

State: Arkansas **Filing Company:** Berkshire Life Insurance Company of America
TOI/Sub-TOI: H111 Individual Health - Disability Income/H111.007 Long Term - Related to marketing with employer or association groups
Product Name: C-AUTH-2013
Project Name/Number: /

Filing at a Glance

Company: Berkshire Life Insurance Company of America
Product Name: C-AUTH-2013
State: Arkansas
TOI: H111 Individual Health - Disability Income
Sub-TOI: H111.007 Long Term - Related to marketing with employer or association groups
Filing Type: Form
Date Submitted: 11/15/2012
SERFF Tr Num: GARD-128763239
SERFF Status: Closed-Approved-Closed
State Tr Num:
State Status: Approved-Closed
Co Tr Num: C-AUTH-2013

Implementation
Date Requested:
Author(s): Sara Cunningham, Caitlin Nickerson
Reviewer(s): Rosalind Minor (primary)
Disposition Date: 11/16/2012
Disposition Status: Approved-Closed
Implementation Date:

State Filing Description:

State: Arkansas **Filing Company:** Berkshire Life Insurance Company of America
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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: 11/16/2012
State Status Changed: 11/16/2012
Deemer Date: Created By: Sara Cunningham
Submitted By: Caitlin Nickerson Corresponding Filing Tracking Number: GARD-128763344

Filing Description:

We are enclosing for your review several revised application supplements. Form C-AUTH-2013 replaces C-AUTH-2011 which was previously approved on 7/13/2011 under File Number GARD-127298755. Form DI-CR-2013 replaces DI-CR-2011 which was previously approved on 7/13/2011 under File Number GARD-127298755. Form NON-MED-AUTH-2013 is new and does not replace any previously approved form. These new forms will be effective January 1, 2013 and will be used with all previously approved applications and supplements, as well as those approved in the future.

These application supplements 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). A separate submission of these forms on behalf of Guardian is also being made with your Department. We would appreciate any efforts your Department can make to coordinate the filing of these forms for all companies.

The NON-MED-AUTH-2013 form is used when applying for disability income insurance that does not require any medical underwriting.

A revision is being made to the C-AUTH-2013 in order to comply with the new language required by the Medical Information Bureau (MIB) that the application contains a clear authorization that a report of personal health information may be made to the MIB. Also included is a statement of variability, which describes those elements of the application that are variable in nature. 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 it for approval.

Company and Contact

Filing Contact Information

Caitlin Nickerson, Policy Forms Filing Specialist I	Caitlin_Nickerson@glic.com
700 South Street	413-395-4319 [Phone]
Pittsfield, MA 01201	413-395-5993 [FAX]

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Filing Company Information

Berkshire Life Insurance Company of America	CoCode: 71714	State of Domicile: Massachusetts
700 South Street	Group Code: 429	Company Type:
Pittsfield, MA 01201	Group Name:	State ID Number:
(413) 499-4321 ext. [Phone]	FEIN Number: 75-1277524	

Filing Fees

Fee Required? Yes
 Fee Amount: \$150.00
 Retaliatory? No
 Fee Explanation: 3 forms at \$50/form
 Per Company: No

Company	Amount	Date Processed	Transaction #
Berkshire Life Insurance Company of America	\$150.00	11/15/2012	64928385

SERFF Tracking #:

GARD-128763239

State Tracking #:

Company Tracking #:

C-AUTH-2013

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	11/16/2012	11/16/2012

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Disposition

Disposition Date: 11/16/2012

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	Yes
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Supporting Document	Statement of Variability	Approved-Closed	Yes
Form	Authorization to Obtain and Release Information	Approved-Closed	Yes
Form	Conditional Receipt for Disability Insurance	Approved-Closed	Yes
Form	Insurance Information Practices and Authorization to Obtain and Release Non-Medical Information	Approved-Closed	Yes

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Form Schedule

Lead Form Number: C-AUTH-2013

Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments
1	Approved-Closed 11/16/2012	Authorization to Obtain and Release Information	C-AUTH-2013	AEF	Initial		45.000	C-AUTH-2013.pdf
2	Approved-Closed 11/16/2012	Conditional Receipt for Disability Insurance	DI-CR-2013	AEF	Initial		53.100	DI-CR-2013.pdf
3	Approved-Closed 11/16/2012	Insurance Information Practices and Authorization to Obtain and Release Non-Medical Information	NON-MED-AUTH-2013	AEF	Initial		50.200	NON-MED-AUTH-2013.pdf

Form Type Legend:

ADV	Advertising	AEF	Application/Enrollment Form
CER	Certificate	CERA	Certificate Amendment, Insert Page, Endorsement or Rider
DDP	Data/Declaration Pages	FND	Funding Agreement (Annuity, Individual and Group)
MTX	Matrix	NOC	Notice of Coverage
OTH	Other	OUT	Outline of Coverage
PJK	Policy Jacket	POL	Policy/Contract/Fraternal Certificate
POLA	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	SCH	Schedule Pages



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 Is Designed To Comply 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, MIB, Inc., 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, and psychological conditions, 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 agree that if I sign this authorization electronically, that it will be equally as effective and valid as if I signed the form through traditional means. I understand, however, that I am under no obligation to sign this document electronically.

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, MIB, Inc., 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 authorize the Company or its legal representatives to make a brief report of my personal health information to the MIB, Inc.

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



- 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.

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)



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 and an administrator for The Guardian Life Insurance Company of America, New York, NY

Insurance Information Practices

This notice is given to you at the time you apply for disability insurance to tell you about the information we may obtain with your application. Only qualified members of our Company's staff or its legal representatives will have access to your file to evaluate your eligibility for insurance. Your authorization will govern our request for information and any later disclosure of that information. We will treat all personal information about you as confidential. You have a right of access and correction with respect to this information. If you wish a more detailed explanation of our Information Practices, please send your written request to the Privacy Office of the Guardian Corporate Family at 7 Hanover Square, New York, NY 10004-2616.

Authorization to Obtain and Release Non-Medical Information

Name of Proposed Insured _____ Date of Birth _____

Address of Proposed Insured _____

I authorize any insurance or reinsurance company, employer, or other organization, institution or person that has any records or knowledge of me to release any and all non-medical information in its possession about me, to Berkshire Life Insurance Company of America ("Company") or its legal representatives. I authorize the Company to obtain information on disability coverage in force or applied for from the Disability Income Reporting System through MIB, Inc.

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. The Company or its legal representatives will not release any information obtained to any person or organization except to reinsurance companies, MIB, Inc. , or other persons or organizations performing business or legal services in connection with an application, or as may be lawfully required, or as I may further authorize.

I know that I may revoke this authorization in writing, at any time, by sending a written request for revocation to the 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 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 agree that if I sign this authorization electronically, that it will be equally as effective and valid as if I signed the form through traditional means. I understand, however, that I am under no obligation to sign this document electronically.

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

Signature of Proposed Insured

Witness Signature

State: Arkansas

Filing Company: Berkshire Life Insurance Company of America

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Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification	Approved-Closed	11/16/2012
Comments:			
Attachment(s):			
Berkshire Application Flesch Score.pdf			

		Item Status:	Status Date:
Satisfied - Item:	Application	Approved-Closed	11/16/2012
Comments:	This is an application filing.		

		Item Status:	Status Date:
Bypassed - Item:	Outline of Coverage	Approved-Closed	11/16/2012
Bypass Reason:	This is an application form filing only.		

		Item Status:	Status Date:
Satisfied - Item:	Statement of Variability	Approved-Closed	11/16/2012
Comments:			
Attachment(s):			
Statement of Variability for C-AUTH-2013.pdf			

BERKSHIRE 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-CR-2013	158	3,834	5,855	53.1
C-AUTH-2013	144	3,412	5,708	45.0
NON-MED-AUTH-2013	16	527	767	50.2



November 9, 2012

Donna K. Owens, Officer
Director of Product Development

Statement of Variability for Filing of Application Form C-AUTH 2013

The following describes the variable data in the application form being submitted for approval. The areas where the variables appear within the application 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 form to be re-approved by your state.

For the application 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	Page 1: 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	Page 1: 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 3	Page 1: 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 4	Page1: 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.