

SERFF Tracking Number: GARD-127298218 State: Arkansas
Filing Company: The Guardian Life Insurance Company of America State Tracking Number: 49205
Company Tracking Number: DI-2011 (12/11)
TOI: H111 Individual Health - Disability Income Sub-TOI: H111.007 Long Term - Related to marketing with employer or association groups
Product Name: DI-2011 (12/11)
Project Name/Number: /

Filing at a Glance

Company: The Guardian Life Insurance Company of America

Product Name: DI-2011 (12/11)

SERFF Tr Num: GARD-127298218 State: Arkansas

TOI: H111 Individual Health - Disability Income

SERFF Status: Closed-Approved-Closed State Tr Num: 49205

Sub-TOI: H111.007 Long Term - Related to marketing with employer or association groups

Co Tr Num: DI-2011 (12/11)

State Status: Approved-Closed

Filing Type: Form

Author: Cindy Ego

Reviewer(s): Rosalind Minor

Date Submitted: 07/01/2011

Disposition Date: 07/13/2011

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

Individual Market Type:

Overall Rate Impact:

Filing Status Changed: 07/13/2011

State Status Changed: 07/13/2011

Deemer Date:

Created By: Cindy Ego

Submitted By: Cindy Ego

Corresponding Filing Tracking Number:

Filing Description:

The Guardian Life Insurance Company of America is submitting application DI-2011 (12/11) which will replace DI-2011 as approved in your state on 01/12/2011, File number GARD126966349, including the use of electronic signatures. DI-CR-2011 will replace DI-CR-2007 which was approved in your state on 08/29/2007, File number GARD-125267185 and C-AUTH-2011 which will replace C-AUTH-2003 which was approved in your state on 05/22/2003.

The submitted forms are filed in our state of domicile, New 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

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submitted.

Applications

Applications DI-2011(12/11), DI-CR-2011 and C-AUTH-2011 will be used to apply for individual disability income insurance by both Berkshire Life Insurance Company of America (Berkshire Life) and The Guardian Life Insurance Company of America (Guardian.) Berkshire Life is a wholly owned subsidiary of Guardian. A separate filing will be submitted on behalf of Guardian. Other previously approved supplements to the application may be used as well.

Additionally, C-AUTH-2011 will be used to apply for life insurance and has been filed under separate cover by The Guardian Life Insurance Company of America on behalf of Berkshire Life Insurance Company of America (Berkshire Life), The Guardian Life Insurance Company of America (Guardian) and The Guardian Insurance and Annuity Company, Inc, (GIAC).We would appreciate any efforts you can make to coordinate the review of these forms. Other previously approved supplements to the application may be used as well.

Marketing

These forms will be marketed on 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 agent.

Certifications or other materials we believe you require are also enclosed, including any filing fee.

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

Fee Required? No
Retaliatory? No
Fee Explanation:
Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
The Guardian Life Insurance Company of America	\$150.00	07/01/2011	49307740

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	07/13/2011	07/13/2011

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Disposition

Disposition Date: 07/13/2011

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	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
Form	Application for Disability Insurance	Approved-Closed	Yes
Form	Conditional Receipt	Approved-Closed	Yes
Form	Authorization to Obtain and Release Information	Approved-Closed	Yes

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Form Schedule

Lead Form Number: DI-2011 (12/11)

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 07/13/2011	DI-2011 (12/11)	Application/Enrollment Form	Application for Disability Insurance	Initial		50.600	DI-2011 (12-11) Package.pdf
Approved-Closed 07/13/2011	DI-CR-2011	Application/Enrollment Form	Conditional Receipt	Initial		53.100	DI-CR-2011.pdf
Approved-Closed 07/13/2011	C-AUTH-2011	Application/Enrollment Form	Authorization to Obtain and Release Information	Initial		51.800	C-AUTH-2011.pdf



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

I. Proposed Insured Information

a. Name (First, Middle Initial, Last)	Suffix	Previous Last Name, if applicable
b. Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	g. Telephone: Home _____	
c. Social Security #: _____	Cell _____	
d. Residence Address (Street, City, State, Zip): _____ _____	E-mail Address: _____	
How long at this address? _____	h. Are you a U.S. citizen <input type="checkbox"/> Yes <input type="checkbox"/> No	
e. Date of Birth (mm/dd/yyyy): _____	If no, please provide: Visa Type _____ Visa Duration _____	
f. Place of Birth: _____	How long have you lived in the U.S. on a full-time basis? _____ <i>(If residence has not been continuous, give dates, and explain in Remarks and Special Requests section 10)</i>	
	Do you expect to remain in the U.S. permanently? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	If no, include details: _____	
	When do you expect to obtain U.S. citizenship or permanent residency? _____	

2. Business Information

a. Current Employer: _____	d. Nature of Business: _____
Number of years with current employer _____	
b. Business Address (Street, City, State, Zip): _____ _____	e. Occupation: _____
	Number of years in this occupation _____
c. Business Telephone: _____	f. Job Title (if medical or dental occupation, state specialty): _____
Business Website: _____	g. Professional licenses and designations held (if none, so state): _____

3. Occupational Information

a. Describe all activities performed in connection with the duties of your occupation, including but not limited to invasive surgical, travel, sales and supervisory duties. If the space provided is not adequate, provide additional details in Remarks & Special Requests section 10.

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. Is this a home-based occupation? Yes No If yes, what percentage of time do you spend working outside the home? ____%

e. How many hours per week are you at work in this occupation? ____ hours

f. 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 in section 10 Remarks and Special Requests.

g. Do you supervise any employees? Yes No If yes, how many? ____

h. Employment Status: Employee (no ownership) Sole Proprietor Partner ____% ownership
 S-Corporation Shareholder ____% ownership C-Corporation Shareholder ____% ownership

i. Do you plan to change your occupation, job or employment within the next six months? Yes No If yes, provide details:

j. Do you have any other part- or full-time occupations, jobs or employment? Yes No If yes, provide details:

4. Other 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

b. Do you plan to apply for or are you currently applying for any other life, long-term care, disability or accident insurance? (In Remarks and Special Requests section 10, 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

c. Describe all disability income pending and in force coverage. **If none, check here**
Type of Insurance: Individual (IDI), Group (G), Group with Conversion Option (GC), Overhead Expense (OE), Disability Buy-Out (DBO), Retirement Protection (RP), Association (A), Other (O – Explain) Status: I = In Force, P = Pending, E = Eligible For

Company Name	Type	Status	Benefit Amount	Benefit Period	Social Insurance Benefit	Catastrophic Benefit	Employer paid? (Y/N)	Is coverage being replaced? (Y/N)	Amount to be Replaced?	Date to be Replaced?
1.										
2.										
3.										
4.										

5. Personal Financial Information of the Proposed Insured

For purposes of this section, **Earned Income** and **Unearned Income** mean the income you are required to report for federal income tax purposes. **Earned Income** includes W-2 wages, salary, tips, fees, bonuses, your share of the distribution of the owners actively involved in a business, net business income, and other sources of revenue. **Unearned income** includes passive income, income from dividends, capital gains, interest (including tax exempt interest), rentals, royalties, retirement plans, alimony, investments, and business interests as an inactive owner. Fill in the income amounts below using your individual and/or business tax returns and supporting schedules. "Actual filed" means the amount of income disclosed in your filed federal income tax return for the requested year. Explain in Section 10 Remarks and Special Requests, any significant fluctuations between years or changes since the end of the most recent calendar year. Show loss amounts in parentheses.

a. **Earned Income** 1. Year-To-Date This Calendar Year \$ _____ 2. Actual Filed Last Calendar Year \$ _____ 3. Actual Filed Two Calendar Years Ago \$ _____

b. **Unearned Income** Sources: _____ 1. Actual Filed Last Calendar Year \$ _____ 2. Actual Filed Two Calendar Years Ago \$ _____

c. Do you participate in a qualified retirement plan such as a 401(k), 403(b), SIMPLE, IRA or profit sharing? Yes No

d. Total Annual Retirement Contribution (including your contribution and employer contributions):

1. Year-To-Date This Calendar Year \$ _____ 2. Actual Last Calendar Year \$ _____ 3. Actual Two Calendar Years Ago \$ _____

e. Do you wish to have this retirement contribution considered as part of your earned income? Yes No

f. Total Net Worth if 6 million dollars or more (assets minus liabilities, excluding primary residence) \$ _____
Sources: _____

g. Have you ever filed bankruptcy? Yes No

If yes, Type: Personal Business Date Filed: _____ Date Discharged: _____

6. Additional Information of the Proposed Insured

(Please provide details in Section 10 Remarks and Special Requests to all "Yes" answers)

- a. Do you plan to reside or travel outside of the U.S.? (If yes, indicate location, frequency, for work or pleasure, date of departure, length of stay.) Yes No
- b. Do you drive a motor vehicle? Yes No
Driver's License State _____ Driver's License # _____
- c. Within the past five years, have you been charged with 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. Indicate "yes" if any apply: 1) your professional license has ever been suspended or revoked; 2) there is a pending investigation or complaint concerning you with a regulatory, governmental, or other entity that oversees your profession; 3) you have ever been disbarred; or 4) you have ever been fined or sanctioned by an entity that oversees your profession. Yes No
- f. Within the last three years, have you participated, or do you plan to participate in any of the following activities: piloting any type of aircraft; mountain 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 any application for insurance declined, postponed, modified, rated, cancelled, rescinded, or have you withdrawn a pending application, or had a renewal or reinstatement request 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. 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
- j. 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
- k. 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

7. Health Information of the Proposed Insured

This Section 7 is left intentionally blank. Information pertaining to my health and medical history will be provided by me in a separate Guardian or Berkshire form or forms which become part of my application. Additional questioning of your health and medical history may be required even when Section 7 is completed.

- a. Name of your primary care physician: If none, check here Address of primary care physician (Street, City, State, Zip): _____
- b. Date and reason last consulted? _____
- c. What treatment or medication was given or recommended? _____ Primary care physician telephone: _____
- d. Height _____ feet _____ inches Current Weight _____ lbs.
- e. Weight change past year: None Gain*: _____ lbs. Loss*: _____ lbs. *Reason for change: _____

(Please provide details to all "Yes" answers in Section 10 Remarks and Special Requests. If any part of questions 7f through 7i is left blank or answered "Yes", no prepayment should be taken and no Conditional Receipt issued.)

- f. 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 or Chronic Fatigue Syndrome? Yes No
- g. Are you currently receiving any medical advice, counseling or treatment for any medical, surgical or psychiatric condition? Yes No
- h. 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
- i. Are you now pregnant? If yes, expected delivery date: _____ Yes No

- j. Are you currently taking prescription medication, or have you been prescribed any medication within the last six months? Yes No
- k. Have you ever had or been treated for cancer or tumor? Yes No
- l. In the last 10 years, have you had, been treated for or received a consultation or counseling for:
1. high blood pressure, chest pain or disorder of the heart or circulatory system? Yes No
 2. diabetes or disorder of the glands, bone, blood or skin? Yes No
 3. arthritis, rheumatism, or disorder of the joints, limbs or muscles? Yes No
 4. disorder or condition of the back, neck or spine? Yes No
 5. disorder of the eyes, ears, nose or throat? Yes No
 6. hernia, hepatitis, or disorder of the liver, gall bladder, esophagus, stomach, pancreas, spleen, intestines, colon or rectum? Yes No
 7. epilepsy, stroke, dizziness, headache, muscle weakness, or disorder of the brain or spinal cord? Yes No
 8. allergy, asthma, sinusitis, emphysema, disorder of the lungs or respiratory system, or sleep apnea? Yes No
 9. complications of pregnancy, infertility, or any disorder of the breasts, reproductive or genital organs, prostate, kidneys, or urinary systems? Yes No
 10. anxiety, depression, nervousness, stress, mental or nervous disorder, or other emotional disorder? Yes No
 11. Chronic Fatigue Syndrome, Fibromyalgia, Epstein Barr Virus or Lyme Disease? Yes No
- m. Do you have any loss of hearing or sight, an amputation of any kind, or any physical deformity, impairment or handicap? Yes No
- n. Have you ever used stimulants, hallucinogens, narcotics or any other controlled substance, 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. 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
- p. Within the past five years, have you had a physical exam or check-up of any kind? Yes No
- q. 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
- r. Other than previously stated on this application, in the last five years have you received medical advice or counseling from physician(s), medical or mental health professional(s), counselor(s), psychotherapist(s), chiropractor(s), or other practitioner(s), or have you been a patient in a hospital, clinic, sanatorium, or other medical facility? Yes No
- s. Within the past 12 months, have you had symptoms of any condition listed in this Section 7, except those conditions listed in question 7h, for which you have not sought medical attention or advice? Yes No
- t. Do either of your parents have a history of: diabetes; cancer; high blood pressure; heart disease; Huntington's Disease or mental illness? Yes No

	Age if Living	Age at Death	Cause of Death
FATHER			
MOTHER			

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

(If any part of questions 7u through 7x is answered "Yes," no prepayment should be taken and no Conditional Receipt issued.)

- u. 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
- v. 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
- w. 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
- x. 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

8. Premium Information

a. What percentage of the premium for the coverage you are applying for will be paid by your employer? None 100% Other ____%

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

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

d. Premium Mode: Annual Semiannual Quarterly Monthly – available with Group Bill and Automatic Bank Draft only

e. Billing Type: Paper Bill

Automatic Bank Draft: New service Add to my existing Guardian or Berkshire service

Group Bill: Existing Account # _____
 New – Billing Name _____ Common Billing Day _____

f. Send premium notices to: Residence Owner's Address Business Other _____

g. Prepayment of Premium – A prepayment must be accompanied by a signed Conditional Receipt and section 7 must be completed.

No money has been submitted with this application.

\$ _____ has been submitted with this application for proposed insurance.

9. Coverage Applied For

Indicate all insurance applied for with this application and specify coverage desired. Complete the appropriate product supplement for Overhead Expense, Disability Buy-Out and Income ProVider. Complete column A and question h when applying for ProVider Plus, column B and question i for Retirement Protection as a stand-alone policy, and column C and questions j through n for Reducing Term.

	Column A	Column B	Column C	Column D	Column E
	Disability Income	Disability Income – Retirement Protection	Reducing Term	Overhead Expense	Disability Buy-Out
a. Indemnity/Benefit Amount	\$ _____	\$ _____	\$ _____	\$ _____	Complete Supplement
b. Policy Form Number					
c. Own Occupation Definition of Disability	<input type="checkbox"/> True <input type="checkbox"/> Modified	Modified	Modified	True	True
d. Premium Structure	<input type="checkbox"/> Level <input type="checkbox"/> Graded	<input type="checkbox"/> Level <input type="checkbox"/> Graded	Level	Level	Level
e. Elimination Period		<input type="checkbox"/> 180 days <input type="checkbox"/> 360 days			
f. Benefit Period/Term		To Age 65			
g. Occupation Class					
Supplemental Benefits	Complete question h	Complete question i	Complete questions j – n	Complete Supplement	Complete Supplement

Complete the Following When Applying for Disability Income

h. Supplemental Benefits – ProVider Plus

	ProVider Plus	ProVider Plus Limited
Residual Disability Benefits	<input type="checkbox"/> Residual Disability <input type="checkbox"/> Partial Disability	<input type="checkbox"/> Basic Residual Disability
Cost of Living Adjustments	<input type="checkbox"/> 3% Compound <input type="checkbox"/> 6% Maximum <input type="checkbox"/> Four-Year Delayed	<input type="checkbox"/> 3% Maximum (CPI-Tied)
Extended Benefits	<input type="checkbox"/> Lump Sum Disability Benefit <input type="checkbox"/> Graded Lifetime Indemnity for Total Disability	
	<input type="checkbox"/> Future Increase Option \$ _____	
Benefits listed at right are available with both ProVider Plus and ProVider Plus Limited	<input type="checkbox"/> Catastrophic Disability Benefit \$ _____	
	<input type="checkbox"/> Retirement Protection Plus: Monthly Indemnity \$ _____ Elimination Period <input type="checkbox"/> 180 days <input type="checkbox"/> 360 days	
	<input type="checkbox"/> Social Insurance Substitute \$ _____	
	<input type="checkbox"/> Unemployment Waiver of Premium	
	<input type="checkbox"/> Other _____ <input type="checkbox"/> Other _____	

Complete the Following When Applying for Retirement Protection (separate policy)

- i. Supplemental Benefits – ProVider Plus: Retirement Protection
- Cost of Living Adjustment: 3% Compound 6% Maximum
 - Future Increase Option \$ _____
 - Other _____

Complete the Following When Applying for Reducing Term Insurance

j. Loss Payee Name: _____

(Must be the individual or entity that the money is owed to.)

Loss Payee Tax ID #: _____

Business Address (Street, City, State, Zip):

Owner Name: _____

Owner Tax ID #: _____

k. Provide type and reason that the obligation was incurred:

- Business Loan
- Purchase Agreement
- Employment Contract
- Student Loan – Have you deferred payments of this loan or do you intend to do so?
 Yes No If yes, describe how long below.

Details: _____

Other _____

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

m. Names of all debtors or guarantors:

- n. 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

10. Remarks and Special Requests

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. For additional space use the Supplement to the Application for Insurance (C-APP-SUPP).

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

12. Representations of the Proposed Insured and Owner

Those parties who sign below, agree that:

1. This Application for Disability Insurance, 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 replaced in answer to Question 4c 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 and those available by law. 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

**Application for Disability Insurance –
Income ProVider Disability Insurance Supplement**

I. Proposed Insured Information

a. Name (First, Middle Initial, Last)

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

2. Personal Disability Insurance

a. Case # _____

b. Supplemental Benefits

Basic Residual Disability

Enhanced Residual Disability

Extended Own Occupation

True Own Occupation

Cost of Living Adjustment

3% 6%

Catastrophic Disability Benefit \$ _____

Other _____



GUARDIAN®

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

Application for Disability Insurance – Disability Buy-Out Insurance Supplement

I. Proposed Insured Information

a. Name (First, Middle Initial, Last) _____ b. Date of Birth (mm/dd/yyyy) _____

2. Disability Buy-Out Insurance

a. Funding: Monthly Lump Sum Down Payment Benefit Amount: Monthly: \$ _____ Lump Sum: \$ _____

b. Supplemental Benefits: Future Increase Option: Monthly: \$ _____ Lump Sum: \$ _____
 Other _____

c. Type of disability buy-sell agreement: 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, Middle Initial, Last) or name of trust or company: _____

Relationship to the Proposed Insured _____

Social Security #: _____

Tax ID #: _____

Address (Street, City, State, Zip):

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 more than four partners or if there are any on whom Disability Buy-Out is not carried or proposed on the Supplement to Application for Insurance, list or explain in the Application for Disability Insurance, Section 10 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 in the Application for Disability Insurance, Section 10 Remarks and Special Requests.

g. Indicate type of business organization: Professional Corporation/Personal Service Partnership
 Commercial Business

h. Business Financial Information

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



GUARDIAN®

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

Application for Disability Insurance – Overhead Expense Insurance Supplement

I. Proposed Insured Information

a. Name (First, Middle Initial, Last)

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

2. Overhead Expense Insurance

a. Supplemental Benefits Future Increase Option \$ _____

Supplemental Overhead Expense Benefit Other _____

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

c. 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? Provide details in the Application for Disability Insurance, Section 10 Remarks and Special Requests.

d. Owner Information (if other than the Proposed Insured)

Name of Owner (First, Middle Initial, Last) or name of trust or company: _____

Relationship to the Proposed Insured: _____

Owner's Address (Street, City, State, Zip): _____

Tax ID or Social Security #: _____

e. Monthly Expenses of the Business Entity – What are the current average monthly overhead expenses incurred for the items shown? (If responsible 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 _____

Mortgage Interest (Paid to Banks, etc.) _____

Other Interest _____

Legal and Professional Services _____

Office Expenses _____

Pension and Profit Sharing Plans _____

Rent or Lease (Other Business Property) _____

Repairs and Maintenance _____

Taxes and Licenses _____

Utilities _____

Wages (exclude compensation for members of insured's profession) _____

Other Expenses (itemized): _____

TOTAL (Should agree with 2b.) \$ _____

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. Available with policy form 4200 Salary Replacement.



- 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.")*

Conditional Receipt for Disability Insurance

This receipt does not create any temporary or interim insurance. This receipt sets the date and conditions under which the insurance being applied for will go into effect. Unless all of the conditions in paragraph 2 below are met in full, no insurance will become effective. No agent of the Company and no broker is authorized to alter or waive any of the Company's requirements.

If Questions 7f, 7g, 7h or 7i on the accompanying Application for Insurance are left blank or answered "Yes" no prepayment should be taken and no Conditional Receipt can be issued. However, with respect to question 7g, if the proposed insured's only medical advice, counseling, or treatment was a routine physical examination resulting in no diagnosis being made or treatment rendered, or for the common cold with a complete recovery, then a prepayment can be taken and a Conditional Receipt can be issued.

If Question 7u, 7v, 7w or 7x is answered "Yes," no prepayment should be taken and no Conditional Receipt can be issued.

1. **Effective Date** – As used herein, "Effective Date" means the latest of (i) the date of the Application for Insurance, (ii) the date of the Representations to the Medical Examiner (or the date of the latest if more than one is required), (iii) the date of this receipt, (iv) the date of the latest completion of any medical examinations, tests, x-rays and electrocardiograms that the Company requires, or (v) the Policy Date, if any, requested in the Application.
2. **Conditions Under Which Insurance May Become Effective** – The insurance in the amount and for the policy applied for will, subject to the limitations in paragraph 4, become effective as of the Effective Date only if all of the following conditions are met:
 - (a) an initial premium payment has been made as acknowledged below and honored on first presentation for payment. The check must be made payable to the Company (do not make check payable to the producer or leave payee blank);
 - (b) on the Effective Date the proposed insured is, in the opinion of the Company authorized officers, insurable and an acceptable risk under the Company rules, limits and standards for the proposed insurance amount, policy, and benefits exactly as applied for without restriction or modification;
 - (c) on the date of this receipt, all answers and statements in any part of the application(s) having an earlier date are complete and true as though given on the date of this receipt;
 - (d) information required by the Company to determine insurability must be received at the Company's Home Office within 60 days of the date of this receipt.

If any one of these conditions is not met, this receipt is void and there shall be no liability on the part of the Company. The Company will return the payment accompanying this receipt in the form of a Company check.

3. **Amendment of Application** – If the Company does not approve the application as applied for or if I request a modification as to the amount of insurance, policy, or benefits subsequent to the date of this receipt, then I understand that this receipt is void and there shall be no liability on the part of the Company. Should the Company offer insurance other than as applied for or in response to my request for a modification, such insurance shall not be effective unless and until:
 - (a) the modified policy is delivered; and
 - (b) an amendment of the application to adjust the provisions of the contract is signed by the proposed insured and the owner; and
 - (c) the health and other conditions affecting the insurability of the proposed insured continues to remain the same as described in the Application for Insurance and the Representations to the Medical Examiner.

One Copy to Applicant

One Copy to Company

4. **Maximum Limits** – If the disability of the proposed insured occurs prior to the Company’s approval, and the proposed insured satisfies the conditions set forth in paragraph 2 above, the Company’s liability shall not be greater than the total amount of insurance (for the policy applied for) set forth in the schedule to the right. This amount shall be inclusive of all of the insurance on the proposed insured under conditional receipt pending and insurance in force with the Company.

Age*	Disability Income Limits	Total Disability Buy-Out Limits	Disability Overhead Expense Limits
under 56	\$5,000/mo.	\$500,000	\$5,000/mo.
56-60	4,000/mo.	400,000	4,000/mo.
61-64	0	**	**

*Age means age of proposed insured at birthday nearest date of Conditional Receipt.
 **Products not available.

5. **Acknowledgement of Payment** – We have received from _____ (applicant):

(a) the sum of \$_____ to pay all or part of the first premium for the proposed disability income insurance policy;

(b) the sum of \$_____ to pay all or part of the first premium for the proposed disability buy-out insurance policy;

(c) the sum of \$_____ to pay all or part of the first premium for the proposed overhead expense insurance policy;

on _____ (proposed insured) in accordance with the Application(s) for insurance.

6. **Period of Coverage** – If less than the first full premium has been paid according to the mode of payment selected for the policy type and the amount of insurance applied for, any insurance effective under paragraphs 2 and 3 above shall be in force only for the pro rata portion of the policy year for which the premium has been paid. This portion of the policy year begins on the Effective Date and does not include any grace period.

I have read this receipt and have received a copy signed by the producer. I understand that insurance becomes effective only if all the conditions of paragraph 2 are met and then only from the Effective Date, and for not more than the limitations in paragraph 4. I understand that if a policy date is requested in the application that is later than the date of either the Application for Insurance or the Representations to the Medical Examiner, I am waiving some rights under this receipt. I further understand that this receipt is void if there is any incorrect, untrue, incomplete or omitted statement of material fact in the Application for Insurance, Representations to the Medical Examiner, or any supplemental form that becomes part of any policy issued.

Signed _____ Applicant(s) Date _____ (mm/dd/yyyy)

Signed _____ Producer Date _____ (mm/dd/yyyy)



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

SERFF Tracking Number: GARD-127298218 State: Arkansas
 Filing Company: The Guardian Life Insurance Company of America State Tracking Number: 49205
 Company Tracking Number: DI-2011 (12/11)
 TOI: H111 Individual Health - Disability Income Sub-TOI: H111.007 Long Term - Related to marketing with employer or association groups
 Product Name: DI-2011 (12/11)
 Project Name/Number: /

Supporting Document Schedules

	Item Status:	Status Date:
Satisfied - Item: Flesch Certification	Approved-Closed	07/13/2011
Comments:		
Attachment: Guardian Application Flesch Score.pdf		

	Item Status:	Status Date:
Satisfied - Item: Application	Approved-Closed	07/13/2011
Comments: This is the application filing.		

	Item Status:	Status Date:
Bypassed - Item: Health - Actuarial Justification	Approved-Closed	07/13/2011
Bypass Reason: n/a - This is an application form filing only.		
Comments:		

	Item Status:	Status Date:
Bypassed - Item: Outline of Coverage	Approved-Closed	07/13/2011
Bypass Reason: n/a- This is an application form filing only.		
Comments:		

THE GUARDIAN LIFE INSURANCE COMPANY OF AMERICA
700 South Street
Pittsfield MA 01201

CERTIFICATION

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

<u>Form Number</u>	<u>Sentences</u>	<u>Words</u>	<u>Syllables</u>	<u>Flesch Score</u>
DI-2011 (12/11)	165	4,732	7,626	50.6
DI-CR-2011	158	3,834	5,855	53.1
C-AUTH-2011	144	3,412	5,708	51.8



June 30, 2011

John J. Monahan, Officer
Director of Individual Market Compliance