TOI: L08 Life - Other SERFF Status: Closed-Approved- Closed State Tr Num: 48906

Sub-TOI: L08.000 Life - Other Co Tr Num: L-AP-2011 State Status: Approved-Closed  
Filing Type: Form Reviewer(s): Linda Bird  
Disposition Date: 06/07/2011

Authors: Lisa Capella, Louis A Conte, Peter Diggins, Margaret Lewis-Forbes, John Monahan, Monica Wilson, Carline Hamilton, Kathleen Tobin

Date Submitted: 05/26/2011 Disposition Status: Approved-Closed

Implementation Date Requested:

Implementation Date:

State Filing Description:

## General Information

Project Name: Life Application 2011  
Project Number: L-AP-2011  
Requested Filing Mode: Review & Approval  
Explanation for Combination/Other:  
Submission Type: New Submission  
Overall Rate Impact:

Status of Filing in Domicile:  
Date Approved in Domicile:  
Domicile Status Comments:  
Market Type: Individual  
Individual Market Type:  
Filing Status Changed: 06/07/2011  
State Status Changed: 06/07/2011  
Created By: Lisa Capella  
Corresponding Filing Tracking Number:

Deemer Date:

Submitted By: Peter Diggins

Filing Description:

Dear Commissioner:

We are enclosing for your review and approval 8 new application forms. Please see Appendix A for more information concerning these forms, including any forms being replaced by the new forms. The expected introduction date for these new forms is August 2011, or upon approval by your Department, if later. Appendix B includes previously approved



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own the new insurance.

#### Foreign Travel and Residence Questionnaire

The Foreign Travel and Residence Questionnaire requests information related to foreign travel or residence. This questionnaire is completed when the applicant is not a US citizen, or when questions pertaining to foreign travel and residence in Section N on the Application for Life Insurance are answered "Yes".

#### Military Status Questionnaire

The Military Status Questionnaire requests information on the proposed insured's military service, whether active or inactive. This questionnaire is completed when the question pertaining to military status in Section N on the Application for Life Insurance is answered "Yes".

Also included is a statement of variability applicable to these applications. Any other special certifications, fees, etc. unique to your state are attached.

The enclosed form will be laser-emitted or pre-printed with the language identical to that approved by your state. We reserve the right to change duplex printing, line location of sentences and words, and the type font (but not the point size) of the form without resubmitting them for approval.

I hope this information is satisfactory and that we may receive your Department's approval of this submission at your earliest convenience. If you have any questions or concerns over this submission, please feel free to contact me at (212) 598-7436 or via SERFF.

Sincerely,

Pete Diggins, Director  
Individual Life Product Filings & Compliance

## Company and Contact

#### Filing Contact Information

Lisa Capella, Specialist  
7 Hanover Square  
New York, NY 10004

lcapella@glic.com  
212-598-1321 [Phone]  
212-919-2592 [FAX]

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**Filing Company Information**

The Guardian Life Insurance Company of CoCode: 64246 State of Domicile: New York  
 America  
 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**

Fee Required? Yes  
 Fee Amount: \$400.00  
 Retaliatory? No  
 Fee Explanation: \$50 per form X 8 forms =\$400.  
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
The Guardian Life Insurance Company of America	\$400.00	05/26/2011	48083481

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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved- Closed	Linda Bird	06/07/2011	06/07/2011

### Filing Notes

Subject	Note Type	Created By	Created On	Date Submitted
State tracking 48906	Note To Reviewer	Lisa Capella	06/06/2011	06/06/2011

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## Disposition

Disposition Date: 06/07/2011

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	Yes	Yes
Supporting Document	Application	Yes	Yes
Supporting Document	Agent's Certification	Yes	Yes
Supporting Document	Appendix A & B	Yes	Yes
Supporting Document	Statement of Variability	Yes	Yes
Form	Application for Life Insurance	Yes	Yes
Form	Conditional Temporary Coverage Agreement and Receipt	Yes	Yes
Form	Amendment to Application	Yes	Yes
Form	Authorization to Obtain and Release Information	Yes	Yes
Form	Personal Financial Supplement	Yes	Yes
Form	Business Financial Supplement	Yes	Yes
Form	Foreign Travel and Residence Questionnaire	Yes	Yes
Form	Military Status Questionnaire	Yes	Yes

*SERFF Tracking Number:* GARD-127178720      *State:* Arkansas  
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**Note To Reviewer**

**Created By:**

Lisa Capella on 06/06/2011 02:01 PM

**Last Edited By:**

Linda Bird

**Submitted On:**

06/07/2011 11:14 AM

**Subject:**

State tracking 48906

**Comments:**

We received approval of State tracking 48905 from you last week. This note is just an FYI that 48906 is the same filing except it was made under our subsidiary Guardian insurance & Annuity Company of America. Thank you.

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## Form Schedule

### Lead Form Number:

Schedule Item Status	Form Number	Form Type Form Name	Action	Action Specific Data	Readability	Attachment
	L-AP-2011 AR	Application/ Enrollment Form Application for Life Insurance	Initial		50.300	L-AP-2011 AR.pdf
	L-AP-CR-2011	Application/ Enrollment Form Conditional Temporary Coverage Agreement and Receipt	Initial		48.000	L-AP-CR-2011.pdf
	P89-2011	Application/ Enrollment Form Amendment to Application	Initial		50.000	P89-2011.pdf
	C-AUTH-2011	Application/ Enrollment Form Authorization to Obtain and Release Information	Initial		47.000	C-AUTH-2011.pdf
	L-AP-PERSFIN-SUPP-2011	Application/ Enrollment Form Personal Financial Supplement	Initial		50.000	L-AP-PERSFIN-SUPP-2011.pdf
	L-AP-BUSFIN-SUPP-2011	Application/ Enrollment Form Business Financial Supplement	Initial		50.200	L-AP-BUSFIN-SUPP-2011.pdf
	L-AP-FTR-SUPP-2011	Application/ Enrollment Form Foreign Travel and Residence Questionnaire	Initial		51.000	L-AP-FTR-SUPP-2011.pdf
	L-AP-MILI-SUPP-2011	Application/ Enrollment Form Military Status Questionnaire	Initial		53.100	L-AP-MILI-SUPP-2011.pdf



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 Part 1

Please print (any changes must be initialed by the Owner and/or proposed insured)

(Page 1 of 8)

### SECTION A Proposed Insured Information

1. First Name \_\_\_\_\_ MI \_\_\_\_\_ Last Name \_\_\_\_\_
2. Previous Name (if changed in the last 5 years) \_\_\_\_\_
3. Social Security # \_\_\_\_\_
4. Sex  Male  Female
5. Date of Birth (mm/dd/yyyy) \_\_\_\_\_
6. Place of Birth \_\_\_\_\_
7. Are you a U.S. citizen?  Yes  No (If no, please complete Foreign Travel and Residence Questionnaire)
8. Marital Status:  Married  Single  Divorced  Separated  Widowed
9. Driver's License Number \_\_\_\_\_ Driver's License State \_\_\_\_\_  
(if none, provide a government photo ID number, issuer and expiration date in Remarks section)
10. Primary Residence (Do not use P.O. Box) \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_
11. How long at this address? \_\_\_\_\_ (If less than 2 years at current address, please provide prior address in Remarks section)
12. Home phone \_\_\_\_\_
13. E-mail address \_\_\_\_\_
14. Telephone Interview – if more information is needed, a representative may call you. Show the most convenient place and range of times for such a call weekdays between the hours of 9:00 a.m. and 9:00 p.m.  
 Home  Business  Other – Phone \_\_\_\_\_ Times \_\_\_\_\_

### SECTION B Employment Information

1. Name of Employer \_\_\_\_\_
2. Street Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_
3. Business Phone \_\_\_\_\_
4. Business Web Site \_\_\_\_\_
5. Occupation \_\_\_\_\_
6. Job Title \_\_\_\_\_
7. Nature of Business \_\_\_\_\_
8. How many years employed? \_\_\_\_\_ (If less than 2 years please furnish information on previous employer in Remarks section, including name and address of previous employer, occupation, nature of business and job title.)



IMNB0001000010201

**SECTION C Owner Information**

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

- 1. Owner:     Individual         Trust             Business Entity         Charity
- 2. Owner name (First, MI, Last) or name of trust, business entity or charity:  
\_\_\_\_\_
- 3. Social Security No./Tax ID No. \_\_\_\_\_ 4. Relationship to proposed insured \_\_\_\_\_
- 5. Full Address (Do not use P.O. Box) \_\_\_\_\_
- 6. Telephone Number \_\_\_\_\_ 7. Owner's E-Mail Address \_\_\_\_\_

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

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

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

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

Date of Trust \_\_\_\_\_

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

**SECTION D Change of Ownership**

- 1. Is there an intention that any group of investors will obtain any right, title, or interest in any policy issued on the life of the proposed insured as a result of this application?  Yes  No
- 2. Will you (the owner/applicant) borrow money to pay the premiums for this policy or have someone else pay these premiums in return for an assignment of policy values back to them?  Yes  No  
*(If Yes to either of these questions, please complete Statement of Owner Intent form)*

**SECTION E Beneficiary Information**

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

Name (First, MI, Last)	Date of Birth	Soc. Sec. No.	Relationship to Insured	Share (enter %)	Beneficiary Type (see key)
					<input type="checkbox"/> P <input type="checkbox"/> S <input type="checkbox"/> T
					<input type="checkbox"/> P <input type="checkbox"/> S <input type="checkbox"/> T
					<input type="checkbox"/> P <input type="checkbox"/> S <input type="checkbox"/> T
					<input type="checkbox"/> P <input type="checkbox"/> S <input type="checkbox"/> T
					<input type="checkbox"/> P <input type="checkbox"/> S <input type="checkbox"/> T
					<input type="checkbox"/> P <input type="checkbox"/> S <input type="checkbox"/> T

Key: P = Primary Beneficiary; S = Secondary Beneficiary; T = Tertiary Beneficiary

**SECTION F Purpose of Insurance**

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

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

**SECTION G Proposed Insurance**

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

**3. Riders**

**Whole Life** (Note: Option Q and R riders are elected in the Dividends Section)

- Waiver of Premium (WP)  Accelerated Benefit Rider (EABR) (please complete required disclosure form)
- Scheduled/Unscheduled Paid-Up Additions (PUA) Rider  Unscheduled Only Paid-Up Additions (PUA) Rider
  - If a Scheduled PUA Payment is desired, indicate annual amount \$ \_\_\_\_\_
  - If an Initial PUA Payment is to be made, indicate amount (not including first Scheduled payment) \$ \_\_\_\_\_
  - If Waiver of Specified Amount benefit is requested, indicate annual Specified Amount \$ \_\_\_\_\_
- Guaranteed Purchase Option (GIO) → select one:  Regular GIO  Limited GIO  L10 GIO (for L10 plan only)  
Indicate GIO Option Amount: \$ \_\_\_\_\_
- Accidental Death Benefit (ADB) → Indicate ADB Face Amount: \$ \_\_\_\_\_
- 10 Year Annually Renewable Term → Term Amount: \$ \_\_\_\_\_
- Select Security Rider  Exchange of Insureds
- DuoGuard (List names & amounts for Designated Lives. Complete a separate application for each Designated Life.)  
\_\_\_\_\_

**Term**

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

**Universal Life and Variable Life Riders**

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

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

- Survivorship Waiver of Premium (Death Waiver) (available on one or both of the base policy insureds)
  - (1st Insured) \_\_\_\_\_  (2nd Insured) \_\_\_\_\_
- Policy Split Option \*  Four Year Term Rider for SUL (on both insureds) → Term Amount: \$ \_\_\_\_\_
- Single Life Term/RTR 85 (available on one or both of the base policy insureds)
  - (1st Insured) \_\_\_\_\_ \$ \_\_\_\_\_  (2nd Insured) \_\_\_\_\_ \$ \_\_\_\_\_
- Second to Die DuoGuard (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)
  - (1st Insured) \_\_\_\_\_ \$ \_\_\_\_\_  (2nd Insured) \_\_\_\_\_ \$ \_\_\_\_\_

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

**Other Riders**

- Other \_\_\_\_\_ \$ \_\_\_\_\_  Other \_\_\_\_\_ \$ \_\_\_\_\_

**SECTION H Premiums**

- 1. Mode
  - Annual  Semiannual  Quarterly  Monthly (list bill only – this may not be available for all products)
  - Guard-O-Matic (complete the appropriate Request Form)
    - New Service  Add to my existing service Existing Policy Number \_\_\_\_\_
    - Other \_\_\_\_\_
- 2. Who is to pay premiums? \_\_\_\_\_
- 3. Send premium notices to:
  - Residence  Business  Owner's address  Other \_\_\_\_\_
  - List Bill
    - New – Billing Name \_\_\_\_\_ Common billing date \_\_\_\_\_
    - Existing account # \_\_\_\_\_
- 4. Automatic Premium Loan (if available)  Yes  No (if left blank, default will be Yes)
- 5. Complete for VUL/UL policies:
  - Initial Premium \$ \_\_\_\_\_ Planned Premium (at the mode indicated above) \$ \_\_\_\_\_
- 6. Prepayment of Premium
  - No money is being submitted with this application.
  - Money is being submitted with this application, in the amount of \$ \_\_\_\_\_. By signing this application, agent is attesting that the above amount of money was collected, that the Conditional Temporary Coverage Agreement and Receipt was provided to the client and that the conditions for providing such Receipt were met. By signing this application, applicant is attesting that the 3 medical questions asked in the Conditional Temporary Coverage Agreement and Receipt form were all answered "NO", and that the applicant has received the Receipt form and agrees to its terms.

**SECTION I Dividends (for participating policies only)**

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

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

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

**SECTION J Additional Information for VUL/UL Policies**

- 1. **Death Benefit Option** (Note, not all options may be available with all policies)
  - Option 1  Option 2  Option 3  Other \_\_\_\_\_
- 2. **Section 7702 Test** (Note, the choice of 7702 Test may not apply to all policies)
 

Section 7702 of the Internal Revenue Code defines Life Insurance and specifies the rules under which the growth of life insurance policy cash values is 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

**SECTION K Financial Information**

- 1. Is the applied for policy in accordance with your insurance objectives and your anticipated financial needs?  Yes  No
- 2. Do you believe you have the financial ability to continue making premium payments on this policy?  Yes  No
- 3. Have you ever filed for personal or business bankruptcy?  Yes  No (If yes, give full details and date of discharge in Remarks section.)
- 4. **Personal Finances** (If this policy is business owned, please also complete the Business Finances section below.)

	Proposed Insured	Owner (if other than insured)
Total Assets	\$	\$
Total Liabilities	\$	\$
Net Worth	\$	\$
Earned Income	\$	\$
Unearned Income (if over \$10,000)	\$	\$

**Business Finances** (Complete only if policy is business owned)

- 5. Type of Business (Check One):  Limited Liability Co.  Sole Proprietor  Partnership  S Corp  
 C Corp  Other \_\_\_\_\_
- 6. Total Assets \$ \_\_\_\_\_ 7. Total Liabilities \$ \_\_\_\_\_ 8. Net Worth \$ \_\_\_\_\_
- 9. Net Profit After Taxes for past Two Years: Last Year \$ \_\_\_\_\_ Previous Year \$ \_\_\_\_\_
- 10. How long has the business been established? \_\_\_\_\_
- 11. What is the nature of the business? \_\_\_\_\_
- 12. What percentage of the business is owned by the proposed insured? \_\_\_\_\_
- 13. Is there business insurance applied for or in force on other key members of this firm?  Yes  No  
If "yes", please provide details: \_\_\_\_\_

**SECTION L Insurance History**

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

Name of Company	Type (e.g. individual or group)	Year Issued	Total Amount	Who Owns the Policy?	Has WP Rider?	Has ADB Rider?
					<input type="checkbox"/>	<input type="checkbox"/>
					<input type="checkbox"/>	<input type="checkbox"/>
					<input type="checkbox"/>	<input type="checkbox"/>
					<input type="checkbox"/>	<input type="checkbox"/>
					<input type="checkbox"/>	<input type="checkbox"/>

- 2. Has the proposed insured ever had life, disability, accident or medical insurance declined, postponed, modified, rated, cancelled or withdrawn a pending application, or had a renewal or reinstatement refused?  Yes  No (if yes, provide full details in Remarks)
- 3. Are any other life, disability or accident insurance products currently being applied for on the life of the insured, or is there any plan to do so in the near future?  Yes  No  
(If "Yes", in the Remarks section, please include amount and company applied with, and whether this other insurance will be in addition to or in lieu of insurance with Guardian/GIAC.)

**SECTION M Replacement**

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

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

**SECTION N Personal History of the Proposed Insured**

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

- |                                                                                                                                                                                                                                                                                                                           | Yes                      | No                       |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------|
| 1. Do you intend to change your occupation?.....                                                                                                                                                                                                                                                                          | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Do you intend to reside outside of the U.S.? <i>(If Yes, complete Foreign Travel and Residence Questionnaire)</i> .....                                                                                                                                                                                                | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Do you intend to travel outside of the U.S.?.....                                                                                                                                                                                                                                                                      | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Have you ever had your driver's license suspended or revoked, or been convicted of DUI or DWI, or within the past five years, have you been charged with and/or convicted of any motor vehicle moving violations? <i>(If yes, details must include date of violation, description of violation and penalty.)</i> ..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Within the last 10 years, have you been convicted of, or pled guilty or no contest to, a felony, or is such a charge pending against you?.....                                                                                                                                                                         | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Within the last 3 years have you flown as a licensed pilot, student pilot, or crew member in any type of aircraft, or do you intend to do so in the future? <i>(If yes, complete Aviation Supplement.)</i> .....                                                                                                       | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Within the past 3 years, have you participated in, or do you intend to participate in, any of the following activities: mountain climbing, rock climbing, scuba diving, hang gliding, parachuting, skydiving; or motor vehicle racing?.....<br><i>(If yes, complete Avocation Supplement.)</i>                         | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Are you, or do you intend to become, a member of the armed forces, including the Reserves, or are you on alert? <i>(If yes, please complete Military Status Questionnaire)</i> .....                                                                                                                                   | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Have you ever used tobacco or any other nicotine product such as cigarettes, cigars, pipe, chewing tobacco, snuff, nicotine gum, nicotine patch, or electronic nicotine delivery device? If yes, please complete chart below.....                                                                                      | <input type="checkbox"/> | <input type="checkbox"/> |

Product Type(s)	Date Last Used	Frequency of Use

**SECTION O Alternate/Additional Life Policy**

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

Please indicate:  Alternate Policy  Additional Policy

Plan of Insurance: \_\_\_\_\_ Face Amount: \_\_\_\_\_

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

**SECTION P Remarks Section**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**SECTION Q Amendments or Corrections (For Home Office Or Customer Service Office Use Only)**

# Representations of the Proposed Insured and Owner

Those parties who sign below, agree that:

1. This application, (Part 1, Part 2, the Authorization, any amendments to the application, and any required supplements or questionnaires) will form the basis for, and will be attached to and become a part of, any policy issued. That all of the statements that are part of the application are correctly recorded, and are complete and true to the best of the knowledge and belief of those persons who made them. Any misrepresentation or omission, if found to be material, may adversely affect acceptance of the risk, claims payment or may cause the Company to seek rescission of any policy that is issued based on this application.
2. No agent, broker or medical examiner has any right to accept risks, make or change contracts, or to waive or modify any of the Company's rights or requirements. No information acquired by any Representative of the Company shall bind the Company unless it shall have been set out in writing in this application.
3. For any policy that will be issued, the policy date is the date from which premiums are calculated and become due. The effective date is the date the policy is delivered and accepted by the owner, and the first premium is paid. Except as provided in the Conditional Temporary Coverage and Receipt (if an advance payment has been made and such Receipt has been issued and its terms complied with) coverage does not begin until the effective date assuming the first premium is paid during the lifetime of, and prior to any change in the health, of the Proposed Insured.
4. Changes or corrections made by the Company and noted in the "Amendments or Corrections" section are ratified by the Owner upon acceptance of a policy containing this application with the noted changes or corrections. Amendments as to plan, amount, classification, age at issue, or benefits, will be made only with the Owner's written consent.
5. By paying premiums on a basis more frequently than annually, the total premium payable during one year's time will be greater than if the premium were paid annually. That is, the cost of paying annualized periodic premiums will be more than the cost of paying one annual premium.
6.  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 by Owner at: \_\_\_\_\_ on \_\_\_\_\_  
City and State mm/dd/yyyy

**X** \_\_\_\_\_  
Signature of Proposed Insured (or Parent/Guardian if Insured under age 18)

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

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

**X** \_\_\_\_\_  
Signature of Additional Owner

**X** \_\_\_\_\_  
Witness (for applications taken by mail – should not be beneficiary)

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

**X** \_\_\_\_\_  
Signature of Licensed Agent

\_\_\_\_\_  
License Number(s)

\_\_\_\_\_  
Agent's Name

\_\_\_\_\_  
State(s) where licensed



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 receipt, "the Company" is the insurer checked above.)

## CONDITIONAL TEMPORARY COVERAGE AGREEMENT AND RECEIPT

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

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

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

**IMPORTANT NOTE TO AGENT: This receipt may only be used if all of the following are true:**

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

- 1) Has the Proposed Insured, within the last 12 months, been treated for or had any known heart attack, stroke or cancer?  Yes  No
- 2) Has the Proposed Insured, within the last 12 months, had an electrocardiogram because of chest pain or any other physical problem?  Yes  No
- 3) Within the past 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 deficiency of the immune system, such as Human Immunodeficiency Virus (HIV)?  Yes  No

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

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

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

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









Life Customer Service Office  
[3900 Burgess Place  
Bethlehem, PA 18017]

Disability Customer Service Office  
[700 South Street  
Pittsfield, MA 01201]

- THE GUARDIAN LIFE INSURANCE COMPANY OF AMERICA
  - THE GUARDIAN INSURANCE & ANNUITY COMPANY, INC.
  - BERKSHIRE LIFE INSURANCE COMPANY OF AMERICA
- (Please check appropriate company(ies). Any insurer checked above is herein referred to as the "Company.")

## Authorization to Obtain and Release Information

Name of Proposed Insured \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address of Proposed Insured \_\_\_\_\_

### This Authorization complies with the HIPAA Privacy Rule

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

**Investigative consumer report. I authorize** the Company or its legal representatives to obtain or have prepared an investigative consumer report as described in the notice given to me.

**Medical Records and other information. I authorize** any physician, medical or mental health professional, practitioner, hospital, clinic, other health facility, pharmacy, pharmacy benefit manager, consumer reporting agency, the Social Security Administration, the Medical Information Bureau, insurance or reinsurance company, or employer or other organization, institution or person that has any records or knowledge of the Proposed Insured or his/her health to release any and all medical and non-medical information in its possession about the Proposed Insured, to the Company or its legal representatives. Medical information means all information in the possession of or derived from providers of health care regarding the medical history, pharmaceutical history, mental or physical condition, or treatment of the Proposed Insured. I understand that the information released could contain reference to or results of HIV Antibody (AIDS) testing, and may relate to the symptoms, evaluation, diagnosis, examination, treatment or prognosis of any mental or physical condition, including psychiatric conditions (but excluding psychotherapy notes), and drug or alcohol abuse.

**I agree** that this authorization shall be valid for two years from the date shown below and that a copy of the authorization shall be as valid as the original.

**I know** that I may revoke this authorization in writing, at any time, by sending a written request for revocation to the Guardian Corporate Secretary at [7 Hanover Square, New York, NY 10004-2616], or the Berkshire Corporate Secretary at [700 South Street, Pittsfield, MA 01201]. I understand that a revocation is not effective to the extent that the Company and/or any of the entities listed above has already relied on this authorization, or to the extent that the Company has a legal right to contest a claim under an insurance policy or to contest the policy itself.

**I understand** that the Company or its legal representatives will use the information obtained by this authorization to determine eligibility for insurance or eligibility for benefits under an existing policy. I further understand that if I refuse to sign this authorization, the Company may not be able to process my application, or pay a claim in the case of coverage which is already in force. The Company or its legal representatives will not release any information obtained to any person or organization except to reinsurance companies, the Medical Information Bureau, Innovative Underwriters Services (a subsidiary of The Guardian Life Insurance Company of America), or other persons or organizations performing business or legal services in connection with an application, claim, or as may be lawfully permitted or required, or as I may further authorize. I understand that any information disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal regulations governing privacy (such as the HIPAA Privacy Rule).

**I acknowledge** that I have been given a copy of this authorization and also acknowledge receipt of the Notice of Insurance Information Practices, which includes the Fair Credit Reporting Act Pre-Notice, the Medical Information Bureau Pre-Notice, and Medical Records.

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

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

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





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)

**PERSONAL FINANCIAL SUPPLEMENT**

Proposed Insured (please print name): \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**PERSONAL INCOME STATEMENT**

	Current Year	Prior Year	
Salary:	_____	_____	Spouse Income if applicable: _____
Bonus:	_____	_____	_____
Interest/Dividends:	_____	_____	
Other Income:	_____	_____	source: _____

**ESTIMATED NET WORTH**

<b>ASSETS:</b>		<b>LIABILITIES:</b>	
Cash/savings	_____	Mortgages	_____
Stocks/bonds	_____		_____
Personal property	_____	Personal loans	_____
Real estate	_____		_____
Net business interest	_____	Other	_____
Other (explain)	_____		_____

**TOTAL ASSETS** \_\_\_\_\_ **TOTAL LIABILITIES** \_\_\_\_\_

**NET WORTH** \_\_\_\_\_

**REAL ESTATE:** This section to be completed if Real Estate holdings indicated

Address	Structure of Ownership	% Ownership	Date of Purchase	Fair Market Value

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.

I declare that all answers on this form are full and correct, to the best of my knowledge and belief. I agree that this Personal Financial Supplement constitutes a part of my application for insurance. The financial disclosures listed above are for the purpose of establishing financial insurability in connection with my application for insurance.

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

\_\_\_\_\_  
 Signature of Owner (if other than Proposed Insured) \_\_\_\_\_  
Date

\_\_\_\_\_  
 Third Party Signature (e.g., CPA, Attorney, Banker) \_\_\_\_\_  
Date

Third Party Printed Name and Designations \_\_\_\_\_

Third Party Address \_\_\_\_\_



**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)

**BUSINESS FINANCIAL SUPPLEMENT**

Proposed Insured (please print name): \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Name of company: \_\_\_\_\_

1. Type or organization:  Corporation  Partnership  Sole Proprietor  Other (explain) \_\_\_\_\_
2. Date Established: \_\_\_\_\_ 3. Nature of Business: \_\_\_\_\_
4. Purpose of Insurance:  Key person  Deferred Comp  Buy/Sell  Loan  Other (explain) \_\_\_\_\_
5. If key person, why is the person to be insured important to the company? \_\_\_\_\_
6. If buy/sell, is there a written agreement in effect?  Yes  No If yes, how is the business being valued in the agreement? \_\_\_\_\_
7. If loan indemnification: \_\_\_\_\_

Name of Debt Holder	Purpose of Loan	Amount of Loan	Date of Loan

8. Other Business Coverage in force:

Company	Amount	Purpose

9. What percentage of the business do you own? \_\_\_\_\_

10. Other officers or partners being insured?  Yes  No If no, why? \_\_\_\_\_

Name	% Ownership	Business Insurance In Force	Amount Currently Applied for

**11. Financial Details of the Business**

Assets: \_\_\_\_\_ Liabilities: \_\_\_\_\_ Fair Market Value: \_\_\_\_\_

Gross Sales / Revenue: [Year Ending: \_\_\_\_\_ ] \_\_\_\_\_ Previous Year: \_\_\_\_\_

Net Income (after taxes): [Year Ending: \_\_\_\_\_ ] \_\_\_\_\_ Previous Year: \_\_\_\_\_

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.

I declare that all answers on this form are full and correct, to the best of my knowledge and belief. I agree that this Business Financial Supplement constitutes a part of my application for insurance. The financial disclosures contained in this form are for the purpose of establishing financial insurability in connection with my application for insurance.

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

\_\_\_\_\_  
 Signature of Owner (if other than Proposed Insured) \_\_\_\_\_  
Date

\_\_\_\_\_  
 Third Party Signature (e.g., CPA, Attorney, Banker) \_\_\_\_\_  
Date

Third Party Printed Name and Designations \_\_\_\_\_

Third Party Address \_\_\_\_\_



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 form, "the Company" is the insurer checked above.)

### FOREIGN TRAVEL AND RESIDENCE QUESTIONNAIRE

Note, this form could be used for either the proposed insured or policyowner

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  Owner  Insured  
Please Print

1. Country of origin: \_\_\_\_\_

2. Current citizenship: \_\_\_\_\_

3. Date of entry into the United States: \_\_\_\_\_

4. Visa type, symbol, number and expiration date: \_\_\_\_\_

5. Employer: \_\_\_\_\_

Address: \_\_\_\_\_

Date of Hire: \_\_\_\_\_

6. Occupation/Duties: \_\_\_\_\_

7. List your assets/property both within and outside the USA \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

8. Have you traveled or resided outside the United States in the past 2 years?  Yes  No (If Yes, please complete below)

City & Country Visited	Dates of Stay (Duration)	Purpose of Travel (Business, pleasure, family visit, etc.)

9. Do you have any future plan to travel or reside outside the USA?  Yes  No (If Yes, please complete below)

City & Country Visiting	Dates of Stay (Duration)	Purpose of Travel (Business, pleasure, family visit, etc.)

10. Please provide a brief description of your duties while traveling or residing abroad. \_\_\_\_\_

\_\_\_\_\_

11. Will you be traveling to hazardous areas or war zones? \_\_\_\_\_

\_\_\_\_\_

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.

I declare that all answers on this form are full and correct, to the best of my knowledge and belief. I agree that this Foreign Travel and Residence Questionnaire constitutes a part of my application for insurance.

\_\_\_\_\_  
Signature of Individual Completing Form (Proposed Insured or Owner)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Agent or other Witness

\_\_\_\_\_  
Date



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 form, "the Company" is the insurer checked above.)

### MILITARY STATUS QUESTIONNAIRE

Name of Proposed Insured: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Policy Number: \_\_\_\_\_

1. Are you now a member of any military service, active or inactive?  Yes  No  
If **NO**, proceed no further. Please complete endorsement below and sign.
2. Branch of service:  Army  Navy  Marines  Air Force  Coast Guard
3. Present duty status:  Active  Active Reserve  Inactive Reserve  
 National Guard  ROTC
4. Present rank: \_\_\_\_\_
5. Present unit: \_\_\_\_\_
6. Military occupational specialty: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
7. Address of present unit: \_\_\_\_\_
8. Present assignment: \_\_\_\_\_  
\_\_\_\_\_
9. Are you now, have you ever been, or do you intend to become a pilot or crewmember of an aircraft? (If "Yes", complete Aviation Supplement)  Yes  No
10. Are you receiving any supplemental or hazardous duty pay based on your duties?  Yes  No  
(If Yes, please give details in Remarks Section)
11. To the best of your knowledge and belief, have you been told or are you aware that:
  - (a) You or your unit will be transferred overseas?  Yes  No
  - (b) You will be transferred to a new unit?  Yes  No
  - (c) You or your unit will be alerted for duty (if presently in Reserve or National Guard)?  Yes  No  
If Yes to any of the above, please provide details in Remarks Section

12. **Remarks** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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.

I declare that all answers on this form are full and correct, to the best of my knowledge and belief. I agree that this Military Questionnaire constitutes a part of my application for insurance.

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

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Agent or other Witness

\_\_\_\_\_  
Date

SERFF Tracking Number: GARD-127178720 State: Arkansas  
 Filing Company: The Guardian Life Insurance Company of America State Tracking Number: 48906  
 Company Tracking Number: L-AP-2011  
 TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other  
 Product Name: Life Application 2011 (GLIC)  
 Project Name/Number: Life Application 2011/L-AP-2011

## Supporting Document Schedules

**Item Status:** **Status Date:**

**Satisfied - Item:** Flesch Certification

**Comments:**

**Attachments:**

Readability Certification.pdf

Certificate of Compliance with Rule 19 and 49 GLIC.pdf

**Item Status:** **Status Date:**

**Satisfied - Item:** Application

**Comments:**

Applications being filed for approval are attached to the form schedule.

**Item Status:** **Status Date:**

**Satisfied - Item:** Agent's Certification

**Comments:**

We are also enclosing a copy of our Agent's Certification that will be used with this application for your information. We are not requesting approval of this form, since it is not part of the application, but it is required to be completed for all applications. We are enclosing the form primarily to demonstrate compliance with the requirement that the agent be asked the appropriate questions regarding replacement of life insurance.

**Attachment:**

Agents Certification.pdf

**Item Status:** **Status Date:**

**Satisfied - Item:** Appendix A & B

**Comments:**

Appendix A & B are attached.

**Attachments:**

AR Appendix A GLIC.pdf

SERFF Tracking Number: GARD-127178720 State: Arkansas  
Filing Company: The Guardian Life Insurance Company of State Tracking Number: 48906  
America  
Company Tracking Number: L-AP-2011  
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other  
Product Name: Life Application 2011 (GLIC)  
Project Name/Number: Life Application 2011/L-AP-2011

AR Appendix B GLIC.pdf

**Item Status:**

**Status**

**Date:**

**Satisfied - Item:** Statement of Variability

**Comments:**

**Attachment:**

Statement of Variability for L-AP-2011.pdf



## **STATE OF ARKANSAS**

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.

<b><u>Form Title</u></b>	<b><u>Form Number</u></b>	<b><u>Flesch Score</u></b>
Application for Life Insurance	L-AP-2011 AR	50.3
Conditional Temporary Coverage Agreement and Receipt	L-AP-CR-2011	48*
Amendment to Application	P89-2011	50*
Authorization to Obtain and Release Information	C-AUTH-2011	47*^
Personal Financial Supplement	L-AP-PERSFIN-SUPP-2011	50*
Business Financial Supplement	L-AP-BUSFIN-SUPP-2011	50.2*
Foreign Travel and Residence Questionnaire	L-AP-FTR-SUPP-2011	51
Military Status Questionnaire	L-AP-MILI-SUPP-2011	53.1

These forms are printed, except for specification pages, schedules and tables, in not less than ten point type, one point leaded.

\*scored with the L-AP-2011

^ fraud warning removed for purposes of scoring

A handwritten signature in black ink, appearing to read 'Pete Diggins'.

Pete Diggins  
Director, Individual Life – Product Filings and Compliance  
Date: **May 24, 2011**



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

Insurer: **The Guardian Life Insurance Company of America**  
Form Number(s):

<b>Form Title</b>	<b>Form Number</b>
Application for Life Insurance	L-AP-2011 AR
Conditional Temporary Coverage Agreement and Receipt	L-AP-CR-2011
Amendment to Application	P89-2011
Authorization to Obtain and Release Information	C-AUTH-2011
Personal Financial Supplement	L-AP-PERSFIN-SUPP-2011
Business Financial Supplement	L-AP-BUSFIN-SUPP-2011
Foreign Travel and Residence Questionnaire	L-AP-FTR-SUPP-2011
Military Status Questionnaire	L-AP-MILI-SUPP-2011

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  
Peter Diggins  
\_\_\_\_\_  
Name  
Director  
\_\_\_\_\_  
Title  
May 25, 2011  
\_\_\_\_\_  
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. 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. a. Is there a current individual Disability Income or Long-Term Care application pending with Berkshire?  Yes  No  
b. Has an individual Disability Income or Long-Term Care application been submitted to Berkshire within the past 6 months?  Yes  No  
*For a yes answer to either question, please provide the policy number and other details in the "Remarks" section.*
  
3. How long have you known the Proposed Insured? \_\_\_\_\_ Years; the Proposed Owner? \_\_\_\_\_ Years
  
4. If Proposed Insured is not gainfully employed, indicate amount of insurance on premium payor's life and relationship to Proposed Insured. \_\_\_\_\_
  
5. If beneficiary is estate, explain in Remarks why, and who will ultimately receive the proceeds of the policy?
  
6. Do you have knowledge of any existing life insurance policy or annuity contract in force on the Proposed Insured?  
 Yes  No
  
7. Do you have knowledge or reason to believe that replacement of an existing life insurance policy or annuity may be involved by reason of this transaction?  Yes  No
  
8. Will the sale of this policy involve the use of Premium Financing?  Yes  No  
(If yes, please provide the name of the lending institution and other details in the Remarks section.)
  
9. a. Did every person signing this application communicate in English well enough to understand and answer each question in English?  Yes  No (If no, please answer questions 9b, 9c, and 9d)  
b. Who acted as interpreter? \_\_\_\_\_  
c. If English was not used as the primary language, which language and/or dialect(s) was the sales interview conducted in? \_\_\_\_\_  
d. For the purpose of completing any Personal Information Telephone Interview, the proposed insured can converse comfortably in: \_\_\_\_\_
  
10. Was a preliminary inquiry previously submitted to Underwriting in connection with this application?  Yes  No  
If yes, please indicate application (policy) number: \_\_\_\_\_
  
11. Is the premium for this policy to be paid by a person or entity other than the policyowner?  Yes  No  
If yes, please provide a letter of authorization (with all required signatures) and also indicate payor's Tax ID number.  
\_\_\_\_\_
  
12. Was this application signed and dated in a state other than the state in which the policyowner lives or works?  
 Yes  No (if yes, please provide details in Remarks)



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



**State of Arkansas  
Appendix A**

<b>New Form Number</b>	<b>Replaces Form Number</b>	<b>Approval Date/ DOI File # of Replaced Form</b>
L-AP-2011 AR	L-AP-2004 AR	12/10/2009 44282,44283
L-AP-CR-2011	L-AP-CR-2004	12/16/2004
P89-2011	P89-05	12/16/2005
C-AUTH-2011	C-AUTH-2003	6/20/2003
L-AP-PERSFIN-SUPP-2011	N/A	N/A
L-AP-BUSFIN-SUPP-2011	N/A	N/A
L-AP-FTR-SUPP-2011	N/A	N/A
L-AP-MILI-SUPP-2011	N/A	N/A

**State of Arkansas  
Appendix B**

Previously Used Forms that will be used with forms submitted

<b>Form Number</b>	<b>Description</b>	<b>Approval Date/ DOI File #</b>
C-NIIP-2003	Notice of Insurance Information Practices	6/20/2003
C-MED-2003	Medical/Paramedical application supplement	6/20/2003
C-AVIA-SUPP-2003	Aviation Supplement	6/20/2003
C-AVOC-SUPP-2003	Avocation Supplement	6/20/2003
C-ADU-SUPP-2003	Alcohol & Drug Use Supplement	6/20/2003
C-AP-SUPP-2003	Blank Application Supplement	6/20/2003

## Statement of Variability for Filing of Application Forms L-AP-2011 et al

The following describes the variable data in the application forms being submitted for approval. The areas where the variables appear within the applications attached to this submission are bracketed. With your Department's consent, we intend to treat these variable fields as information that can vary, without requiring the application forms to be re-approved by your state.

For each of the applications referred to above, the following are being filed as variable:

Variable	Page Location/ Description	Range of Data, if applicable, or explanation of data
Variable 1	<b>Page 1:</b> Customer Service Office Address	This is the mailing address of our Customer Service Office used to correspond with the company. We are considering this as variable data since we would like to retain the ability to change the address of the company without resubmitting the applications. The current CSO address is 3900 Burgess Place, Bethlehem, PA 18017.
Variable 2	<b>Page 3, Section G:</b> Whole Life Riders	This section will reflect the available riders that can be attached to the whole life policy to which this application is being used. We are considering this variable data since we would like to retain the ability to update the riders that are available on our whole life portfolio without requiring a filing of the applications.
Variable 3	<b>Page 3, Section G:</b> Term Riders	This section will reflect the available riders that can be attached to the term life policy to which this application is being used. We are considering this variable data since we would like to retain the ability to update the riders that are available on our term life portfolio without requiring a filing of the applications.
Variable 4	<b>Page 3, Section G:</b> Universal Life and Variable Life Riders	This section will reflect the available riders that can be attached to a variable or universal life policy to which this application is being used. We are considering this variable data since we would like to retain the ability to update the riders that are available on our variable and universal life portfolios without requiring a filing of the applications.
Variable 5	<b>Page 3, Section G:</b> Riders for Survivorship Products	This section will reflect the available riders that can be attached to a survivorship life policy to which this application is being used. We are considering this variable data since we would like to retain the ability to update the riders that are available on our survivorship portfolio without requiring a filing of the applications.
Variable 6	<b>Page 1 on C-AUTH-2011 only:</b> Disability Customer Service Office	This is the mailing address of our Disability Customer Service Office used to correspond with the company. We are considering this as variable data since we would like to retain the ability to change the address of the company without resubmitting the applications. The current CSO address is 700 South Street, Pittsfield, MA 01201.
Variable 7	<b>Page 1 on C-AUTH-2011 only:</b> Guardian Corporate Secretary Home Office Address	This is the home office address of The Guardian Life Insurance Company of America. We are considering this as variable data since we would like to retain the ability to change the address of Guardian without resubmitting the applications. The current home office address is 7 Hanover Square, New York, NY 10004-2616.
Variable 8	<b>Page 1 on C-AUTH-2011 only:</b> Berkshire Corporate Secretary Home Office Address	This is the home office address of Berkshire Life Insurance Company of America. We are considering this as variable data since we would like to retain the ability to change the address of Berkshire without resubmitting the applications. The current home office address is 700 South Street, Pittsfield, MA 01201.