Filing at a Glance

Company: Berkshire Life Insurance Company of America

Product Name: 1406	SERFF Tr Num: GARD-127298755	State: Arkansas
TOI: H11I Individual Health - Disability Income	SERFF Status: Closed-Approved-Closed	State Tr Num: 49199
Sub-TOI: H11I.007 Long Term - Related to marketing with employer or association groups	Co Tr Num: 1406	State Status: Approved-Closed
Filing Type: Form/Rate		Reviewer(s): Rosalind Minor
	Author: Cindy Ego	Disposition Date: 02/01/2012
	Date Submitted: 06/30/2011	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: 02/01/2012
	State Status Changed: 07/13/2011
Deemer Date:	Created By: Cindy Ego
Submitted By: Cindy Ego	Corresponding Filing Tracking Number:

Filing Description:

Berkshire Life Insurance Company of America is submitting the forms listed below for your review and approval. The application and riders will be used with policy 1400 (06/10). Policy 1400 (06/10) and the riders to be replaced as indicated below were approved in your state on 03/02/2010, File Number GARD-126519729.

Forms 1417(07/11), 1417-A (07/11), 1418 (07/11), 1418-A (07/11), 1419 (07/11), and 1426-E (07/11) are new and do not replace any previously approved forms.

Form 1406 (07/11) includes a language revision and will replace the form indicated below.

We are submitting new rate factors for form 1415 (07/11). The language is exactly the same as previously approved.

The premium rates included in this filing will be calculated based on factors that will be applied to the existing approved and proposed rates for the true own occupation definition of disability. The ABE rider and the Benefit Purchase rider are no-cost riders.

Application DI-2011 (12/11) will replace DI-2011 as approved in your state on 03/02/2010, File number GARD-126519729 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-125267134 and C-AUTH-2011 which will replace C-AUTH-2003 which was approved in your state on 05/22/2003.

These forms and rates are filed concurrently in our state of domicile, Massachusetts. Additionally we are concurrently filing riders with the exact language for use with previously approved Policy Forms 1500 (06/10) and 1600 (06/10). The only differences between these filings are the rates. The riders for policy form 1500 (06/10) have unisex rates and are used for employer-sponsored programs where the employer is paying the premium. The riders for policy form 1600 (06/10) have unisex rates and will be used primarily for employer sponsored programs where the employee is paying the premiums. Any effort you can make to keep these three filings together will be appreciated. If the forms submitted in your state contain a state suffix, all references in this letter to such form number without a state suffix apply to the suffixed version submitted.

RIDERS REPLACES
1406 (07/11) Automatic Benefit Enhancement Rider 1406 (06/10)
1415 (07/11) Retirement Protection Plus Rider 1415 (06/10)
1417 (07/11) Basic Residual Disability Benefit Rider
1418 (07/11) 3% Maximum Cost of Living Adjustment Rider
1419 (07/11) Benefit Purchase Rider
1417-A (07/11) Basic Residual Disability Benefit Rider – Add-on
1418-A (07/11) 3% Maximum Cost of Living Adjustment Rider – Add-on

ENDORSEMENT
1426-E (07/11) Endorsement Amending “Incontestable” Provision

APPLICATION REPLACES

DI-2011 (12/11) Application For Disability Insurance DI-2011
DI-CR-2011) Conditional Receipt DI-CR-2007

C-AUTH-2011 Authorization to Obtain and Release Information C-AUTH-2003

Riders

Automatic Benefit Enhancement Rider – 1406 (07/11) The Automatic Benefit Enhancement Rider is a no-cost rider that will provide up to six annual automatic increases in the future, with each increase representing 4% of the then current monthly indemnity of the base policy. No proof of insurability is required. Exercised increases are at attained age rates.

Retirement Protection Plus (RPP) Disability Benefit Rider – 1415 (07/11) – The Retirement Protection Plus Disability Benefit Rider provides a monthly indemnity benefit payable to an irrevocable trust in the event an insured is totally disabled and is not gainfully employed. When the insured reaches age 65, the trust assets are distributed to the insured.

Basic Residual Disability Benefit Rider – 1417 (07/11), 1417-A (07/11) The Basic Residual Disability Benefit Rider provides a benefit when the insured is gainfully employed in their occupation and is not totally disabled under the terms of the policy but, solely because of sickness or injury, the insured's loss of income is at least 20% of the insured's prior income, and either 1) the insured is able to perform one or more, but not all, of the material and substantial duties of their occupation or 2) they are able to perform all of the material and substantial duties of their occupation but not for the length of time they normally require.

3% Maximum Cost of Living Adjustment Rider – 1418 (07/11), 1418-A (07/11) The 3% Maximum Cost of Living Adjustment Rider provides an adjustment in monthly indemnity on the anniversary of a claim applicable for the next 12 months while benefits are payable. Adjustments are triggered by the change in the CPI-U, but will never be greater than 3% in any given year.

Upon recovery, the insured receives the incremental monthly indemnity generated by this rider at no additional cost.

Benefit Purchase Rider – 1419 (07/11) The Benefit Purchase Rider is a no cost rider that provides an insured an opportunity to purchase additional coverage once every three years without providing evidence of good health. A special benefit purchase option offer may be used by the insured if he or she loses his or her group LTD coverage and it is not subsequently replaced or the insured has at least a 50% increase in income.

Endorsements

Endorsement Amending "Incontestable" Provision- 1426-E (07/11 – This endorsement is included to address the incontestable period provision if a separate policy is issued under the benefit purchase rider.

Applications

Application DI-2011(12/11), and DI-CR-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.

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.)

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.

Enclosed with this submission are rate factors for these forms as well as the supporting actuarial material. 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
Pittsfield, MA 01201
413-395-4319 [Phone]

Filing Company Information

Berkshire Life Insurance Company of America	CoCode: 71714	State of Domicile: Massachusetts
700 South Street	Group Code:	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:	$550.00
Retaliatory?	No
Fee Explanation:	11 forms @ $50
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Berkshire Life Insurance Company of America	$550.00	06/30/2011	49292381

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	02/01/2012	02/01/2012
Approved-Closed	Rosalind Minor	07/13/2011	07/13/2011

Amendments

Schedule	Schedule Item Name	Created By	Created On	Date Submitted
Form	Basic Residual Disability Benefit Rider	Cindy Ego	01/30/2012	01/30/2012
Form	Basic Residual Disability Benefit Rider - Add-on	Cindy Ego	01/30/2012	01/30/2012
Supporting Document	Outline of Coverage	Cindy Ego	01/30/2012	01/30/2012
Form	Basic Residual Disability Benefit Rider	Cindy Ego	01/30/2012	01/30/2012
Form	Basic Residual Disability Benefit Rider - Add-on	Cindy Ego	01/30/2012	01/30/2012
Supporting Document	Outline of Coverage	Cindy Ego	01/30/2012	01/30/2012
Supporting Document	Red-Lined Forms	Cindy Ego	01/30/2012	01/30/2012

Disposition

Disposition Date: 02/01/2012
Implementation Date:
Status: Approved-Closed
Comment:

The outline of coverage and rider forms will maintain their original approval date of 7/13/11. The other replacement forms are being withdrawn on this date.

Company Name:	**Overall % Indicated Change:**	**Overall % Rate Impact:**	**Written Premium Change for this Program:**	**# of Policy Holders Affected for this Program:**	**Written Premium for this Program:**	**Maximum % Change (where required):**	**Minimum % Change (where required):**
Berkshire Life Insurance Company of America	0.000%	0.000%	$0	0	$0	0.000%	0.000%

SERFF Tracking Number:	*GARD-127298755*	*State:*	*Arkansas*
Filing Company:	*Berkshire Life Insurance Company of America*	*State Tracking Number:*	*49199*
Company Tracking Number:	*1406*		
TOI:	*H11I Individual Health - Disability Income*	*Sub-TOI:*	*H11I.007 Long Term - Related to marketing with employer or association groups*
Product Name:	*1406*		
Project Name/Number:	*/*		

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 *(revised)*	Outline of Coverage	Approved-Closed	Yes
Supporting Document	Outline of Coverage	Withdrawn	No
Supporting Document	Outline of Coverage	Withdrawn	No
Supporting Document	Red-Lined Forms	Approved-Closed	Yes
Form	Automatic Benefit Enhancement Rider	Approved-Closed	Yes
Form	Retirement Protection Plus Rider	Approved-Closed	Yes
Form *(revised)*	Basic Residual Disability Benefit Rider	Approved-Closed	Yes
Form	Basic Residual Disability Benefit Rider	Withdrawn	No
Form	Basic Residual Disability Benefit Rider	Withdrawn	No
Form	3% Maximum Cost of Living Adjustment Rider	Approved-Closed	Yes
Form	Benefit Purchase Rider	Approved-Closed	Yes
Form *(revised)*	Basic Residual Disability Benefit Rider - Add-on	Approved-Closed	Yes
Form	Basic Residual Disability Benefit Rider - Add-on	Withdrawn	No
Form	Basic Residual Disability Benefit Rider - Add-on	Withdrawn	No
Form	3% Maximum Cost of Living Adjustment Rider- Add-on	Approved-Closed	Yes
Form	Endorsement Amending "Incontestable" Provision	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

Disposition

Disposition Date: 07/13/2011
Implementation Date:
Status: Approved-Closed
Comment:

Company Name:	Overall % Indicated Change:	Overall % Rate Impact:	Written Premium Change for this Program:	# of Policy Holders Affected for this Program:	Written Premium for this Program:	Maximum % Change (where required):	Minimum % Change (where required):
Berkshire Life Insurance Company of America	0.000%	0.000%	$0	0	$0	0.000%	0.000%

SERFF Tracking Number:	*GARD-127298755*	*State:*	*Arkansas*
Filing Company:	*Berkshire Life Insurance Company of America*	*State Tracking Number:*	*49199*
Company Tracking Number:	*1406*		
TOI:	*H11I Individual Health - Disability Income*	*Sub-TOI:*	*H11I.007 Long Term - Related to marketing with employer or association groups*
Product Name:	*1406*		
Project Name/Number:	*/*		

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 *(revised)*	Outline of Coverage	Approved-Closed	Yes
Supporting Document	Outline of Coverage	Withdrawn	No
Supporting Document	Outline of Coverage	Withdrawn	No
Supporting Document	Red-Lined Forms	Approved-Closed	Yes
Form	Automatic Benefit Enhancement Rider	Approved-Closed	Yes
Form	Retirement Protection Plus Rider	Approved-Closed	Yes
Form *(revised)*	Basic Residual Disability Benefit Rider	Approved-Closed	Yes
Form	Basic Residual Disability Benefit Rider	Withdrawn	No
Form	Basic Residual Disability Benefit Rider	Withdrawn	No
Form	3% Maximum Cost of Living Adjustment Rider	Approved-Closed	Yes
Form	Benefit Purchase Rider	Approved-Closed	Yes
Form *(revised)*	Basic Residual Disability Benefit Rider - Add-on	Approved-Closed	Yes
Form	Basic Residual Disability Benefit Rider - Add-on	Withdrawn	No
Form	Basic Residual Disability Benefit Rider - Add-on	Withdrawn	No
Form	3% Maximum Cost of Living Adjustment Rider- Add-on	Approved-Closed	Yes
Form	Endorsement Amending "Incontestable" Provision	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

Amendment Letter

Submitted Date: 01/30/2012

Comments:

We are going to use the riders and outlines of coverage as originall approved. We are withdrawing the revised forms from further consideration.

Sorry about any inconvenience we have caused.

Changed Items:

Form Schedule Item Changes:

Form Schedule Item Changes:

Form Number	Form Type	Form Name	Action	Form Action Other	Previous Filing #	Replaced Form #	Readability Score	Attachments
1417 (07/11)	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Basic Residual Disability Benefit Rider	Initial				51.200	1417_07-11.pdf
1417-A (07/11)	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Basic Residual Disability Benefit Rider - Add-on	Initial				52.100	1417-A _07-11_.pdf

Supporting Document Schedule Item Changes:

Satisfied -Name: Outline of Coverage

Comment:

TDOC (12-11).pdf

Amendment Letter

Submitted Date: 01/30/2012

Comments:

We have corrected an error we discovered in the Basic Residual Disability Benefit Riders which have not been marketed or sold in your state. The revisions do not impact the rates previously approved by your Department.

Specifically, we slightly modified the definition of Residual Disability and Residually Disabled so as to ensure that we are paying residual indemnity in all appropriate situations—a correction that benefits the insured. Again, these riders have not yet been marketed or sold and the revisions do not impact the rates previously approved by your Department.

The Basic Residual Disability Benefit Rider – 1417 (07/11), 1417-A (07/11) provides a benefit when the insured is gainfully employed in their occupation and is not totally disabled under the terms of the policy but, solely because of sickness or injury, the insured's loss of income is at least 20% of the insured's prior income; and either 1) the insured is unable to perform one or more of the material and substantial duties of their occupation; or 2) they are able to perform all of the material and substantial duties of their occupation, but not for the length of time they normally require.

Attached are the revised riders along with red-lined versions.

Changed Items:

Form Schedule Item Changes:

Form Schedule Item Changes:

Form Number	Form Type	Form Name	Action	Form Action Other	Previous Filing #	Replaced Form #	Readability Score	Attachments
1417 (07/11)	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Basic Residual Disability Benefit Rider	Initial				51.200	1417_07-11.pdf
1417-A (07/11)	Policy/Contract/Fraternal Certificate:	Basic Residual Disability	Initial				52.100	1417-A _07-11_.pdf

Amendment, Insert Page, Endorsement or Rider

Benefit Rider - Add-on

Supporting Document Schedule Item Changes:

Satisfied -Name: Outline of Coverage

Comment:

TDOC (12-11).pdf

User Added -Name: Red-Lined Forms

Comment:

1417 _07-11__red-line.pdf

1417-A _07-11__Red-Line.pdf

TDOC _12-11_ Red-Lined.pdf

Form Schedule

Lead Form Number: 1406 (07/11)

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 07/13/2011	1406 (07/11)	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Automatic Benefit Enhancement Rider	Initial		50.500	1406 _07-11_.pdf
Approved-Closed 07/13/2011	1415 (07/11)	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Retirement Protection Plus Rider	Initial		52.000	1415 _07-11_.pdf
Approved-Closed 02/01/2012	1417 (07/11)	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Basic Residual Disability Benefit Rider	Initial		51.200	1417_07-11.pdf
Approved-Closed 07/13/2011	1418 (07/11)	Policy/Contract/Fraternal	3% Maximum Cost of Living Adjustment Rider	Initial		51.800	1418 _07-11_.pdf

		Certificate: Amendment, Insert Page, Endorsement or Rider				
Approved-Closed 07/13/2011	1419 (07/11)	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Benefit Purchase Rider	Initial	50.900	1419 _07-11_.pdf
Approved-Closed 02/01/2012	1417-A (07/11)	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Basic Residual Disability Benefit Rider - Add-on	Initial	52.100	1417-A _07-11_.pdf
Approved-Closed 07/13/2011	1418-A (07/11)	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	3% Maximum Cost of Living Adjustment Rider- Add-on	Initial	51.500	1418-A _07-11_.pdf
Approved-Closed 07/13/2011	1426-E (07/11)	Policy/Contract/Fraternal Certificate:	Endorsement Amending "Incontestable" Provision	Initial	51.200	1426-E (07-11).pdf

SERFF Tracking Number:	*GARD-127298755*	*State:*	*Arkansas*
Filing Company:	*Berkshire Life Insurance Company of America*	*State Tracking Number:*	*49199*
Company Tracking Number:	*1406*		
TOI:	*H11I Individual Health - Disability Income*	*Sub-TOI:*	*H11I.007 Long Term - Related to marketing with employer or association groups*
Product Name:	*1406*		
Project Name/Number:	*/*		

		Amendment, Insert Page, Endorsement or Rider				
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
700 South Street
Pittsfield, MA 01201

AUTOMATIC BENEFIT ENHANCEMENT RIDER

This rider is a part of the Policy to which it is attached. All provisions of the Policy apply to this rider and remain the same except where We change them by this rider.

The Policy is amended by adding or changing the following provisions:

DEFINITIONS

Automatic Increase
Automatic Increase means the increase in the Monthly Indemnity that takes effect under the terms and conditions of this rider unless You refuse it. While You are eligible for Automatic Increases, the Automatic Increase is equal to the Indexed Monthly Indemnity in effect immediately prior to the Policy Anniversary multiplied by the Automatic Increase Rate.

Automatic Increase Rate
The Automatic Increase Rate is shown in the Schedule Page.

Indexed Monthly Indemnity
The Indexed Monthly Indemnity is the Monthly Indemnity of the Policy, including any Automatic Increases that We have issued, but excluding any Monthly Indemnity issued under an Additional Monthly Benefit Rider and any Monthly Indemnity added pursuant to a Cost of Living Adjustment Rider.

Rider Review Date
The Rider Review Date means the sixth Policy Anniversary and every sixth Policy Anniversary thereafter while this rider is in effect.

PROVISIONS RELATING TO AUTOMATIC BENEFIT ENHANCEMENT

Automatic Benefit Enhancement
This rider provides for up to six annual Automatic Increases as follows:

- On each Policy Anniversary, unless You refuse, We will increase Your Monthly Indemnity by the Automatic Increase.
- No Automatic Increase will be made which will cause the Monthly Indemnity to exceed the maximum amount of allowable Monthly Indemnity available to You based on Our underwriting guidelines in effect as of the Effective Date of the Policy.
- We will not require any evidence of insurability for an Automatic Increase to take effect.
- Each Automatic Increase that You accept will remain in effect for as long as the Policy is in force and the premium is paid.
- The premium for each Automatic Increase will be based on the rates in effect on the date of issue of the Automatic Increase. The premium will be based on the following factors:

  - the Automatic Increase amount; and
  - Your Age on the date of issue of the Automatic Increase; and
  - the Class of Risk and Occupation Class of the Policy to which this rider is attached; and
  - any special class rating that applies to the Policy to which this rider is attached; and
  - any rider that is attached to the Policy that adjusts or determines a benefit based upon Monthly Indemnity.

Refusal of an Automatic Increase
You may refuse an Automatic Increase:

- by submitting to Us a written request within 31 days after an Automatic Increase premium becomes due; or
- by not paying the premium for the Automatic Increase when it is due.

Automatic Increases which are refused may not be exercised later. If You refuse two consecutive Automatic Increases, all further Automatic Increases will be forfeited and this rider terminates.

Automatic Increases While Disabled or During a Suspension Period
Automatic Increases will not be added to Your Monthly Indemnity for any period in which You are Disabled or during a Suspension Period. If the Suspension Period ends, or You recover and We are no longer paying benefits or waiving premiums, then Automatic Increases will resume on the next Policy Anniversary and continue until the next Rider Review Date.

Any scheduled Automatic Increase will be forfeited during a period while premiums are being waived or during a Suspension Period.

Rider Renewal
After a Rider Review Date and before the next Policy Anniversary, You may submit an application to renew this rider for the smallest of:

- another six Automatic Increases; or
- the number of Automatic Increases between your attained Age and Age 60; or
- the number of Automatic Increases which will not cause the Monthly Indemnity to exceed the maximum amount of allowable Monthly Indemnity available to You based on Our underwriting rules in effect at the time You apply for rider renewal.

If You apply to renew this rider, You must provide evidence of Your medical insurability, Income, occupation, employment and other insurance in force, applied for, or for which You are eligible. We may require additional evidence of financial insurability to renew this rider.

Your application to renew this rider will be underwritten in accordance with Our underwriting guidelines in effect at the time You apply for renewal to determine if You are eligible to renew this rider.

If benefits have been paid by Us under the Policy, You are not eligible to renew this rider.

Premium
There is no premium for this rider.

TERMINATION

Termination of the Automatic Benefit Enhancement
This rider will terminate on the date when the first of the following events occurs:

- We do not renew this rider; or
- You attain Age 60; or
- The date of Your refusal of a second consecutive Automatic Increase; or
- Any date on which Your Monthly Indemnity equals or exceeds the maximum amount of allowable Monthly Indemnity available to You based on Our underwriting guidelines in effect as of the Effective Date of the Policy or the last Rider Review Date, whichever is later; or
- On a Rider Review Date if You are Disabled; or
- On a Rider Review Date during a Suspension Period; or
- On the date the Policy terminates.

Berkshire Life Insurance Company of America

Secretary

Berkshire Life Insurance Company of America
700 South Street
Pittsfield, MA 01201

RETIREMENT PROTECTION PLUS (RPP) DISABILITY BENEFIT RIDER

This rider is a part of the Policy to which it is attached. All provisions of the Policy apply to this rider and remain the same except where We change them by this rider.

The Policy is amended by adding or changing the following provisions:

DEFINITIONS

Accumulation Period
The Accumulation Period for this rider is shown in the Schedule Page. It is an uninterrupted period of consecutive days that begins on the first day that You are Totally Disabled and not Gainfully Employed, and during which the Elimination Period must be satisfied.

Elimination Period
The Elimination Period for this rider is shown in the Schedule Page. The Elimination Period is the number of days that must elapse before benefits become payable. The Elimination Period starts on the first day that You are Totally Disabled and not Gainfully Employed. You must be Totally Disabled and not Gainfully Employed, from the same cause or a different cause for this entire period. The days within this period need not be consecutive, but they must occur within the Accumulation Period. Benefits will not accrue or be payable during the Elimination Period.

RPP Monthly Indemnity
RPP Monthly Indemnity is shown in the Schedule Page. It is the amount We will pay to the Trustee for each month You are Totally Disabled and not Gainfully Employed.

Trust
Trust means the irrevocable trust account established by You into which the RPP Monthly Indemnity will be paid.

Trustee
The Trustee is responsible for the administration of the Trust. If a successor Trustee is required, one will be named by Us.

PROVISIONS RELATING TO THE RPP BENEFIT

This rider provides an RPP Benefit if You are Totally Disabled and not Gainfully Employed.

During a period of Disability, the premium for this rider will be waived if premiums are then being waived for the Policy to which this rider is attached.

The RPP Monthly Indemnity, Elimination Period, Accumulation Period, Benefit Period, Expiration Date and the annual premium for this rider are shown in the Schedule Page.

RPP Benefit
When You are Totally Disabled and not Gainfully Employed, We will pay the RPP Monthly Indemnity as follows:

- You must become Totally Disabled while the Policy is in force.
- You must have executed any documents that may be necessary to establish the Trust and to facilitate payment of the RPP Monthly Indemnity.
- You must satisfy the Elimination Period of this rider.

- After You have satisfied the Elimination Period of this rider, RPP Monthly Indemnity will be payable at the end of each month while You are Totally Disabled and not Gainfully Employed.
- The RPP Monthly Indemnity is paid into the Trust established for this purpose.

We will not increase the RPP Monthly Indemnity because You are Totally Disabled from more than one cause at the same time.

Distribution of Trust Assets
Trust assets will be distributed in accordance with the terms of the Trust.

Premium and Renewal
The premium for this rider is shown in the Schedule Page. You may not renew this rider after Age 65.

TERMINATION

Termination of the RPP Benefit
The RPP Monthly Indemnity will no longer be payable on the date that the first of the following events occurs:

- You are no longer Totally Disabled; or
- You become Gainfully Employed; or
- the Benefit Period ends; or
- You attain Age 65; or
- this rider terminates.

Berkshire Life Insurance Company of America

Secretary

Berkshire Life Insurance Company of America
700 South Street
Pittsfield, MA 01201

BASIC RESIDUAL DISABILITY BENEFIT RIDER

This rider is a part of the Policy to which it is attached. All provisions of the Policy apply to this rider and remain the same except where We change them by this rider.

The Policy is amended by adding or changing the following provisions:

DEFINITIONS

CPI-U
CPI-U means the Consumer Price Index for All Urban Consumers, or any later replacement of it, as published by the United States Department of Labor.

Current Index Month
Current Index Month means the anniversary of the Original Index Month immediately preceding the Review Date.

Disability or Disabled
Disability or Disabled is amended to also include Residual Disability or Residually Disabled.

Original Index Month
Original Index Month means the calendar month 90 days before the date on which You were first Disabled in the same claim.

Residual Disability or Residually Disabled
Residual Disability or Residually Disabled means that You are Gainfully Employed and You are not Totally Disabled under the terms of the Policy, but solely due to Injury or Sickness:

- You experience a Loss of Income that is at least 20% of Your Prior Income; and either
- You are able to perform one or more, but not all, of the material and substantial duties of Your Occupation; or
- You are able to perform all of the material and substantial duties of Your Occupation but not for the length of time they normally require.

Working an average of more than 40 hours in a week, in itself, is not a material and substantial duty.

Residual Indemnity
Residual Indemnity means the amount We will pay for each month of Residual Disability. It is a percentage of the Monthly Indemnity.

Review Date
Review Date means the recurrence each year of the date on which You were first Disabled in the same claim.

PROVISIONS RELATING TO RESIDUAL DISABILITY

Residual Disability Benefit
When You are Residually Disabled, We will pay Residual Indemnity as follows:

- You must become Disabled while the Policy is in force.
- You must satisfy the Elimination Period.
- After You have satisfied the Elimination Period, Residual Indemnity will be payable at the end of each month while You are Residually Disabled.

For each month benefits are payable under this rider, Residual Indemnity may never exceed Loss of Income, except as stated in the Enhancements to Residual Indemnity provision.

Payment of Residual Indemnity
Residual Indemnity will be determined by the formula (a) divided by (b) multiplied by (c), where:

(a) is Your Loss of Income for the month in which You are Residually Disabled; and
(b) is Your Prior Income; and
(c) is the Monthly Indemnity.

Enhancements to Residual Indemnity
During the first six months in which Residual Indemnity is payable, We will deem Your Loss of Income to be 50% of Your Prior Income or the actual percentage of loss, if greater.

If Your Loss of Income is more than 75% of Prior Income in any month of Residual Disability while Residual Indemnity is payable, We will deem such loss to be 100%.

We will not increase the Residual Indemnity because You are Disabled from more than one cause at the same time.

Adjustment of Prior Income and Prior Business Expenses
On the Review Date while Residual Indemnity is payable, We will adjust Your Prior Income and Prior Business Expenses for the next 12 months to reflect any changes in cost of living since the start of claim. We will adjust the Prior Income and Prior Business Expenses by multiplying each by the actual percentage change in the CPI-U between the Current Index Month and the Original Index Month. The adjusted Prior Income and adjusted Prior Business Expenses will apply to the 12-month period that follows the Review Date and will be used to determine Your Loss of Income.

The adjustment to Prior Income and Prior Business Expenses may vary from year to year as the CPI-U rises or falls in relation to the Original Index Month. We will make no change that would reduce Prior Income or Prior Business Expenses below what they were at the start of claim.

We will adjust the Prior Income and Prior Business Expenses on each Review Date while Residual Indemnity is payable until the first of the following events occurs:

- a Recovery Benefit is payable; or
- the Benefit Period ends; or
- this rider terminates.

Recovery Benefit
We will pay You a Recovery Benefit if:

- You are no longer Disabled; and
- You return to Full Time Gainful Employment immediately following a period of Disability for which We paid benefits under the Policy; and
- Your Loss of Income is at least 20% of Your Prior Income; and
- Your Loss of Income is solely due to the Injury or Sickness that caused Your Disability.

The Recovery Benefit payable will be a percentage of the Monthly Indemnity for the Policy. The Recovery Benefit will be determined by the formula (a) divided by (b) multiplied by (c), where:

(a) is Your Loss of Income for the month in which You are claiming a Recovery Benefit; and
(b) is Your Prior Income; and
(c) is the Monthly Indemnity in effect on the last Review Date before Your Disability ended.

We will continue to waive premiums while You are receiving a Recovery Benefit even if it exceeds the six-month period after You recover as stated in the Waiver of Premium provision of the Policy. We will continue to waive premiums until the later of:

- the end of the six-month period after You recover; or
- the date the Recovery Benefit is no longer payable.

Proof of Loss
In addition to any Proof of Loss required by the Policy, You must provide Us with written Proof of Loss necessary to establish that Your Loss of Income is solely the result of the Injury or Sickness that caused Your Disability.

Premium and Renewal
The premium for this rider is shown in the Schedule Page. You may not renew this rider after the Expiration Date of the Policy.

TERMINATION

Termination of Residual Indemnity
Residual Indemnity will no longer be payable on the date that the first of the following events occurs:

- You are no longer Residually Disabled; or
- Your Loss of Income is no longer solely due to the Injury or Sickness that caused Your Residual Disability; or
- You become Totally Disabled; or
- the Benefit Period ends; or
- this rider terminates.

Termination of Recovery Benefit
Recovery Benefit will no longer be payable on the date that the first of the following events occurs:

- You become Disabled; or
- You are no longer Gainfully Employed Full Time; or
- Your Loss of Income is no longer solely due to the Injury or Sickness that caused Your Disability; or
- Your Loss of Income is less than 20% of Your Prior Income; or
- the Benefit Period ends; or
- this rider terminates.

Berkshire Life Insurance Company of America

Secretary

Berkshire Life Insurance Company of America
700 South Street
Pittsfield, MA 01201

3% MAXIMUM COST OF LIVING ADJUSTMENT RIDER

This rider is a part of the Policy to which it is attached. All provisions of the Policy apply to this rider and remain the same except where We change them by this rider.

The Policy is amended by adding or changing the following provisions:

DEFINITIONS

Cost of Living Adjustment Factor
Cost of Living Adjustment Factor for the first Review Date is determined by dividing the CPI-U for the Index Month by the CPI-U for the Original Index Month. Cost of Living Adjustment Factor for any subsequent Review Date is determined by dividing the CPI-U for the Index Month by the CPI-U for the Index Month as of the Prior Review Date. The Cost of Living Adjustment Factor will never be less than 1.00 or greater than 1.03.

CPI-U
CPI-U means the Consumer Price Index for All Urban Consumers, or any later replacement for it, as published by the Bureau of Labor Statistics of the United States Department of Labor.

Incremental Monthly Indemnity
Incremental Monthly Indemnity means the difference between the adjusted Monthly Indemnity in effect on the last Review Date before Your claim ends and the Monthly Indemnity as shown in the Schedule Page.

Index Month
Index Month means the calendar month 90 days before each Review Date.

Original Index Month
Original Index Month means the calendar month 90 days before the date You were first Disabled in the same claim

Review Date
Review Date means the recurrence each year of the date on which You were first Disabled in the same claim.

PROVISIONS RELATING TO COST OF LIVING ADJUSTMENT

Cost of Living Adjustment
On the Review Date while You are Disabled and benefits are payable, We will adjust the Monthly Indemnity for the next 12 months to reflect any changes in cost of living. The adjusted Monthly Indemnity will apply to the 12-month period that follows the Review Date while You remain Disabled in the same claim.

On the first Review Date, We will adjust the Monthly Indemnity by multiplying the Monthly Indemnity by the Cost of Living Adjustment Factor. On each subsequent Review Date while benefits are payable, We will adjust the Monthly Indemnity by multiplying the prior year's adjusted Monthly Indemnity by the Cost of Living Adjustment Factor.

If You are no longer Disabled and We are no longer paying benefits under the Policy, We will increase the Monthly Indemnity shown on the Schedule Page by the Incremental Monthly Indemnity, if any, if the Incremental Monthly Indemnity is at least $200.

There will be no extra premium charge for the Incremental Monthly Indemnity until the Expiration Date.

Adjusted Monthly Indemnity After the Expiration Date
At the time You first renew the Policy after the Expiration Date, You may choose one of the following amounts for any claim for Total Disability that begins after that date:

- the Monthly Indemnity shown in the Schedule Page; or
- the increased indemnity, if any, last created by this rider.

We will base Your premium after the Expiration Date on the amount of Monthly Indemnity You select. You must meet all the conditions in the Policy for renewal after the Expiration Date.

Premium and Renewal
The premium for this rider is shown in the Schedule Page. You may not renew this rider after the Expiration Date.

TERMINATION

Termination of Cost of Living Adjustment
We will adjust the Monthly Indemnity on each Review Date until the first of the following events occurs:

- You are no longer Disabled; or
- the Benefit Period ends; or
- this rider terminates.

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Secretary

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700 South Street
Pittsfield, MA 01201

BENEFIT PURCHASE RIDER

This rider is a part of the Policy to which it is attached. All provisions of the Policy apply to this rider and remain the same except where We change them by this rider.

This Policy is amended by adding or changing the following provisions:

DEFINITIONS

Benefit Purchase Period
Benefit Purchase Period means the 61 day period beginning 30 days immediately before the Review Date and ending 30 days immediately following the Review Date.

Increase Policy
Increase Policy means the additional Monthly Indemnity purchased under this rider.

Review Date
Review Date means the third Policy Anniversary and every third Policy Anniversary thereafter while this rider is in effect.

PROVISIONS RELATING TO BENEFIT PURCHASE OFFERS

Benefit Purchase Offer
On each Review Date, We will review Your eligibility for an Increase Policy. To keep this rider in effect and to determine eligibility for an Increase Policy, We will require an application and other evidence which demonstrate that You are insurable under Our then current underwriting guidelines, except that You do not have to provide evidence of Your medical insurability. We must receive the application and other evidence We require during the Benefit Purchase Period.

Evidence of insurability will include documentation of Your Income, occupation, employment and all other disability insurance with any insurer that is in force, which You have applied for, or for which You are eligible, and additional evidence of financial insurability, as necessary.

Our offer for an Increase Policy will be the maximum amount of additional Monthly Indemnity available to You, if any, based on the information received and Our then current underwriting guidelines.

Special Benefit Purchase Option Offer
You may be eligible to apply for an Increase Policy one time between each Review Date if You meet at least one of the following conditions:

1. You are no longer eligible to participate in Your employer's group long term disability (LTD) plan; or
2. a group LTD plan under which You were covered ends and has not been converted or replaced; or
3. You have had at least a 50% increase in Your Income during the first three years after the Effective Date of the Policy, or since the last Review Date.

An offer for an Increase Policy may be available if, within 90 days after the date one of the above conditions occurs, You notify Us by submitting an application and evidence which demonstrates that You are insurable under Our then current underwriting guidelines. You do not have to provide evidence of Your medical insurability.

Evidence of insurability will include documentation of Your Income, occupation, employment and all other disability insurance with any insurer that is in force, which You have applied for, or for which You are eligible, and additional evidence of financial insurability, as necessary.

Conditions and Limitations
Any offer for an Increase Policy is subject to the following conditions and limitations:

- The Increase Policy will be issued on a separate policy form then in use on a regular basis in the place where You live.

- The Increase Policy may not include the same provisions, benefits or riders as the Policy to which this rider is attached.

- The Increase Policy cannot have a shorter Elimination Period or a longer Benefit Period than the Policy to which this rider is attached.

- We will not issue an Increase Policy with less than $200 of Monthly Indemnity.

- The premium for each Increase Policy will be based on the rates in effect on the date of issue of the Increase Policy. The premium will be based on the following factors:
  - the Monthly Indemnity of the Increase Policy; and
  - Your Age on the date of issue of the Increase Policy; and
  - the Class of Risk of the Policy to which this rider is attached; and
  - Your Occupation Class on the date of issue of the Increase Policy; and
  - any special class rating that applies to the Policy to which this rider is attached; and
  - the policy form of the Increase Policy; and
  - any rider that is attached to the Increase Policy that adjusts or determines a benefit based upon Monthly Indemnity.

- Conditions that are excluded by name or specific description under the terms of the Policy to which this rider is attached will be excluded under the Increase Policy.

- In order for an Increase Policy to become effective, We must receive the first premium.

Benefit Purchase Offers When Disabled or Benefits are Payable or during a Suspension Period
You are not eligible for an Increase Policy when You are Disabled or when benefits are payable or during a Suspension Period.

If You recover and benefits are no longer payable or We are not waiving premiums, or the Suspension Period ends, You may request an Increase Policy according to the Benefit Purchase Offer or Special Benefit Purchase Option Offer provisions.

Premium
There is no premium for this rider.

TERMINATION

Termination of the Benefit Purchase Rider
This rider terminates when the first of the following events occurs:

- An application for an Increase Policy and required evidence of insurability is not received during the Benefit Purchase Period; or
- Less than 50% of Our offer for an Increase Policy is accepted; or
- The initial premium for any Increase Policy is not paid; or
- The date of Your written request to reduce the Monthly Indemnity of the Policy to which this rider is attached; or
- The date of Your written request to terminate this rider; or
- You attain Age 55; or
- The Policy terminates.

Berkshire Life Insurance Company of America

Secretary

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700 South Street
Pittsfield, MA 01201

BASIC RESIDUAL DISABILITY BENEFIT RIDER

As of the Effective Date shown below, this rider is attached to the Policy. All provisions of the Policy apply to this rider and remain the same except where We change them by this rider.

Policy Number:

Insured:

Effective Date of this rider:

The Policy is amended by adding or changing the following provisions:

DEFINITIONS

CPI-U
CPI-U means the Consumer Price Index for All Urban Consumers, or any later replacement of it, as published by the United States Department of Labor.

Current Index Month
Current Index Month means the anniversary of the Original Index Month immediately preceding the Review Date.

Disability or Disabled
Disability or Disabled is amended to also include Residual Disability or Residually Disabled.

Original Index Month
Original Index Month means the calendar month 90 days before the date on which You were first Disabled in the same claim.

Residual Disability or Residually Disabled
Residual Disability or Residually Disabled means that You are Gainfully Employed and You are not Totally Disabled under the terms of the Policy, but solely due to Injury or Sickness:

- You experience a Loss of Income that is at least 20% of Your Prior Income; and either
- You are able to perform one or more, but not all, of the material and substantial duties of Your Occupation; or
- You are able to perform all of the material and substantial duties of Your Occupation but not for the length of time they normally require.

Working an average of more than 40 hours in a week, in itself, is not a material and substantial duty.

Residual Indemnity
Residual Indemnity means the amount We will pay for each month of Residual Disability. It is a percentage of the Monthly Indemnity.

Review Date
Review Date means the recurrence each year of the date on which You were first Disabled in the same claim.

PROVISIONS RELATING TO RESIDUAL DISABILITY

Residual Disability Benefit
When You are Residually Disabled, We will pay Residual Indemnity as follows:

- You must become Disabled while the Policy is in force.

- You must satisfy the Elimination Period.
- After You have satisfied the Elimination Period, Residual Indemnity will be payable at the end of each month while You are Residually Disabled.

For each month benefits are payable under this rider, Residual Indemnity may never exceed Loss of Income, except as stated in the Enhancements to Residual Indemnity provision.

Payment of Residual Indemnity
Residual Indemnity will be determined by the formula (a) divided by (b) multiplied by (c), where:

(a) is Your Loss of Income for the month in which You are Residually Disabled; and
(b) is Your Prior Income; and
(c) is the Monthly Indemnity.

Enhancements to Residual Indemnity
During the first six months in which Residual Indemnity is payable, We will deem Your Loss of Income to be 50% of Your Prior Income or the actual percentage of loss, if greater.

If Your Loss of Income is more than 75% of Prior Income in any month of Residual Disability while Residual Indemnity is payable, We will deem such loss to be 100%.

We will not increase the Residual Indemnity because You are Disabled from more than one cause at the same time.

Adjustment of Prior Income and Prior Business Expenses
On the Review Date while Residual Indemnity is payable, We will adjust Your Prior Income and Prior Business Expenses for the next 12 months to reflect any changes in cost of living since the start of claim. We will adjust the Prior Income and Prior Business Expenses by multiplying each by the actual percentage change in the CPI-U between the Current Index Month and the Original Index Month. The adjusted Prior Income and adjusted Prior Business Expenses will apply to the 12-month period that follows the Review Date and will be used to determine Your Loss of Income.

The adjustment to Prior Income and Prior Business Expenses may vary from year to year as the CPI-U rises or falls in relation to the Original Index Month. We will make no change that would reduce Prior Income or Prior Business Expenses below what they were at the start of claim.

We will adjust the Prior Income and Prior Business Expenses on each Review Date while Residual Indemnity is payable until the first of the following events occurs:
- a Recovery Benefit is payable; or
- the Benefit Period ends; or
- this rider terminates.

Recovery Benefit
We will pay You a Recovery Benefit if:
- You are no longer Disabled; and
- You return to Full Time Gainful Employment immediately following a period of Disability for which We paid benefits under the Policy; and
- Your Loss of Income is at least 20% of Your Prior Income; and
- Your Loss of Income is solely due to the Injury or Sickness that caused Your Disability.

The Recovery Benefit payable will be a percentage of the Monthly Indemnity for the Policy. The Recovery Benefit will be determined by the formula (a) divided by (b) multiplied by (c), where:

(a) is Your Loss of Income for the month in which You are claiming a Recovery Benefit; and
(b) is Your Prior Income; and
(c) is the Monthly Indemnity in effect on the last Review Date before Your Disability ended.

We will continue to waive premiums while You are receiving a Recovery Benefit even if it exceeds the six-month period after You recover as stated in the Waiver of Premium provision of the Policy. We will continue to waive premiums until the later of:

- the end of the six-month period after You recover; or
- the date the Recovery Benefit is no longer payable.

Proof of Loss
In addition to any Proof of Loss required by the Policy, You must provide Us with written Proof of Loss necessary to establish that Your Loss of Income is solely the result of the Injury or Sickness that caused Your Disability.

Premium and Renewal
The premium for this rider is shown in the Schedule Page. You may not renew this rider after the Expiration Date of the Policy.

Incontestable
This rider will be incontestable as to the statements, except fraudulent statements, contained in the application for this rider after it has been in force for two years during Your lifetime from the Effective Date of this rider, excluding any period during which You are Disabled. No claim for a loss incurred or Disability that begins after two years from this date, excluding any period during which You are Disabled, will be reduced or denied because a sickness or physical condition existed prior to the Effective Date of this rider. This assumes that such sickness or physical condition was not excluded from Coverage by name or description under the Policy.

In the event of a reinstatement, this rider will be incontestable as to statements made by You, except fraudulent statements, contained in the application for reinstatement of the Policy after it has been in force for a period of two years following the date the Policy was reinstated, excluding any period during which You are Disabled.

TERMINATION

Termination of Residual Indemnity
Residual Indemnity will no longer be payable on the date that the first of the following events occurs:

- You are no longer Residually Disabled; or
- Your Loss of Income is no longer solely due to the Injury or Sickness that caused Your Residual Disability; or
- You become Totally Disabled; or
- the Benefit Period ends; or
- this rider terminates.

Termination of Recovery Benefit
Recovery Benefit will no longer be payable on the date that the first of the following events occurs:

- You become Disabled; or
- You are no longer Gainfully Employed Full Time; or
- Your Loss of Income is no longer solely due to the Injury or Sickness that caused Your Disability; or
- Your Loss of Income is less than 20% of Your Prior Income; or
- the Benefit Period ends; or
- this rider terminates.

Berkshire Life Insurance Company of America

Secretary

Berkshire Life Insurance Company of America
700 South Street
Pittsfield, MA 01201

3% MAXIMUM COST OF LIVING ADJUSTMENT RIDER

As of the Effective Date shown below, this rider is attached to the Policy. All provisions of the Policy apply to this rider and remain the same except where We change them by this rider.

Policy Number:

Insured:

Effective Date of this rider:

The Policy is amended by adding or changing the following provisions:

DEFINITIONS

Cost of Living Adjustment Factor
Cost of Living Adjustment Factor for the first Review Date is determined by dividing the CPI-U for the Index Month by the CPI-U for the Original Index Month. Cost of Living Adjustment Factor for any subsequent Review Date is determined by dividing the CPI-U for the Index Month by the CPI-U for the Index Month as of the Prior Review Date. The Cost of Living Adjustment Factor will never be less than 1.00 or greater than 1.03.

CPI-U
CPI-U means the Consumer Price Index for All Urban Consumers, or any later replacement for it, as published by the Bureau of Labor Statistics of the United States Department of Labor.

Incremental Monthly Indemnity
Incremental Monthly Indemnity means the difference between the adjusted Monthly Indemnity in effect on the last Review Date before Your claim ends and the Monthly Indemnity as shown in the Schedule Page.

Index Month
Index Month means the calendar month 90 days before each Review Date.

Original Index Month
Original Index Month means the calendar month 90 days before the date You were first Disabled in the same claim

Review Date
Review Date means the recurrence each year of the date on which You were first Disabled in the same claim.

PROVISIONS RELATING TO COST OF LIVING ADJUSTMENT

Cost of Living Adjustment
On the Review Date while You are Disabled and benefits are payable, We will adjust the Monthly Indemnity for the next 12 months to reflect any changes in cost of living. The adjusted Monthly Indemnity will apply to the 12-month period that follows the Review Date while You remain Disabled in the same claim.

On the first Review Date, We will adjust the Monthly Indemnity by multiplying the Monthly Indemnity by the Cost of Living Adjustment Factor. On each subsequent Review Date while benefits are payable, We will adjust the Monthly Indemnity by multiplying the prior year's adjusted Monthly Indemnity by the Cost of Living Adjustment Factor.

If You are no longer Disabled and We are no longer paying benefits under the Policy, We will increase the

Monthly Indemnity shown on the Schedule Page by the Incremental Monthly Indemnity, if any, if the Incremental Monthly Indemnity is at least $200.

There will be no extra premium charge for the Incremental Monthly Indemnity until the Expiration Date.

Adjusted Monthly Indemnity After the Expiration Date
At the time You first renew the Policy after the Expiration Date, You may choose one of the following amounts for any claim for Total Disability that begins after that date:

- the Monthly Indemnity shown in the Schedule Page; or
- the increased indemnity, if any, last created by this rider.

We will base Your premium after the Expiration Date on the amount of Monthly Indemnity You select. You must meet all the conditions in the Policy for renewal after the Expiration Date.

Premium and Renewal
The premium for this rider is shown in the Schedule Page. You may not renew this rider after the Expiration Date.

Incontestable
This rider will be incontestable as to the statements, except fraudulent statements, contained in the application for this rider after it has been in force for two years during Your lifetime from the Effective Date of this rider, excluding any period during which You are Disabled. No claim for a loss incurred or Disability that begins after two years from this date, excluding any period during which You are Disabled, will be reduced or denied because a sickness or physical condition existed prior to the Effective Date of this rider. This assumes that such sickness or physical condition was not excluded from Coverage by name or description under the Policy.

In the event of a reinstatement, this rider will be incontestable as to statements made by You, except fraudulent statements, contained in the application for reinstatement of the Policy after it has been in force for a period of two years following the date the Policy was reinstated, excluding any period during which You are Disabled.

TERMINATION

Termination of Cost of Living Adjustment
We will adjust the Monthly Indemnity on each Review Date until the first of the following events occurs:

- You are no longer Disabled; or
- the Benefit Period ends; or
- this rider terminates.

Berkshire Life Insurance Company of America

Secretary

Berkshire Life Insurance Company of America
700 South Street
Pittsfield, MA 01201

ENDORSEMENT AMENDING "INCONTESTABLE" PROVISION

This endorsement is a part of the Policy to which it is attached. All provisions of the Policy apply to this endorsement and remain the same except where modified by this endorsement.

The Policy is amended by adding or changing the following provision:

> The Policy will be incontestable as to the statements, except fraudulent statements, contained in the application for the Policy after it has been in force for a period of two years during Your lifetime from the Effective Date of the Policy, excluding any period during which You are Disabled.
>
> In the event of a reinstatement, the Policy will be incontestable as to the statements, except fraudulent statements, contained in the application for reinstatement of the Policy after it has been in force for a period of two years during Your lifetime following the date the Policy was reinstated, excluding any period during which You are Disabled.

Berkshire Life Insurance Company of America

Secretary

☐ **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: ☐ Male ☐ Female

c. Social Security #: _____

d. Residence Address (Street, City, State, Zip):

_____

_____

How long at this address? _____

e. Date of Birth (mm/dd/yyyy): _____

f. Place of Birth: _____

g. Telephone: Home _____

Cell _____

E-mail Address: _____

h. Are you a U.S. citizen ☐ Yes ☐ No

If no, please provide: Visa Type _____ Visa Duration _____

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

(If residence has not been continuous, give dates, and explain in Remarks and Special Requests section 10)

Do you expect to remain in the U.S. permanently? ☐ Yes ☐ No

If no, include details: _____

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

2. Business Information

a. Current Employer: _____

Number of years with current employer _____

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

_____

_____

c. Business Telephone: _____

Business Website: _____

d. Nature of Business:

_____

e. Occupation: _____

Number of years in this occupation _____

f. Job Title (if medical or dental occupation, state specialty):

_____

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 1. Actual Filed Last Calendar Year 2. Actual Filed Two Calendar Years Ago
Sources: _____ $_____ $_____

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? _____ Driver's License State _____ Driver's License # ☐ Yes ☐ No

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	☐ True ☐ Modified	Modified	Modified	True	True
d. Premium Structure	☐ Level ☐ Graded	☐ Level ☐ Graded	Level	Level	Level
e. Elimination Period		☐ 180 days ☐ 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	☐ Residual Disability ☐ Partial Disability	☐ Basic Residual Disability
Cost of Living Adjustments	☐ 3% Compound ☐ 6% Maximum ☐ Four-Year Delayed	☐ 3% Maximum (CPI-Tied)
Extended Benefits	☐ Lump Sum Disability Benefit ☐ Graded Lifetime Indemnity for Total Disability	
	☐ Future Increase Option $_____	
Benefits listed at right are available with both ProVider Plus and ProVider Plus Limited	☐ Catastrophic Disability Benefit $_____ ☐ Retirement Protection Plus: *Monthly Indemnity* $_____ *Elimination Period* ☐ 180 days ☐ 360 days ☐ Social Insurance Substitute $_____ ☐ Unemployment Waiver of Premium ☐ Other_____ ☐ 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 _____

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

GUARDIAN®

Application for Disability Insurance –

Disability Buy-Out Insurance Supplement

1. 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		$	$	$

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

1. 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: _____

Tax ID or Social Security #: _____

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

_____

_____

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)

One Copy to Applicant **One Copy to Company**

GUARDIAN℠

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

*IMNB000000004

Rate Information

Rate data applies to filing.

Filing Method:

Rate Change Type: Neutral

Overall Percentage of Last Rate Revision: %

Effective Date of Last Rate Revision:

Filing Method of Last Filing:

Company Rate Information

Company Name:	Overall % Indicated Change:	Overall % Rate Impact:	Written Premium Change for this Program:	# of Policy Holders Affected for this Program:	Written Premium for this Program:	Maximum % Change (where required):	Minimum % Change (where required):
Berkshire Life Insurance Company of America	0.000%	0.000%	$0	0	$0	0.000%	0.000%

Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification	Approved-Closed	07/13/2011

Comments:

Attachment:

1400 Flesch Score.pdf

		Item Status:	Status Date:
Satisfied - Item:	Application	Approved-Closed	07/13/2011

Comments:

Included in this submission for approval.

Attachment:

DI-2011 (12-11) Package.pdf

		Item Status:	Status Date:
Satisfied - Item:	Health - Actuarial Justification	Approved-Closed	07/13/2011

Comments:

Attachment:

1400 Actuarial Memorandum Generic 20110630.pdf

		Item Status:	Status Date:
Satisfied - Item:	Outline of Coverage	Approved-Closed	02/01/2012

Comments:

Attachment:

TDOC (12-11).pdf

		Item Status:	Status Date:

SERFF Tracking Number:	*GARD-127298755*	*State:*	*Arkansas*
Filing Company:	*Berkshire Life Insurance Company of America*	*State Tracking Number:*	*49199*
Company Tracking Number:	*1406*		
TOI:	*H11I Individual Health - Disability Income*	*Sub-TOI:*	*H11I.007 Long Term - Related to marketing with employer or association groups*
Product Name:	*1406*		
Project Name/Number:	*/*		

Satisfied - Item: Red-Lined Forms Approved-Closed 02/01/2012

Comments:

Attachments:

1417 _07-11__red-line.pdf

1417-A _07-11__Red-Line.pdf

TDOC _12-11_ Red-Lined.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.

Form Number	Sentences	Words	Syllables	Flesch Score
1404 (07/11)	14	444	707	54.9
1405 (07/11)	53	1667	2581	50.7
1412 (07/11)	26	712	1116	56.2
1413 (07/11)	14	467	711	59.3
1414 (07/11)	15	746	1216	50.5
1416 (07/11)	13	377	609	52.3
1404-A (07/11)	18	621	976	51.2
1411-A (07/11)	14	573	883	51.6
1411-A-FIO (07/11)	10	399	630	50.1
1412-A (07/11)	30	889	1396	52.7
1413-A (07/11)	18	644	1002	51.2
DI-2011	165	4732	7626	50.6
DI-NM-2009	73	1825	2,760	53.5

January 3, 2011

Donna K. Owens, Officer
Director of Product Development

☐ **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: ☐ Male ☐ Female

c. Social Security #: _____

d. Residence Address (Street, City, State, Zip):

_____

_____

How long at this address? _____

e. Date of Birth (mm/dd/yyyy): _____

f. Place of Birth: _____

g. Telephone: Home _____

Cell _____

E-mail Address: _____

h. Are you a U.S. citizen ☐ Yes ☐ No

If no, please provide: Visa Type _____ Visa Duration _____

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

(If residence has not been continuous, give dates, and explain in Remarks and Special Requests section 10)

Do you expect to remain in the U.S. permanently? ☐ Yes ☐ No

If no, include details: _____

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

2. Business Information

a. Current Employer: _____

Number of years with current employer _____

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

_____

_____

c. Business Telephone: _____

Business Website: _____

d. Nature of Business:

_____

e. Occupation: _____

Number of years in this occupation _____

f. Job Title (if medical or dental occupation, state specialty):

_____

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 1. Actual Filed Last Calendar Year 2. Actual Filed Two Calendar Years Ago
Sources: _____ $_____ $_____

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? _____ Driver's License State _____ Driver's License # ☐ Yes ☐ No

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	☐ True ☐ Modified	Modified	Modified	True	True
d. Premium Structure	☐ Level ☐ Graded	☐ Level ☐ Graded	Level	Level	Level
e. Elimination Period		☐ 180 days ☐ 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	☐ Residual Disability ☐ Partial Disability	☐ Basic Residual Disability
Cost of Living Adjustments	☐ 3% Compound ☐ 6% Maximum ☐ Four-Year Delayed	☐ 3% Maximum (CPI-Tied)
Extended Benefits	☐ Lump Sum Disability Benefit ☐ Graded Lifetime Indemnity for Total Disability	
	☐ Future Increase Option $_____	
Benefits listed at right are available with both ProVider Plus and ProVider Plus Limited	☐ Catastrophic Disability Benefit $_____ ☐ Retirement Protection Plus: *Monthly Indemnity* $_____ *Elimination Period* ☐ 180 days ☐ 360 days ☐ Social Insurance Substitute $_____ ☐ Unemployment Waiver of Premium ☐ Other_____ ☐ 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 _____

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

GUARDIAN®

Application for Disability Insurance –

Disability Buy-Out Insurance Supplement

1. 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		$	$	$

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

1. 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: _____

Tax ID or Social Security #: _____

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

_____

_____

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
Pittsfield, Massachusetts

Actuarial Memorandum

Riders on Policy Form 1400

1406 (07/11)	Automatic Benefit Enhancement Rider
1415 (07/11)	Retirement Protection Plus Rider
1417 (07/11)	Basic Residual Disability Benefit Rider
1418 (07/11)	3% Maximum Cost of Living Adjustment Rider
1419 (07/11)	Benefit Purchase Rider
1417-A (07/11)	Basic Residual Disability Benefit Rider: Add-on Version
1418-A (07/11)	3% Maximum Cost of Living Adjustment Rider: Add-on Version

Purpose

The purpose of this memorandum is to certify that the premiums for the policy form shown on the cover page of this memorandum satisfy state requirements. This memorandum should not be used for any other purpose.

The purpose of this filing is multiple. First, three new riders to policy form 1400 (06/10) are being submitted. The new riders are the Basic Residual Disability Benefit rider, the 3% Maximum Cost of Living Adjustment rider and the Benefit Purchase Rider. Second, new policy language is being filed for the existing Automatic Benefit Enhancement (ABE) rider that will extend the renewal date from five years to six years. ABE is a no-cost rider and will remain so. Third, new premium rates are being submitted for policies that contain a modified own occupation definition of disability. Lastly, new premium rates are being submitted for the Retirement Protection Plan (RPP) rider.

The average effect of the proposed rate changes for policies with the modified own occupation definition of disability is 0.3%, and for the RPP rider it is 2.4%.

This filing applies only to new business and new coverages added to existing policies. The new coverages may be added to policy form 1400 (06/10). Premium rates on inforce business will not change due to the non-cancelable nature of the policy form.

Benefits

Policy form 1400 pays a monthly benefit if the insured is disabled due to an injury or a sickness. Benefits are paid, after the insured has satisfied an elimination period, for a time up to the maximum benefit period stated in the policy. The policy forms are non-cancellable and guaranteed renewable until the expiration date of the policy, which is at age 65 or 67. After age 65 or 67, the coverage may be extended on a conditionally renewable basis while the insured is gainfully employed on a full-time basis as defined in the contract.

For base policy benefits, totally disabled means that, due to sickness or injury, the insured is unable to perform the material and substantial duties of his or her occupation. This definition of disability will be hereafter referred to as true own occupation. The definition of disability may be changed to include the requirement that the insured is not gainfully employed, hereafter referred to as modified own occupation.

Benefits for mental or substance-related disorders may be limited to 24 months during the insured's lifetime.

The following optional benefits included in this filing are:

- Automatic Benefit Enhancement Rider: This rider permits automatic increases to the monthly indemnity on each policy anniversary. The increases apply to the base policy, the residual riders, and the cost of living adjustment riders.

- Retirement Protection Plus (RPP) Disability Benefit Rider: This rider provides an additional monthly benefit payable to an irrevocable trust in the event the insured is totally disabled and is not employed. When the insured reaches age 65, the trust assets are distributed to the insured.

- Basic Residual Disability Benefit Rider: This rider pays a proportionate benefit while the insured is working and is not totally disabled but suffers an income loss due to a disability of at least 20% of pre-disability income. During the first six months of a residual claim, the income loss will be deemed to be 50% or the actual percentage of loss, whichever is greater. If the income loss is greater than 75%, the rider pays 100% of the monthly benefit. In addition, this rider provides a proportionate recovery benefit if the insured is no longer disabled but continues to experience an income loss as the result of the prior disability. The insured may satisfy the elimination period with a total disability or a residual disability.

- 3% Maximum Cost of Living Adjustment Rider: This rider increases the monthly benefit payable while the insured is disabled. Annual compound increases occur on anniversaries of the date of disability and are based on the increase in the Consumer Price Index subject to a 0% minimum and 3% maximum increase.

- Benefit Purchase Rider: This rider provides the insured the opportunity to apply for additional disability insurance coverage at specified dates without providing evidence of medical insurability. To keep this rider in effect, the insured must submit an application and other evidence of insurability during the Benefit Purchase Period.

The add-on versions of the 3% Maximum Cost of Living Adjustment and Basic Residual Disability Benefit riders are identical to the regular versions of the riders except for contract language related to contestability provisions.

Rate Tables

The issue ages for the policy forms are 18 – 60 for level premiums and 18 – 50 for the graded premiums.

The premiums vary by the following factors:

- Age: Issue age and Attained Age
- Sex: Male or Female
- Underwriting Class: Preferred, Select, Standard
- Definition of Disability: Modified Own Occupation or True Own Occupation
- Maximum Benefit Period: 2 years, 5 years, 10 years, To Age 65, To Age 67
- Elimination Period: 30 days, 60 days, 90 days, 180 days, 360 days or 720 days
- Occupation Class: 6, 5, 4, 3, 2, 1, 6M, 5M, 4M, 3M, 2M, 1M
- Premium Structure: Level or Graded

The 720-day elimination period is not available in: Arkansas, Connecticut, Delaware, Idaho, Iowa, New Jersey, Pennsylvania, South Carolina, Texas, Utah, Vermont, Virginia, Washington and West Virginia. The 360-day elimination period is not available with a 2-year benefit period in the following states: Arkansas, Connecticut, Delaware, Idaho, New Jersey, Pennsylvania, South Carolina, Texas, Utah, Vermont, Virginia, Washington and West Virginia.

The annual policy fee is $30 for monthly indemnities of $1,000 and more. For monthly indemnities less than $1,000, the policy fee is $75. If a policy is the result of a successful Future Insurance Option or Benefit Purchase Rider exercise, the policy fee is $15.

The premium rates for the riders included in this filing will be calculated based on factors applied to the existing approved rates. The premium rate factors for the Basic Residual Disability Benefit and 3% Maximum Cost of Living Adjustment riders are shown below in Table 1, and the factors for the RPP rider is shown below in Table 2. These factors are used to calculate the premium rates for the riders when they are attached to a policy with a true own occupation definition of disability. The ABE rider and the Benefit Purchase rider are no-cost riders.

Table 1: Basic Residual Disability Benefit Rider and 3% Maximum Cost of Living Adjustment Rider True Own Occupation Premium Rate Factors to be Applied to Existing True Own Occupation Rates

Rider Rate	Factor	Applied to Existing Rates
Basic Residual Disability Benefit on Individual Disability Income Policy	0.86	Residual Disability on Individual Disability Income Policy
3% Maximum Cost of Living Adjustment Rider on Individual Disability Income Policy	0.75	3% Compound Cost of Living Adjustment Rider on Individual Disability Income Policy
3% Maximum Cost of Living Adjustment Rider on Individual Disability Income Policy with Basic Residual Disability Benefit Rider Attached	0.71	3% Compound Cost of Living Adjustment Rider on Individual Disability Income Policy with Residual Disability Rider Attached

Table 2: RPP Rider Premium Rate Factors to be Applied to Existing True Own Occupation Base Policy Rates

Occupation Class	Factor	Applied to Existing Rates
6 & 6M	0.98	Individual Disability Income Policy
5 & 5M	0.96	Individual Disability Income Policy
4 & 4M	0.94	Individual Disability Income Policy
3 & 3M	0.92	Individual Disability Income Policy
2 & 2M	0.92	Individual Disability Income Policy
1 & 1M	0.92	Individual Disability Income Policy

The premium rates for policies with a modified own occupation definition of disability also will be calculated based on factors applied to the true own occupation premium rates. These factors are shown in Table 3. The factor is 1.00 for the RPP and Catastrophic

riders because these rider benefits are not affected if the base policy definition of disability changes from true own occupation to modified own occupation.

Table 3: Premium Rate Factors to Existing True Own Occupation Rates for Modified Own Occupation Rates

Occupation Class	Base Policy and all riders except RPP and Catastrophic	RPP and Catastrophic Riders
6 & 6M	0.98	1.00
5 & 5M	0.96	1.00
4 & 4M	0.94	1.00
3 & 3M	0.92	1.00
2 & 2M	0.92	1.00
1 & 1M	0.92	1.00

There are five discounts that are available with policy form 1400 (06/10), including the riders in this memorandum. The discounts are:

- The Association discount is a 10% discount, funded through better persistency.

- The Professional Group discount is a 10% discount for eligible groups. It is funded through anticipated improved morbidity experience on these groups relative to traditionally marketed individual business.

- The Student and Resident discount is a 10% discount for eligible groups at professional training programs or schools. It is funded through anticipated improved morbidity experience on these groups relative to traditionally marketed individual business.

- The Preferred Occupation discount is a 10% discount that is available to certain eligible occupations that have demonstrated better morbidity than their occupation class. This discount may not be available to all plan designs. The Preferred Occupation discount is justified by morbidity savings.

- Mental and/or Substance Related Disorders Limitation Discount: This discount is a 10% discount for policies for which benefits for Mental and/or Substance Related Disorders are limited to 24 months during the insured's lifetime unless the insured is continuously confined in a hospital and under the regular care of physician. This discount varies by benefit period, as shown in Table 4, and is justified by morbidity savings.

Table 4: Mental and/or Substance-Related Disorders Limitation Discount Percentage

Benefit Period	Discount
To Age 67	10%
To Age 65	10%
10 Years	8%
5 Years	6%

Benefit Period	Discount
All Other Benefit Periods	Not Available

The premium modal factors are shown in Table 5 below:

Table 5: Modal Factors Applied to Annual Premiums

Mode	Factor
Annual	1.000000
Semi-Annual	0.515000
Quarterly	0.262650
Monthly	0.085833
Guard-o-matic	0.083333

Marketing Method
Policies will be marketed to individuals through career agents and independent brokers. The target market is small business owners and professionals.

Underwriting
The policy form is subject to medical and financial underwriting. Medical underwriting may include application questions, lab tests, inspection reports, MIB reports, attending physician statements, and physician or para-medical exams. Financial underwriting may be used to verify income.

Pricing Assumptions

The gross premiums for this policy form were developed in a manner such that, along with investment income from accumulated assets, these premiums would be sufficient to fund future benefits and expenses, and provide the company with a reasonable profit margin. This is the method described on pages 196-202 of the Society of Actuaries textbook *Health Insurance Provided Through Individual Policies*, Second Edition, by E.L. Bartleson.

1. Morbidity

The claim incidence and claim termination rate assumptions for the base policy and disability riders were developed by making adjustments to the 1985 Commissioner's Individual Disability Table (1985 CIDA) based on the experience of Berkshire Life Insurance Company of America and industry experience.

Exhibit 1 contains sample claim costs for the base policy and selected riders. The claim costs for other riders were developed similarly. Exhibit 2 contains the projected experience for a cohort of newly-issued business.

2. Policy Termination Rates

The policy termination rates used in pricing are shown in Table 6 below, and they include terminations due to death.

Table 6: Policy Termination Rates

Policy Duration	Issue Age			
	25	35	45	55
1	6%	6%	5%	6%
2	5%	5%	5%	6%
3	5%	5%	4%	6%
4	4%	4%	4%	5%
5	4%	4%	4%	5%
6	3%	3%	4%	5%
7	3%	3%	3%	6%
8	3%	3%	3%	6%
9	3%	3%	3%	7%
10	3%	3%	3%	8%
11	3%	3%	3%	9%
12	3%	3%	3%	9%
13	2%	2%	4%	9%
14	2%	2%	4%	10%
15	2%	2%	4%	10%
16	2%	2%	4%	10%
17	2%	2%	4%	10%
18	2%	2%	4%	10%
19	2%	2%	4%	10%
20	2%	2%	4%	10%
21+	2%	2%	4%	10%

3. Expenses

The expense assumptions for a cohort of business are shown in Table 7 below:

Table 7: Expense Assumptions

Category	First Year	Renewal Years
Maintenance	5.4% of premium	5.4% of premium
Premium Tax	2% of premium	2% of premium
Claim Expense: Initial	$4,925 per claim	$4,925 per claim
Claim Expense: Ongoing	3.7% of paid claims	3.7% of paid claims
Acquisition	$929 per policy 15% of premium	N/A

4. Commissions

The commission schedule varies by policy duration. The commissions, including field compensation, bonuses and agency funding, are shown in Table 8 below.

Table 8: Commission Rates by Policy Duration and Issue Age (Includes Bonuses and Field Compensation)

Policy Year	All Issue Ages
1	102.5%
2 – 5	19.8%
6 – 10	15.8%
11+	7.2%

5. Interest Rate

The interest rate used in pricing is 5.5%

6. Issue Ages

The issue ages for the policy form are shown below.

Category	Level Premiums	Graded Premiums
Base: Non-Cancellable Rates	18 – 60	18 – 50
Base & AMB Rider: Conditionally Renewable Rates	65 – 99	65 – 99
Graded Lifetime Indemnity for Total Disability Rider	18 – 60	18 – 50
Lump Sum Rider	18 – 55	18 – 50
Automatic Benefit Enhancement Rider	18 – 50	18 – 50
Future Increase Option Rider	18 – 50	18 – 50
Benefit Purchase Rider	18 – 50	18 – 50
Unemployment Premium Waiver Rider	18 – 55	18 - 50
All Other Riders	18 – 60	18 – 50

7. Average Premium

The average premium for policy form 1400, including riders, is expected to be $1,850.

8. Profit Margin

The anticipated profit margin for this product is 10 - 15% of premium.

Berkshire Life Insurance Company of America
Pittsfield, Massachusetts

Certification

The expected loss ratio was determined by computing the ratio of the present value of future expected claim costs to the present value of future expected gross premiums, using the same persistency, interest, and morbidity assumptions as used in developing the gross premiums.

The expected loss ratio for the policy form in this filing is at least 50%. To the best of my knowledge and judgment, these premiums comply with the laws and regulations of the state, and the benefits are reasonable in relation to the premiums.

Margaret H. Donavan

June 30, 2011
Date

Margaret H. Donavan, FSA, MAAA
Second Vice President and Actuary
Berkshire Life Insurance Company of America

Berkshire Life Insurance Company of America
Pittsfield, Massachusetts

Exhibit 1

Annual Claim Cost per $100 Monthly Indemnity
To Age 65 Benefit Period, Occupation Class 5, 90-day Elimination Period
Basic Residual Disability Benefit Rider

	FEMALE					MALE			
Policy	Issue Age				Policy	Issue Age			
Year	25	35	45	55	Year	25	35	45	55
1	1.44	2.34	6.65	7.50	1	1.42	1.37	3.26	6.04
2	1.39	2.67	6.95	7.04	2	1.39	1.47	3.47	6.02
3	1.43	3.02	7.23	6.52	3	1.34	1.54	3.81	5.91
4	1.51	3.41	7.20	6.24	4	1.30	1.67	4.18	5.69
5	1.56	3.81	7.41	5.59	5	1.30	1.82	4.41	5.33
6	1.70	4.44	7.72	3.95	6	1.33	2.05	4.89	3.85
7	1.89	4.91	7.54	2.31	7	1.33	2.19	5.10	2.37
8	2.09	5.18	7.63	2.17	8	1.38	2.40	5.28	2.31
9	2.33	5.64	7.35	1.98	9	1.44	2.65	5.44	2.17
10	2.50	6.09	7.34	1.49	10	1.52	2.91	5.77	1.68
11	2.77	6.54	6.98	-	11	1.63	3.21	5.60	-
12	3.16	6.83	6.54	-	12	1.75	3.41	5.58	-
13	3.58	7.10	6.04	-	13	1.83	3.75	5.46	-
14	4.03	7.07	5.78	-	14	1.99	4.11	5.25	-
15	4.51	7.28	5.18	-	15	2.16	4.33	4.91	-
16	5.26	7.58	3.64	-	16	2.44	4.81	3.53	-
17	5.81	7.40	2.10	-	17	2.59	5.02	2.15	-
18	6.13	7.48	1.99	-	18	2.85	5.19	2.10	-
19	6.66	7.21	1.84	-	19	3.14	5.34	2.00	-
20	7.20	7.20	1.40	-	20	3.47	5.67	1.59	-
21	7.72	6.84	-	-	21	3.82	5.49	-	-
22	8.07	6.40	-	-	22	4.06	5.46	-	-
23	8.40	5.92	-	-	23	4.45	5.34	-	-
24	8.36	5.66	-	-	24	4.87	5.14	-	-
25	8.59	5.06	-	-	25	5.14	4.81	-	-
26	8.96	3.55	-	-	26	5.71	3.44	-	-
27	8.74	2.03	-	-	27	5.96	2.07	-	-
28	8.83	1.93	-	-	28	6.16	2.05	-	-
29	8.51	1.79	-	-	29	6.34	1.96	-	-
30	8.50	1.39	-	-	30	6.72	1.58	-	-
31	8.06	-	-	-	31	6.51	-	-	-
32	7.54	-	-	-	32	6.47	-	-	-
33	6.97	-	-	-	33	6.33	-	-	-
34	6.67	-	-	-	34	6.09	-	-	-
35	5.95	-	-	-	35	5.69	-	-	-
36	4.16	-	-	-	36	4.07	-	-	-
37	2.36	-	-	-	37	2.44	-	-	-
38	2.27	-	-	-	38	2.42	-	-	-
39	2.11	-	-	-	39	2.33	-	-	-
40	1.66	-	-	-	40	1.89	-	-	-

Berkshire Life Insurance Company of America
Pittsfield, Massachusetts

Exhibit 1

Annual Claim Cost per $100 Monthly Indemnity
To Age 65 Benefit Period, Occupation Class 5, 90-day Elimination Period
3% Maximum Cost of Living Adjustment Rider

FEMALE

Policy	Issue Age			
Year	25	35	45	55
1	1.27	2.13	4.58	2.98
2	1.29	2.38	4.56	2.63
3	1.32	2.64	4.52	2.27
4	1.39	2.91	4.48	1.86
5	1.49	3.16	4.34	1.48
6	1.62	3.54	4.29	1.31
7	1.77	3.79	4.11	1.13
8	1.93	4.08	3.85	0.84
9	2.11	4.27	3.61	0.48
10	2.35	4.44	3.28	0.01
11	2.54	4.56	2.97	-
12	2.86	4.54	2.63	-
13	3.16	4.48	2.27	-
14	3.48	4.45	1.86	-
15	3.78	4.31	1.47	-
16	4.25	4.26	1.30	-
17	4.54	4.08	1.12	-
18	4.87	3.82	0.84	-
19	5.11	3.57	0.48	-
20	5.29	3.25	0.01	-
21	5.44	2.94	-	-
22	5.41	2.60	-	-
23	5.35	2.24	-	-
24	5.31	1.83	-	-
25	5.14	1.45	-	-
26	5.08	1.27	-	-
27	4.86	1.09	-	-
28	4.55	0.81	-	-
29	4.25	0.46	-	-
30	3.86	0.01	-	-
31	3.49	-	-	-
32	3.08	-	-	-
33	2.64	-	-	-
34	2.16	-	-	-
35	1.71	-	-	-
36	1.50	-	-	-
37	1.29	-	-	-
38	0.95	-	-	-
39	0.54	-	-	-
40	0.01	-	-	-

MALE

Policy	Issue Age			
Year	25	35	45	55
1	1.04	0.98	1.82	2.25
2	1.02	1.03	1.94	2.12
3	1.01	1.10	2.02	1.93
4	1.02	1.16	2.11	1.70
5	1.00	1.23	2.20	1.41
6	1.01	1.34	2.32	1.29
7	1.04	1.45	2.37	1.17
8	1.06	1.53	2.40	0.90
9	1.09	1.62	2.39	0.53
10	1.13	1.72	2.31	0.01
11	1.18	1.81	2.26	-
12	1.23	1.93	2.12	-
13	1.31	2.01	1.94	-
14	1.39	2.09	1.70	-
15	1.47	2.18	1.42	-
16	1.61	2.30	1.30	-
17	1.73	2.35	1.17	-
18	1.84	2.38	0.90	-
19	1.95	2.36	0.53	-
20	2.06	2.28	0.01	-
21	2.16	2.23	-	-
22	2.31	2.09	-	-
23	2.40	1.90	-	-
24	2.49	1.66	-	-
25	2.60	1.39	-	-
26	2.76	1.27	-	-
27	2.81	1.14	-	-
28	2.84	0.87	-	-
29	2.82	0.51	-	-
30	2.73	0.01	-	-
31	2.66	-	-	-
32	2.49	-	-	-
33	2.27	-	-	-
34	1.99	-	-	-
35	1.65	-	-	-
36	1.51	-	-	-
37	1.36	-	-	-
38	1.03	-	-	-
39	0.60	-	-	-
40	0.01	-	-	-

Berkshire Life Insurance Company of America
Pittsfield, Massachusetts

Exhibit 1

Annual Claim Cost per $100 Monthly Indemnity
To Age 65 Benefit Period, Occupation Class 5, 180-day Elimination Period
RPP Rider

FEMALE

Policy	Issue Age			
Year	25	35	45	55
1	4.93	8.70	23.57	28.90
2	4.98	9.85	24.49	28.50
3	5.10	11.07	25.30	27.80
4	5.32	12.37	26.36	26.42
5	5.75	13.72	26.96	24.94
6	6.26	15.74	27.78	25.36
7	6.86	17.23	28.43	25.78
8	7.58	18.98	28.56	24.59
9	8.38	20.49	28.90	22.86
10	9.39	21.96	28.69	20.73
11	10.37	23.37	28.65	-
12	11.72	24.29	28.25	-
13	13.19	25.10	27.55	-
14	14.72	26.14	26.18	-
15	16.33	26.73	24.72	-
16	18.72	27.54	25.15	-
17	20.50	28.18	25.58	-
18	22.59	28.31	24.42	-
19	24.37	28.65	22.75	-
20	26.12	28.43	20.71	-
21	27.80	28.39	-	-
22	28.88	27.99	-	-
23	29.84	27.30	-	-
24	31.08	25.94	-	-
25	31.78	24.48	-	-
26	32.74	24.93	-	-
27	33.50	25.37	-	-
28	33.65	24.26	-	-
29	34.05	22.64	-	-
30	33.80	20.67	-	-
31	33.74	-	-	-
32	33.26	-	-	-
33	32.44	-	-	-
34	30.82	-	-	-
35	29.09	-	-	-
36	29.63	-	-	-
37	30.18	-	-	-
38	28.90	-	-	-
39	27.02	-	-	-
40	24.77	-	-	-

MALE

Policy	Issue Age			
Year	25	35	45	55
1	3.79	3.87	9.40	21.88
2	3.68	4.13	10.43	22.91
3	3.67	4.50	11.38	23.65
4	3.69	4.86	12.39	23.97
5	3.70	5.26	13.65	23.72
6	3.73	5.86	15.00	25.20
7	3.87	6.49	16.34	26.68
8	3.99	7.11	17.71	26.28
9	4.16	7.78	19.08	25.13
10	4.36	8.51	20.14	23.40
11	4.62	9.31	21.61	-
12	4.93	10.33	22.63	-
13	5.37	11.28	23.35	-
14	5.80	12.28	23.67	-
15	6.28	13.53	23.42	-
16	6.99	14.86	24.91	-
17	7.74	16.20	26.39	-
18	8.47	17.55	26.04	-
19	9.27	18.90	24.97	-
20	10.15	19.95	23.35	-
21	11.12	21.40	-	-
22	12.32	22.41	-	-
23	13.45	23.13	-	-
24	14.65	23.44	-	-
25	16.14	23.19	-	-
26	17.71	24.67	-	-
27	19.31	26.16	-	-
28	20.93	25.85	-	-
29	22.54	24.84	-	-
30	23.78	23.32	-	-
31	25.52	-	-	-
32	26.72	-	-	-
33	27.57	-	-	-
34	27.93	-	-	-
35	27.64	-	-	-
36	29.42	-	-	-
37	31.20	-	-	-
38	30.86	-	-	-
39	29.70	-	-	-
40	27.96	-	-	-

Berkshire Life Insurance Company of America
Pittsfield, Massachusetts

Exhibit 1

Annual Claim Cost per $100 Monthly Indemnity
To Age 65 Benefit Period, Occupation Class 5, 90-day Elimination Period
Modified Own Occupation Individual Disability Income Policy

FEMALE

Policy	Issue Age			
Year	25	35	45	55
1	5.61	9.89	26.78	32.84
2	5.66	11.19	27.83	32.39
3	5.79	12.58	28.75	31.60
4	6.05	14.05	29.96	30.02
5	6.54	15.59	30.63	28.34
6	7.11	17.89	31.57	28.82
7	7.80	19.58	32.31	29.29
8	8.61	21.57	32.46	27.94
9	9.53	23.28	32.84	25.98
10	10.67	24.95	32.60	23.56
11	11.78	26.56	32.56	-
12	13.32	27.60	32.10	-
13	14.98	28.52	31.31	-
14	16.73	29.70	29.75	-
15	18.56	30.37	28.09	-
16	21.28	31.29	28.58	-
17	23.29	32.03	29.07	-
18	25.67	32.17	27.75	-
19	27.69	32.56	25.85	-
20	29.68	32.31	23.53	-
21	31.59	32.26	-	-
22	32.82	31.81	-	-
23	33.91	31.03	-	-
24	35.32	29.48	-	-
25	36.11	27.82	-	-
26	37.20	28.33	-	-
27	38.07	28.83	-	-
28	38.24	27.57	-	-
29	38.69	25.73	-	-
30	38.41	23.49	-	-
31	38.34	-	-	-
32	37.80	-	-	-
33	36.87	-	-	-
34	35.03	-	-	-
35	33.06	-	-	-
36	33.67	-	-	-
37	34.29	-	-	-
38	32.84	-	-	-
39	30.70	-	-	-
40	28.15	-	-	-

MALE

Policy	Issue Age			
Year	25	35	45	55
1	4.30	4.40	10.68	24.86
2	4.18	4.69	11.85	26.03
3	4.17	5.12	12.94	26.87
4	4.19	5.52	14.08	27.23
5	4.20	5.98	15.51	26.96
6	4.24	6.66	17.04	28.64
7	4.40	7.38	18.57	30.32
8	4.54	8.08	20.13	29.86
9	4.72	8.84	21.69	28.56
10	4.96	9.67	22.88	26.59
11	5.25	10.58	24.56	-
12	5.61	11.74	25.72	-
13	6.11	12.82	26.54	-
14	6.59	13.96	26.90	-
15	7.13	15.38	26.62	-
16	7.95	16.89	28.30	-
17	8.80	18.40	29.99	-
18	9.62	19.94	29.59	-
19	10.54	21.48	28.37	-
20	11.53	22.67	26.54	-
21	12.63	24.32	-	-
22	14.00	25.47	-	-
23	15.29	26.28	-	-
24	16.65	26.64	-	-
25	18.34	26.35	-	-
26	20.13	28.04	-	-
27	21.94	29.72	-	-
28	23.78	29.37	-	-
29	25.62	28.22	-	-
30	27.02	26.50	-	-
31	29.00	-	-	-
32	30.36	-	-	-
33	31.33	-	-	-
34	31.74	-	-	-
35	31.41	-	-	-
36	33.43	-	-	-
37	35.46	-	-	-
38	35.06	-	-	-
39	33.75	-	-	-
40	31.77	-	-	-

Berkshire Life Insurance Company of America
Pittsfield, Massachusetts

Exhibit 2: Anticipated Loss Ratios

Policy Year	Earned Premium	Incurred Claims	Loss Ratio
1	1,000,000	363,992	36%
2	943,270	385,235	41%
3	896,420	386,066	43%
4	854,904	373,436	44%
5	823,354	367,563	45%
6	793,930	373,333	47%
7	771,046	372,485	48%
8	749,761	370,098	49%
9	728,546	369,259	51%
10	707,162	368,426	52%
11	624,445	349,717	56%
12	610,161	354,385	58%
13	596,686	357,229	60%
14	585,869	358,809	61%
15	576,096	358,037	62%
16	567,095	373,687	66%
17	558,823	368,770	66%
18	550,799	366,635	67%
19	543,399	363,203	67%
20	534,688	355,353	66%
21	380,702	291,452	77%
22	377,987	291,831	77%
23	375,605	290,910	77%
24	373,931	286,151	77%
25	372,611	277,323	74%
26	370,997	288,267	78%
27	368,733	271,596	74%
28	368,694	267,580	73%
29	371,234	259,514	70%
30	376,542	242,542	64%
31	197,631	129,524	66%
32	205,274	123,903	60%
33	212,209	121,109	57%
34	217,840	115,538	53%
35	219,241	107,081	49%
36	218,823	112,723	52%
37	214,447	100,268	47%
38	210,158	97,023	46%
39	205,955	90,109	44%
40	201,836	76,864	38%
Lifetime Loss Ratio			50.6%

Berkshire Life Insurance Company of America
700 South Street • Pittsfield, Massachusetts 01201
1-800-819-2468

DISABILITY INCOME PROTECTION COVERAGE
REQUIRED OUTLINE OF COVERAGE

Policy Form 1400

1. READ YOUR POLICY CAREFULLY – This outline provides a very brief description of Your Policy. This is not the insurance contract and only the actual provisions will control. The Policy itself sets forth in detail the rights and obligations of both You and Your insurance company. It is, therefore, important that YOU READ YOUR POLICY CAREFULLY.

2. DISABILITY INCOME PROTECTION – Policies of this category are designed to provide, to persons insured, Coverage for Disabilities resulting from a covered Injury or Sickness, subject to any limitations set forth in the Policy. Coverage is not provided for basic hospital, basic medical-surgical, or major medical expenses.

3. BENEFITS OF THE POLICY – The Policy provides benefits for Total Disability.

   $_____ Monthly Indemnity will be paid each month while You are Totally Disabled.

   Benefits will start at the end of an Elimination Period of _____.

   Your Benefit Period is _____.

   Total Disability Definition – The definition of Total Disability that applies to the Policy is checked below:

   ☐ Total Disability or Totally Disabled means that, solely due to Injury or Sickness, You are not able to perform the material and substantial duties of Your Occupation.

   You will be Totally Disabled even if You are Gainfully Employed in another occupation so long as, solely due to Injury or Sickness, You are not able to work in Your Occupation.

   Working an average of more than 40 hours in a week, in itself, is not a material and substantial duty.

   Your Occupation means the occupation (or occupations, if more than one) in which You are Gainfully Employed during the 12 months prior to the time You become Disabled.

   ☐ Total Disability or Totally Disabled means that, solely due to Injury or Sickness, You are not able to perform the material and substantial duties of Your Occupation.

   You will be Totally Disabled even if You are Gainfully Employed in another occupation so long as, solely due to Injury or Sickness, You are not able to work in Your Occupation.

   Working an average of more than 40 hours in a week, in itself, is not a material and substantial duty.

   Your Occupation means the occupation (or occupations, if more than one) in which You are Gainfully Employed during the 12 months prior to the time You become Disabled.

   If You have limited Your Occupation to the performance of the material and substantial duties of a single medical specialty or to a single dental specialty, We will deem that specialty to be Your Occupation.

☐ Total Disability or Totally Disabled means that, solely due to Injury or Sickness, You are not able to perform the material and substantial duties of Your Occupation and You are not Gainfully Employed.

Working an average of more than 40 hours in a week, in itself, is not a material and substantial duty.

Your Occupation means the occupation (or occupations, if more than one) in which You are Gainfully Employed during the 12 months prior to the time You become Disabled.

OPTIONAL BENEFITS – You have applied for those optional benefits checked below. There is a separate premium charge for each added benefit.

☐ Social Insurance Substitute Rider 1401 (All classes) – This rider provides a benefit for Disability when the benefits that You may be receiving from any social insurance plan do not equal or exceed the SIS Maximum Monthly Indemnity.

Your SIS Maximum Monthly Indemnity is $_____ per month.

The SIS benefit each month is equal to the SIS Maximum Monthly Indemnity less any benefits You are receiving from a social insurance plan. Social insurance benefits include benefits for disability from workers' compensation or occupational disease law or for disability or retirement from Social Security.

This benefit will be added to the Monthly Indemnity of the Policy in each month when such indemnity is payable for Disability.

This rider terminates on the earlier of the Expiration Date or the date You retire under the Social Security Act.

☐ Two-Year Residual Disability Benefit Rider 1403 (see Residual Disability Benefit Rider 1402 below)

Benefits for Residual Disability may be payable for up to 24 months in any one claim.

☐ Residual Disability Benefit Rider 1402 (Classes 6, 6M, 5, 5M, 4, 4M, 3 and 3M) – This rider provides reduced Monthly Indemnity when You are Residually Disabled.

Residual Disability means that You are Gainfully Employed and are not Totally Disabled under the terms of the Policy; but solely because of Injury or Sickness, Your Loss of Income is at least 15% of Your Prior Income.

The rider has the same Elimination Period as Your Policy.

For each month of the first 12 months that You are eligible for a Residual Disability benefit in the same claim, the policy will pay a Loss of Income Indemnity. The Loss of Income Indemnity is equal to Your Loss of Income less any individual disability insurance benefits You are receiving, or that You are eligible to receive from Berkshire Life Insurance Company of America and all other insurance companies on policies that are in force before the effective date of this rider. The Loss of Income Indemnity will not exceed your Monthly Indemnity. If you continue to be Residually Disabled after the Loss of Income Indemnity has been paid for 12 months, the policy pays a Residual Indemnity.

Your Residual Indemnity is based on the following formula:

$$\text{Residual Indemnity} = \frac{\text{Loss of Income}}{\text{Prior Income}} \times \text{Monthly Indemnity}$$

If You have a Social Insurance Substitute Rider, an Automatic Benefit Enhancement Rider, or an Additional Monthly Benefit Rider, any Monthly Benefits provided by these riders will be added to the Monthly Indemnity of this formula.

You may be Totally or Residually Disabled to satisfy the Elimination Period of the Policy or rider and to meet the conditions for waiver of premium.

You may not renew this rider after the Expiration Date.

☐ 3% Compound Cost Of Living Adjustment Rider 1404 (Classes 6, 6M, 5, 5M, 4, 4M, 3 and 3M) – This rider provides on the anniversary of a claim, while benefits are payable, a 3% adjustment in Monthly Indemnity that will be applicable to benefits paid for the next 12 months.

If You have a Social Insurance Substitute Rider, an Automatic Benefit Enhancement Rider, or an Additional Monthly Benefit Rider, any Monthly Benefits provided by these riders will be adjusted in the same manner.

You may not renew this rider after the Expiration Date.

☐ Future Increase Option Rider 1405 (Classes 6, 6M, 5, 5M, 4, 4M, 3 and 3M) – This rider gives You the right to apply for additional disability income insurance in future years despite any change in Your health or occupation. Your Option Date each year is the Policy Anniversary until You are Age 55.

This rider includes a Special Option Date that may be used once while this rider is in effect if You lose Your Group Long-Term Disability Coverage and it is not subsequently replaced.

Your total Future Increase Option is $_____.

Until You are Age 45, You may apply for all or part of the remaining Total Increase Option on any one Option Date. On or after Age 45, You may apply for up to one-third of the remaining Total Increase Option, or the remaining Total Increase Option if it is less than $1,000, on any Option Date.

Each Increase Policy applied for during an Option Period or a Special Option Period will be underwritten to determine the maximum amount of Monthly Indemnity, if any, available to You. You must provide evidence of Your Income, employment and all other disability insurance with any insurer that is in force, which You have applied for, or for which You are eligible. We may require additional evidence of financial insurability, as necessary. You do not have to provide evidence of Your medical insurability or occupation.

This rider expires after You are Age 55 or, if earlier, when You use Your last Increase Option.

☐ Automatic Benefit Enhancement Rider 1406 (Classes 6, 6M, 5, 5M, 4, 4M, 3 and 3M) – This rider provides for an Automatic Increase of 4% in the Monthly Indemnity of the Policy on each of six consecutive Policy Anniversaries.

After a Rider Review Date and before the next Policy Anniversary, You may submit an application to renew this rider for the smallest of:

- another six Automatic Increases; or
- the number of Automatic Increases between your attained Age and Age 60, whichever is less; or
- the number of Automatic Increases which will not cause the Monthly Indemnity to exceed the maximum amount of allowable Monthly Indemnity, if any, available to You based on Our underwriting rules in effect at the time You apply for rider renewal.

If You apply to renew this rider, You must provide evidence of Your medical insurability, Income, occupation, employment and other insurance in force, applied for, or for which You are eligible. We may require additional evidence of financial insurability to renew this rider.

Your application to renew this rider will be underwritten in accordance with Our underwriting rules in effect at the time You apply for renewal to determine if You are eligible to renew this rider.

If benefits have been paid by Us under the Policy, You are not eligible to renew this rider.

This rider is renewable at six-year intervals but not past Age 60.

☐ Partial Disability Benefit Rider 1407 (Classes 2, 2M, 1 and 1M) – This rider provides one-half of the Monthly Indemnity when You are Partially Disabled after a period of Total Disability.

The Partial Indemnity of this rider is payable for six months or, if earlier, the end of the Benefit Period.

You must be Totally Disabled for the length of the Elimination Period before You become Partially Disabled.

Partial Disability means that You are Gainfully Employed but, because of Injury or Sickness:

– You are able to perform one or more but not all of the material and substantial duties of Your Occupation; or
– You are unable to perform the material and substantial duties of Your Occupation for more than one-half of the time normally required.

You may not renew this rider after the Expiration Date.

☐ Unemployment Waiver of Premium Rider 1409 (All classes) – Under this rider, We will waive the premiums of the Policy if You become unemployed and receive unemployment compensation for at least 60 consecutive days.

We will waive the premiums for a 12-month period beginning on the date You become unemployed even if You return to work.

Premiums may not be waived for a subsequent Unemployment Period until 48 months have elapsed from the end of the previous Unemployment Period.

You may not renew this rider after You are Age 60.

☐ Catastrophic Disability Benefit Rider 1410 (Classes 6, 6M, 5, 5M, 4, 4M, 3 and 3M) – This rider provides a Catastrophic Disability Benefit if You are Catastrophically Disabled.

Catastrophically Disabled means that due to Injury or Sickness You are: unable to perform two or more of the Activities of Daily Living without Human Standby Assistance; or You are Cognitively Impaired; or You are Irrecoverably Disabled. The Activities of Daily Living are Bathing, Dressing, Eating, Transferring, Toileting and Continence.

$_____ Catastrophic Disability Monthly Benefit will be paid at the end of each month while You are Catastrophically Disabled. Benefits will start at the end of an Elimination Period of _____.

Cognitive Impairment means You have suffered a severe deterioration or loss in Your cognitive capacity which requires Substantial Supervision to protect You or others from threats to health and safety. Substantial Supervision means continual supervision by another person that may include physical assistance, cueing by verbal prompting, gestures, or other similar demonstrations. The Cognitive Impairment must result from Injury, Sickness, Alzheimer's disease, senility or irreversible dementia, and must be supported by reliable clinical evidence and standardized tests that reliably measure Your impairment in short- or long-term memory; Your orientation as to person (such as who You are), place (such as Your location), and time (such as day, date and year); and deductive or abstract reasoning.

Irrecoverably Disabled means that, even if You are Gainfully Employed, Injury or Sickness results in Your total, complete and irrecoverable loss of: the sight in both eyes; or hearing in both ears; or speech; or the use of both hands, both feet, or one hand and one foot, in their entirety.

Maximum Monthly Catastrophic Disability Indemnity is equal to two times the Catastrophic Disability Indemnity shown in the Schedule Page.

You may not renew this rider after the Expiration Date.

☐ 6% Maximum Cost Of Living Adjustment Rider 1412 (Classes 6, 6M, 5, 5M, 4, 4M, 3 and 3M) – This rider adjusts the Monthly Indemnity of Your Policy at the end of each 12 months in a continuous claim to reflect any changes in the cost of living.

We will adjust Your Monthly Indemnity based on changes in the Consumer Price Index for All Urban Consumers (CPI-U) from the start of claim. If You have a Social Insurance Substitute Rider, an Automatic Benefit Enhancement Rider, or an Additional Monthly Benefit Rider, any Monthly Benefits provided by these riders will be adjusted in the same manner.

Your Monthly Indemnity may vary from year to year as the CPI-U rises or falls in relation to the Original Index Month. The adjustment to the Monthly Indemnity will never be less than what a 3% compound rate would provide or more than a 6% compound rate would provide.

You may not renew this rider after the Expiration Date.

☐ Four-Year Delayed Cost Of Living Adjustment Rider 1413 (Classes 6, 6M, 5, 5M, 4, 4M, 3 and 3M) – This rider provides, starting on the fourth anniversary of a claim while benefits are payable, a 3% adjustment in Monthly Indemnity that will be applicable to benefits paid for the next 12 months.

If You have a Social Insurance Substitute Rider, an Automatic Benefit Enhancement Rider, or an Additional Monthly Benefit Rider, any Monthly Benefits provided by these riders will be adjusted in the same manner.

You may not renew this rider after the Expiration Date.

☐ Graded Lifetime Indemnity for Total Disability Rider 1414 (Classes 6, 6M, 5, 5M, 4, 4M, 3 and 3M) – This rider provides lifetime benefits if You become Totally Disabled before Age 65 and remain continuously Totally disabled in the same claim after the Expiration Date. The Lifetime Indemnity percentage is based on Your Age when the continuous Total Disability begins. For each year after Age 45, the percentage decreases by 5%.

You may not renew this rider after You attain Age 65 and are not Totally Disabled.

☐ Retirement Protection Plus Disability Benefit Rider 1415 (Classes 6, 6M, 5, 5M, 4, 4M, 3 and 3M) – This rider provides an RPP Monthly Indemnity benefit payable to an irrevocable trust if You are Totally Disabled and not Gainfully Employed.

$_____ RPP Monthly Indemnity will be paid at the end of each month while You are Totally Disabled and not Gainfully Employed.

Benefits will start at the end of an Elimination Period of _____

You may not renew this rider after Age 65.

☐ Lump Sum Disability Benefit Rider 1416 (Classes 6, 6M, 5, 5M, 4, 4M, 3 and 3M) – This rider provides a lump sum benefit at the later of the Expiration Date of the Policy or the end of the Benefit Period if Disabled. The Lump Sum Benefit Amount will only be paid if the Policy and this rider are in force on the Expiration Date of the Policy, and if the sum of Contributing Payments is equal to or greater than the Qualifying Amount. The Lump Sum Benefit Amount is equal to the sum of Contributing Payments multiplied by 35%.

Contributing Payments are any Total Disability benefits and/or Residual Disability benefits paid under the Policy until the later of the Expiration Date or the end of the Benefit Period if Disabled.

Your Qualifying Amount is $_____.

You may not renew this rider after the Expiration Date.

☐ Basic Residual Disability Benefit Rider 1417 (Classes 6, 6M, 5, 5M, 4, 4M, 3 and 3M) – This rider provides reduced Monthly Indemnity when You are Residually Disabled.

Residual Disability or Residually Disabled means that You are Gainfully Employed and You are not Totally Disabled under the terms of the Policy, but solely due to Injury or Sickness:

- You experience a Loss of Income that is at least 20% of Your Prior Income; and either
- You are able to perform one or more, but not all, of the material and substantial duties of Your Occupation; or
- You are able to perform all of the material and substantial duties of Your Occupation but not for the length of time they normally require.

Working an average of more than 40 hours in a week, in itself, is not a material and substantial duty.

The rider has the same Elimination Period as Your Policy.

Your Residual Indemnity is based on the following formula:

$$\text{Residual Indemnity} = \frac{\text{Loss of Income}}{\text{Prior Income}} \times \text{Monthly Indemnity}$$

During the first six months in which Residual Indemnity is payable, We will deem Your Loss of Income to be 50% of Your Prior Income or the actual percentage of loss, if greater.

If You have a Social Insurance Substitute Rider or an Automatic Benefit Enhancement Rider, any Monthly Benefits provided by these riders will be added to the Monthly Indemnity of this formula.

You may be Totally or Residually Disabled to satisfy the Elimination Period of the Policy and to meet the conditions for waiver of premium.

You may not renew this rider after the Expiration Date.

☐ 3% Maximum Cost Of Living Adjustment Rider 1418 (Classes 6, 6M, 5, 5M, 4, 4M, 3 and 3M) – This rider adjusts the Monthly Indemnity of Your Policy at the end of each 12 months in a continuous claim to reflect any changes in the cost of living.

On the first Review Date, We will adjust the Monthly Indemnity by multiplying the Monthly Indemnity by the Cost of Living Adjustment Factor. On each subsequent Review Date while benefits are payable, We will adjust the Monthly Indemnity by multiplying the prior year's adjusted Monthly Indemnity by the Cost of Living Adjustment Factor.

The Cost of Living Adjustment Factor will never be less than 1.00 or greater than 1.03.

You may not renew this rider after the Expiration Date.

☐ Benefit Purchase Rider 1419 (Classes 6, 6M, 5, 5M, 4, 4M, 3 and 3M) – This rider gives You the opportunity to apply for additional disability income insurance in future years despite any change in Your health. We will review Your eligibility for an Increase Policy on every third Policy Anniversary while this rider is in effect. To keep this rider in effect, You must submit an application and other evidence of insurability during the Benefit Purchase Period.

You may apply for one Increase Policy between each Review Date while this rider is in effect if You have at least a 50% increase in Your Income during the first three years after the Effective Date of the Policy or since the last Review Date, or You lose Your Group Long-Term Disability Coverage and it is not subsequently replaced.

Each Increase Policy applied for during a Benefit Purchase Period or as part of a Special Benefit Purchase Option Offer will be underwritten to determine the maximum amount of Monthly Indemnity, if any, available to You. You must provide evidence of Your Income, occupation, employment and all other disability insurance with any insurer that is in force, which You have applied for, or for which You are eligible. We may require additional evidence of financial insurability, as necessary. You do not have to provide evidence of Your medical insurability.

This rider terminates when the first of the following events occurs:

- An application for an Increase Policy and required evidence of insurability is not received during the Benefit Purchase Period; or
- Less than 50% of Our offer to increase the Monthly Indemnity is accepted; or
- The initial premium for any Increase Policy is not paid; or
- The date of Your request to decrease the Monthly Indemnity of the Policy to which this rider is attached; or
- The date of Your written request to terminate this rider; or
- You attain Age 55; or
- The Policy terminates.

4. EXCLUSIONS AND LIMITATIONS OF THE POLICY – We will not pay benefits for any Disability:

- caused by, contributed to, or which results from military training, military action, military conflict, or war, whether declared or undeclared, while You are serving in the military or units auxiliary thereto, or working for contracted military services;
- during any period of time in which You are incarcerated;
- caused by, contributed to, or which results from Your commission of, or attempt to commit, a criminal offense as defined under local, state, or federal law;
- caused by, contributed to, or which results from Your being engaged in an illegal occupation;
- caused by, contributed to, or which results from the suspension, revocation or surrender of Your professional or occupational license or certification;
- caused by, contributed to, or which results from an intentionally self-inflicted Injury;
- during the first three months of Disability or the Elimination Period, if longer, that is caused by, contributed to, or which results from normal pregnancy or childbirth; or
- due to any loss We have excluded by name or specific description.

LIMITATION WHILE OUTSIDE THE UNITED STATES OR CANADA-You must be living full time in the 50 states which comprise the United States of America, the District of Columbia or Canada in order to receive benefits under the Policy, except for incidental travel or vacation; otherwise, benefits will cease. Incidental travel or vacation means being outside of the 50 states which comprise the United States of America, the District of Columbia or Canada for less than 60 days in a 12-month period. You may not recover benefits that have ceased pursuant to this limitation.

If benefits under the Policy have ceased pursuant to this limitation and You return to the 50 states that comprise the United States of America, the District of Columbia or Canada, You may become eligible to resume receiving benefits under the Policy. You must satisfy all terms and conditions of the Policy in order to be eligible to resume receiving benefits under the Policy.

If You remain outside of the 50 states which comprise the United States of America, the District of Columbia or Canada, premiums will become due beginning six months after benefits cease.

PRE-EXISTING CONDITION LIMITATION – We will not cover any loss that begins in the first two years after the Effective Date from a Pre-existing Condition.

Pre-existing Condition means a physical or mental condition:

- that was misrepresented or not disclosed in Your application; and
- for which You received professional medical advice, diagnosis or treatment within two years before the Effective Date; or
- that caused symptoms within one year before the Effective Date for which a prudent person would usually seek professional medical advice, diagnosis or treatment.

MENTAL AND/OR SUBSTANCE-RELATED DISORDERS LIMITATION – Benefits for any Disability due to a Mental and/or Substance-Related Disorder will be paid for a period not longer than the Maximum Benefit Period for Mental and/or Substance-Related Disorders as shown in the Schedule Page of the Policy.

After the Maximum Benefit Period for Mental and/or Substance-Related Disorders and subject to the Policy provisions, We will only pay benefits while You are continuously confined in a Hospital for treatment of a Disability due to a Mental and/or Substance-Related Disorder, and You are under the regular medical care of a Physician.

Under no circumstance will We pay benefits for any Disability due to a Mental and/or Substance-Related Disorder that We have excluded by name or specific description.

5. RENEWABILITY OF THE POLICY – You may renew the Policy at the end of each Premium Term until the Expiration Date. During that time, We cannot change the premium or cancel the Policy.

   After the Expiration Date, You may renew the Policy at the end of each Premium Term as long as You are not Disabled and You are Gainfully Employed Full Time for at least ten months each year and the premium is paid on time.

   Your premium will be at Our rates then in effect for persons of Your Age, Class of Risk, Occupation Class, and any special class rating that applies to the Policy. We have the right to change such premiums on a class basis on any Policy Anniversary.

Berkshire Life Insurance Company of America
700 South Street
Pittsfield, MA 01201

BASIC RESIDUAL DISABILITY BENEFIT RIDER

This rider is a part of the Policy to which it is attached. All provisions of the Policy apply to this rider and remain the same except where We change them by this rider.

The Policy is amended by adding or changing the following provisions:

DEFINITIONS

CPI-U
CPI-U means the Consumer Price Index for All Urban Consumers, or any later replacement of it, as published by the United States Department of Labor.

Current Index Month
Current Index Month means the anniversary of the Original Index Month immediately preceding the Review Date.

Disability or Disabled
Disability or Disabled is amended to also include Residual Disability or Residually Disabled.

Original Index Month
Original Index Month means the calendar month 90 days before the date on which You were first Disabled in the same claim.

Residual Disability or Residually Disabled
Residual Disability or Residually Disabled means that You are Gainfully Employed and You are not Totally Disabled under the terms of the Policy, but solely due to Injury or Sickness:

- You experience a Loss of Income that is at least 20% of Your Prior Income; and either
- You are unable to perform one or more~~, but not all,~~ of the material and substantial duties of Your Occupation; or
- You are able to perform all of the material and substantial duties of Your Occupation but not for the length of time they normally require.

Working an average of more than 40 hours in a week, in itself, is not a material and substantial duty.

Residual Indemnity
Residual Indemnity means the amount We will pay for each month of Residual Disability. It is a percentage of the Monthly Indemnity.

Review Date
Review Date means the recurrence each year of the date on which You were first Disabled in the same claim.

PROVISIONS RELATING TO RESIDUAL DISABILITY

Residual Disability Benefit
When You are Residually Disabled, We will pay Residual Indemnity as follows:

- You must become Disabled while the Policy is in force.
- You must satisfy the Elimination Period.
- After You have satisfied the Elimination Period, Residual Indemnity will be payable at the end of each month while You are Residually Disabled.

For each month benefits are payable under this rider, Residual Indemnity may never exceed Loss of Income, except as stated in the Enhancements to Residual Indemnity provision.

Payment of Residual Indemnity
Residual Indemnity will be determined by the formula (a) divided by (b) multiplied by (c), where:

(a) is Your Loss of Income for the month in which You are Residually Disabled; and
(b) is Your Prior Income; and
(c) is the Monthly Indemnity.

Enhancements to Residual Indemnity
During the first six months in which Residual Indemnity is payable, We will deem Your Loss of Income to be 50% of Your Prior Income or the actual percentage of loss, if greater.

If Your Loss of Income is more than 75% of Prior Income in any month of Residual Disability while Residual Indemnity is payable, We will deem such loss to be 100%.

We will not increase the Residual Indemnity because You are Disabled from more than one cause at the same time.

Adjustment of Prior Income and Prior Business Expenses
On the Review Date while Residual Indemnity is payable, We will adjust Your Prior Income and Prior Business Expenses for the next 12 months to reflect any changes in cost of living since the start of claim. We will adjust the Prior Income and Prior Business Expenses by multiplying each by the actual percentage change in the CPI-U between the Current Index Month and the Original Index Month. The adjusted Prior Income and adjusted Prior Business Expenses will apply to the 12-month period that follows the Review Date and will be used to determine Your Loss of Income.

The adjustment to Prior Income and Prior Business Expenses may vary from year to year as the CPI-U rises or falls in relation to the Original Index Month. We will make no change that would reduce Prior Income or Prior Business Expenses below what they were at the start of claim.

We will adjust the Prior Income and Prior Business Expenses on each Review Date while Residual Indemnity is payable until the first of the following events occurs:

- a Recovery Benefit is payable; or
- the Benefit Period ends; or
- this rider terminates.

Recovery Benefit
We will pay You a Recovery Benefit if:

- You are no longer Disabled; and
- You return to Full Time Gainful Employment immediately following a period of Disability for which We paid benefits under the Policy; and
- Your Loss of Income is at least 20% of Your Prior Income; and
- Your Loss of Income is solely due to the Injury or Sickness that caused Your Disability.

The Recovery Benefit payable will be a percentage of the Monthly Indemnity for the Policy. The Recovery Benefit will be determined by the formula (a) divided by (b) multiplied by (c), where:

(a) is Your Loss of Income for the month in which You are claiming a Recovery Benefit; and
(b) is Your Prior Income; and
(c) is the Monthly Indemnity in effect on the last Review Date before Your Disability ended.

We will continue to waive premiums while You are receiving a Recovery Benefit even if it exceeds the six-month period after You recover as stated in the Waiver of Premium provision of the Policy. We will continue to waive premiums until the later of:

- the end of the six-month period after You recover; or
- the date the Recovery Benefit is no longer payable.

Proof of Loss
In addition to any Proof of Loss required by the Policy, You must provide Us with written Proof of Loss necessary to establish that Your Loss of Income is solely the result of the Injury or Sickness that caused Your Disability.

Premium and Renewal
The premium for this rider is shown in the Schedule Page. You may not renew this rider after the Expiration Date of the Policy.

TERMINATION

Termination of Residual Indemnity
Residual Indemnity will no longer be payable on the date that the first of the following events occurs:

- You are no longer Residually Disabled; or
- Your Loss of Income is no longer solely due to the Injury or Sickness that caused Your Residual Disability; or
- You become Totally Disabled; or
- the Benefit Period ends; or
- this rider terminates.

Termination of Recovery Benefit
Recovery Benefit will no longer be payable on the date that the first of the following events occurs:

- You become Disabled; or
- You are no longer Gainfully Employed Full Time; or
- Your Loss of Income is no longer solely due to the Injury or Sickness that caused Your Disability; or
- Your Loss of Income is less than 20% of Your Prior Income; or
- the Benefit Period ends; or
- this rider terminates.

Berkshire Life Insurance Company of America

Secretary

Berkshire Life Insurance Company of America
700 South Street
Pittsfield, MA 01201

BASIC RESIDUAL DISABILITY BENEFIT RIDER

As of the Effective Date shown below, this rider is attached to the Policy. All provisions of the Policy apply to this rider and remain the same except where We change them by this rider.

Policy Number:

Insured:

Effective Date of this rider:

The Policy is amended by adding or changing the following provisions:

DEFINITIONS

CPI-U
CPI-U means the Consumer Price Index for All Urban Consumers, or any later replacement of it, as published by the United States Department of Labor.

Current Index Month
Current Index Month means the anniversary of the Original Index Month immediately preceding the Review Date.

Disability or Disabled
Disability or Disabled is amended to also include Residual Disability or Residually Disabled.

Original Index Month
Original Index Month means the calendar month 90 days before the date on which You were first Disabled in the same claim.

Residual Disability or Residually Disabled
Residual Disability or Residually Disabled means that You are Gainfully Employed and You are not Totally Disabled under the terms of the Policy, but solely due to Injury or Sickness:

- You experience a Loss of Income that is at least 20% of Your Prior Income; and either
- You are unable to perform one or more~~, but not all,~~ of the material and substantial duties of Your Occupation; or
- You are able to perform all of the material and substantial duties of Your Occupation but not for the length of time they normally require.

Working an average of more than 40 hours in a week, in itself, is not a material and substantial duty.

Residual Indemnity
Residual Indemnity means the amount We will pay for each month of Residual Disability. It is a percentage of the Monthly Indemnity.

Review Date
Review Date means the recurrence each year of the date on which You were first Disabled in the same claim.

PROVISIONS RELATING TO RESIDUAL DISABILITY

Residual Disability Benefit
When You are Residually Disabled, We will pay Residual Indemnity as follows:

- You must become Disabled while the Policy is in force.

- You must satisfy the Elimination Period.
- After You have satisfied the Elimination Period, Residual Indemnity will be payable at the end of each month while You are Residually Disabled.

For each month benefits are payable under this rider, Residual Indemnity may never exceed Loss of Income, except as stated in the Enhancements to Residual Indemnity provision.

Payment of Residual Indemnity
Residual Indemnity will be determined by the formula (a) divided by (b) multiplied by (c), where:

(a) is Your Loss of Income for the month in which You are Residually Disabled; and
(b) is Your Prior Income; and
(c) is the Monthly Indemnity.

Enhancements to Residual Indemnity
During the first six months in which Residual Indemnity is payable, We will deem Your Loss of Income to be 50% of Your Prior Income or the actual percentage of loss, if greater.

If Your Loss of Income is more than 75% of Prior Income in any month of Residual Disability while Residual Indemnity is payable, We will deem such loss to be 100%.

We will not increase the Residual Indemnity because You are Disabled from more than one cause at the same time.

Adjustment of Prior Income and Prior Business Expenses
On the Review Date while Residual Indemnity is payable, We will adjust Your Prior Income and Prior Business Expenses for the next 12 months to reflect any changes in cost of living since the start of claim. We will adjust the Prior Income and Prior Business Expenses by multiplying each by the actual percentage change in the CPI-U between the Current Index Month and the Original Index Month. The adjusted Prior Income and adjusted Prior Business Expenses will apply to the 12-month period that follows the Review Date and will be used to determine Your Loss of Income.

The adjustment to Prior Income and Prior Business Expenses may vary from year to year as the CPI-U rises or falls in relation to the Original Index Month. We will make no change that would reduce Prior Income or Prior Business Expenses below what they were at the start of claim.

We will adjust the Prior Income and Prior Business Expenses on each Review Date while Residual Indemnity is payable until the first of the following events occurs:
- a Recovery Benefit is payable; or
- the Benefit Period ends; or
- this rider terminates.

Recovery Benefit
We will pay You a Recovery Benefit if:
- You are no longer Disabled; and
- You return to Full Time Gainful Employment immediately following a period of Disability for which We paid benefits under the Policy; and
- Your Loss of Income is at least 20% of Your Prior Income; and
- Your Loss of Income is solely due to the Injury or Sickness that caused Your Disability.

The Recovery Benefit payable will be a percentage of the Monthly Indemnity for the Policy. The Recovery Benefit will be determined by the formula (a) divided by (b) multiplied by (c), where:

(a) is Your Loss of Income for the month in which You are claiming a Recovery Benefit; and
(b) is Your Prior Income; and
(c) is the Monthly Indemnity in effect on the last Review Date before Your Disability ended.

We will continue to waive premiums while You are receiving a Recovery Benefit even if it exceeds the six-month period after You recover as stated in the Waiver of Premium provision of the Policy. We will continue to waive premiums until the later of:

- the end of the six-month period after You recover; or
- the date the Recovery Benefit is no longer payable.

Proof of Loss
In addition to any Proof of Loss required by the Policy, You must provide Us with written Proof of Loss necessary to establish that Your Loss of Income is solely the result of the Injury or Sickness that caused Your Disability.

Premium and Renewal
The premium for this rider is shown in the Schedule Page. You may not renew this rider after the Expiration Date of the Policy.

Incontestable
This rider will be incontestable as to the statements, except fraudulent statements, contained in the application for this rider after it has been in force for two years during Your lifetime from the Effective Date of this rider, excluding any period during which You are Disabled. No claim for a loss incurred or Disability that begins after two years from this date, excluding any period during which You are Disabled, will be reduced or denied because a sickness or physical condition existed prior to the Effective Date of this rider. This assumes that such sickness or physical condition was not excluded from Coverage by name or description under the Policy.

In the event of a reinstatement, this rider will be incontestable as to statements made by You, except fraudulent statements, contained in the application for reinstatement of the Policy after it has been in force for a period of two years following the date the Policy was reinstated, excluding any period during which You are Disabled.

TERMINATION

Termination of Residual Indemnity
Residual Indemnity will no longer be payable on the date that the first of the following events occurs:

- You are no longer Residually Disabled; or
- Your Loss of Income is no longer solely due to the Injury or Sickness that caused Your Residual Disability; or
- You become Totally Disabled; or
- the Benefit Period ends; or
- this rider terminates.

Termination of Recovery Benefit
Recovery Benefit will no longer be payable on the date that the first of the following events occurs:

- You become Disabled; or
- You are no longer Gainfully Employed Full Time; or
- Your Loss of Income is no longer solely due to the Injury or Sickness that caused Your Disability; or
- Your Loss of Income is less than 20% of Your Prior Income; or
- the Benefit Period ends; or
- this rider terminates.

Berkshire Life Insurance Company of America

Secretary

Berkshire Life Insurance Company of America
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DISABILITY INCOME PROTECTION COVERAGE
REQUIRED OUTLINE OF COVERAGE

Policy Form 1400

1. READ YOUR POLICY CAREFULLY – This outline provides a very brief description of Your Policy. This is not the insurance contract and only the actual provisions will control. The Policy itself sets forth in detail the rights and obligations of both You and Your insurance company. It is, therefore, important that YOU READ YOUR POLICY CAREFULLY.

2. DISABILITY INCOME PROTECTION – Policies of this category are designed to provide, to persons insured, Coverage for Disabilities resulting from a covered Injury or Sickness, subject to any limitations set forth in the Policy. Coverage is not provided for basic hospital, basic medical-surgical, or major medical expenses.

3. BENEFITS OF THE POLICY – The Policy provides benefits for Total Disability.

   $_____ Monthly Indemnity will be paid each month while You are Totally Disabled.

   Benefits will start at the end of an Elimination Period of _____.

   Your Benefit Period is _____.

   Total Disability Definition – The definition of Total Disability that applies to the Policy is checked below:

   ☐ Total Disability or Totally Disabled means that, solely due to Injury or Sickness, You are not able to perform the material and substantial duties of Your Occupation.

   You will be Totally Disabled even if You are Gainfully Employed in another occupation so long as, solely due to Injury or Sickness, You are not able to work in Your Occupation.

   Working an average of more than 40 hours in a week, in itself, is not a material and substantial duty.

   Your Occupation means the occupation (or occupations, if more than one) in which You are Gainfully Employed during the 12 months prior to the time You become Disabled.

   ☐ Total Disability or Totally Disabled means that, solely due to Injury or Sickness, You are not able to perform the material and substantial duties of Your Occupation.

   You will be Totally Disabled even if You are Gainfully Employed in another occupation so long as, solely due to Injury or Sickness, You are not able to work in Your Occupation.

   Working an average of more than 40 hours in a week, in itself, is not a material and substantial duty.

   Your Occupation means the occupation (or occupations, if more than one) in which You are Gainfully Employed during the 12 months prior to the time You become Disabled.

   If You have limited Your Occupation to the performance of the material and substantial duties of a single medical specialty or to a single dental specialty, We will deem that specialty to be Your Occupation.

☐ Total Disability or Totally Disabled means that, solely due to Injury or Sickness, You are not able to perform the material and substantial duties of Your Occupation and You are not Gainfully Employed.

Working an average of more than 40 hours in a week, in itself, is not a material and substantial duty.

Your Occupation means the occupation (or occupations, if more than one) in which You are Gainfully Employed during the 12 months prior to the time You become Disabled.

OPTIONAL BENEFITS – You have applied for those optional benefits checked below. There is a separate premium charge for each added benefit.

☐ Social Insurance Substitute Rider 1401 (All classes) – This rider provides a benefit for Disability when the benefits that You may be receiving from any social insurance plan do not equal or exceed the SIS Maximum Monthly Indemnity.

Your SIS Maximum Monthly Indemnity is $_____ per month.

The SIS benefit each month is equal to the SIS Maximum Monthly Indemnity less any benefits You are receiving from a social insurance plan. Social insurance benefits include benefits for disability from workers' compensation or occupational disease law or for disability or retirement from Social Security.

This benefit will be added to the Monthly Indemnity of the Policy in each month when such indemnity is payable for Disability.

This rider terminates on the earlier of the Expiration Date or the date You retire under the Social Security Act.

☐ Two-Year Residual Disability Benefit Rider 1403 (see Residual Disability Benefit Rider 1402 below)

Benefits for Residual Disability may be payable for up to 24 months in any one claim.

☐ Residual Disability Benefit Rider 1402 (Classes 6, 6M, 5, 5M, 4, 4M, 3 and 3M) – This rider provides reduced Monthly Indemnity when You are Residually Disabled.

Residual Disability means that You are Gainfully Employed and are not Totally Disabled under the terms of the Policy; but solely because of Injury or Sickness, Your Loss of Income is at least 15% of Your Prior Income.

The rider has the same Elimination Period as Your Policy.

For each month of the first 12 months that You are eligible for a Residual Disability benefit in the same claim, the policy will pay a Loss of Income Indemnity. The Loss of Income Indemnity is equal to Your Loss of Income less any individual disability insurance benefits You are receiving, or that You are eligible to receive from Berkshire Life Insurance Company of America and all other insurance companies on policies that are in force before the effective date of this rider. The Loss of Income Indemnity will not exceed your Monthly Indemnity. If you continue to be Residually Disabled after the Loss of Income Indemnity has been paid for 12 months, the policy pays a Residual Indemnity.

Your Residual Indemnity is based on the following formula:

$$\text{Residual Indemnity} = \frac{\text{Loss of Income}}{\text{Prior Income}} \times \text{Monthly Indemnity}$$

If You have a Social Insurance Substitute Rider, an Automatic Benefit Enhancement Rider, or an Additional Monthly Benefit Rider, any Monthly Benefits provided by these riders will be added to the Monthly Indemnity of this formula.

You may be Totally or Residually Disabled to satisfy the Elimination Period of the Policy or rider and to meet the conditions for waiver of premium.

You may not renew this rider after the Expiration Date.

☐ 3% Compound Cost Of Living Adjustment Rider 1404 (Classes 6, 6M, 5, 5M, 4, 4M, 3 and 3M) – This rider provides on the anniversary of a claim, while benefits are payable, a 3% adjustment in Monthly Indemnity that will be applicable to benefits paid for the next 12 months.

If You have a Social Insurance Substitute Rider, an Automatic Benefit Enhancement Rider, or an Additional Monthly Benefit Rider, any Monthly Benefits provided by these riders will be adjusted in the same manner.

You may not renew this rider after the Expiration Date.

☐ Future Increase Option Rider 1405 (Classes 6, 6M, 5, 5M, 4, 4M, 3 and 3M) – This rider gives You the right to apply for additional disability income insurance in future years despite any change in Your health or occupation. Your Option Date each year is the Policy Anniversary until You are Age 55.

This rider includes a Special Option Date that may be used once while this rider is in effect if You lose Your Group Long-Term Disability Coverage and it is not subsequently replaced.

Your total Future Increase Option is $_____.

Until You are Age 45, You may apply for all or part of the remaining Total Increase Option on any one Option Date. On or after Age 45, You may apply for up to one-third of the remaining Total Increase Option, or the remaining Total Increase Option if it is less than $1,000, on any Option Date.

Each Increase Policy applied for during an Option Period or a Special Option Period will be underwritten to determine the maximum amount of Monthly Indemnity, if any, available to You. You must provide evidence of Your Income, employment and all other disability insurance with any insurer that is in force, which You have applied for, or for which You are eligible. We may require additional evidence of financial insurability, as necessary. You do not have to provide evidence of Your medical insurability or occupation.

This rider expires after You are Age 55 or, if earlier, when You use Your last Increase Option.

☐ Automatic Benefit Enhancement Rider 1406 (Classes 6, 6M, 5, 5M, 4, 4M, 3 and 3M) – This rider provides for an Automatic Increase of 4% in the Monthly Indemnity of the Policy on each of six consecutive Policy Anniversaries.

After a Rider Review Date and before the next Policy Anniversary, You may submit an application to renew this rider for the smallest of:

- another six Automatic Increases; or
- the number of Automatic Increases between your attained Age and Age 60, whichever is less; or
- the number of Automatic Increases which will not cause the Monthly Indemnity to exceed the maximum amount of allowable Monthly Indemnity, if any, available to You based on Our underwriting rules in effect at the time You apply for rider renewal.

If You apply to renew this rider, You must provide evidence of Your medical insurability, Income, occupation, employment and other insurance in force, applied for, or for which You are eligible. We may require additional evidence of financial insurability to renew this rider.

Your application to renew this rider will be underwritten in accordance with Our underwriting rules in effect at the time You apply for renewal to determine if You are eligible to renew this rider.

If benefits have been paid by Us under the Policy, You are not eligible to renew this rider.

This rider is renewable at six-year intervals but not past Age 60.

☐ Partial Disability Benefit Rider 1407 (Classes 2, 2M, 1 and 1M) – This rider provides one-half of the Monthly Indemnity when You are Partially Disabled after a period of Total Disability.

The Partial Indemnity of this rider is payable for six months or, if earlier, the end of the Benefit Period.

You must be Totally Disabled for the length of the Elimination Period before You become Partially Disabled.

Partial Disability means that You are Gainfully Employed but, because of Injury or Sickness:

– You are able to perform one or more but not all of the material and substantial duties of Your Occupation; or
– You are unable to perform the material and substantial duties of Your Occupation for more than one-half of the time normally required.

You may not renew this rider after the Expiration Date.

☐ Unemployment Waiver of Premium Rider 1409 (All classes) – Under this rider, We will waive the premiums of the Policy if You become unemployed and receive unemployment compensation for at least 60 consecutive days.

We will waive the premiums for a 12-month period beginning on the date You become unemployed even if You return to work.

Premiums may not be waived for a subsequent Unemployment Period until 48 months have elapsed from the end of the previous Unemployment Period.

You may not renew this rider after You are Age 60.

☐ Catastrophic Disability Benefit Rider 1410 (Classes 6, 6M, 5, 5M, 4, 4M, 3 and 3M) – This rider provides a Catastrophic Disability Benefit if You are Catastrophically Disabled.

Catastrophically Disabled means that due to Injury or Sickness You are: unable to perform two or more of the Activities of Daily Living without Human Standby Assistance; or You are Cognitively Impaired; or You are Irrecoverably Disabled. The Activities of Daily Living are Bathing, Dressing, Eating, Transferring, Toileting and Continence.

$_____ Catastrophic Disability Monthly Benefit will be paid at the end of each month while You are Catastrophically Disabled. Benefits will start at the end of an Elimination Period of _____.

Cognitive Impairment means You have suffered a severe deterioration or loss in Your cognitive capacity which requires Substantial Supervision to protect You or others from threats to health and safety. Substantial Supervision means continual supervision by another person that may include physical assistance, cueing by verbal prompting, gestures, or other similar demonstrations. The Cognitive Impairment must result from Injury, Sickness, Alzheimer's disease, senility or irreversible dementia, and must be supported by reliable clinical evidence and standardized tests that reliably measure Your impairment in short- or long-term memory; Your orientation as to person (such as who You are), place (such as Your location), and time (such as day, date and year); and deductive or abstract reasoning.

Irrecoverably Disabled means that, even if You are Gainfully Employed, Injury or Sickness results in Your total, complete and irrecoverable loss of: the sight in both eyes; or hearing in both ears; or speech; or the use of both hands, both feet, or one hand and one foot, in their entirety.

Maximum Monthly Catastrophic Disability Indemnity is equal to two times the Catastrophic Disability Indemnity shown in the Schedule Page.

You may not renew this rider after the Expiration Date.

☐ 6% Maximum Cost Of Living Adjustment Rider 1412 (Classes 6, 6M, 5, 5M, 4, 4M, 3 and 3M) – This rider adjusts the Monthly Indemnity of Your Policy at the end of each 12 months in a continuous claim to reflect any changes in the cost of living.

We will adjust Your Monthly Indemnity based on changes in the Consumer Price Index for All Urban Consumers (CPI-U) from the start of claim. If You have a Social Insurance Substitute Rider, an Automatic Benefit Enhancement Rider, or an Additional Monthly Benefit Rider, any Monthly Benefits provided by these riders will be adjusted in the same manner.

Your Monthly Indemnity may vary from year to year as the CPI-U rises or falls in relation to the Original Index Month. The adjustment to the Monthly Indemnity will never be less than what a 3% compound rate would provide or more than a 6% compound rate would provide.

You may not renew this rider after the Expiration Date.

☐ Four-Year Delayed Cost Of Living Adjustment Rider 1413 (Classes 6, 6M, 5, 5M, 4, 4M, 3 and 3M) – This rider provides, starting on the fourth anniversary of a claim while benefits are payable, a 3% adjustment in Monthly Indemnity that will be applicable to benefits paid for the next 12 months.

If You have a Social Insurance Substitute Rider, an Automatic Benefit Enhancement Rider, or an Additional Monthly Benefit Rider, any Monthly Benefits provided by these riders will be adjusted in the same manner.

You may not renew this rider after the Expiration Date.

☐ Graded Lifetime Indemnity for Total Disability Rider 1414 (Classes 6, 6M, 5, 5M, 4, 4M, 3 and 3M) – This rider provides lifetime benefits if You become Totally Disabled before Age 65 and remain continuously Totally disabled in the same claim after the Expiration Date. The Lifetime Indemnity percentage is based on Your Age when the continuous Total Disability begins. For each year after Age 45, the percentage decreases by 5%.

You may not renew this rider after You attain Age 65 and are not Totally Disabled.

☐ Retirement Protection Plus Disability Benefit Rider 1415 (Classes 6, 6M, 5, 5M, 4, 4M, 3 and 3M) – This rider provides an RPP Monthly Indemnity benefit payable to an irrevocable trust if You are Totally Disabled and not Gainfully Employed.

$_____ RPP Monthly Indemnity will be paid at the end of each month while You are Totally Disabled and not Gainfully Employed.

Benefits will start at the end of an Elimination Period of _____

You may not renew this rider after Age 65.

☐ Lump Sum Disability Benefit Rider 1416 (Classes 6, 6M, 5, 5M, 4, 4M, 3 and 3M) – This rider provides a lump sum benefit at the later of the Expiration Date of the Policy or the end of the Benefit Period if Disabled. The Lump Sum Benefit Amount will only be paid if the Policy and this rider are in force on the Expiration Date of the Policy, and if the sum of Contributing Payments is equal to or greater than the Qualifying Amount. The Lump Sum Benefit Amount is equal to the sum of Contributing Payments multiplied by 35%.

Contributing Payments are any Total Disability benefits and/or Residual Disability benefits paid under the Policy until the later of the Expiration Date or the end of the Benefit Period if Disabled.

Your Qualifying Amount is $_____.

You may not renew this rider after the Expiration Date.

☐ Basic Residual Disability Benefit Rider 1417 (Classes 6, 6M, 5, 5M, 4, 4M, 3 and 3M) – This rider provides reduced Monthly Indemnity when You are Residually Disabled.

Residual Disability or Residually Disabled means that You are Gainfully Employed and You are not Totally Disabled under the terms of the Policy, but solely due to Injury or Sickness:

- You experience a Loss of Income that is at least 20% of Your Prior Income; and either
- You are unable to perform one or more~~, but not all,~~ of the material and substantial duties of Your Occupation; or
- You are able to perform all of the material and substantial duties of Your Occupation but not for the length of time they normally require.

Working an average of more than 40 hours in a week, in itself, is not a material and substantial duty.

The rider has the same Elimination Period as Your Policy.

Your Residual Indemnity is based on the following formula:

$$\text{Residual Indemnity} = \frac{\text{Loss of Income}}{\text{Prior Income}} \times \text{Monthly Indemnity}$$

During the first six months in which Residual Indemnity is payable, We will deem Your Loss of Income to be 50% of Your Prior Income or the actual percentage of loss, if greater.

If You have a Social Insurance Substitute Rider or an Automatic Benefit Enhancement Rider, any Monthly Benefits provided by these riders will be added to the Monthly Indemnity of this formula.

You may be Totally or Residually Disabled to satisfy the Elimination Period of the Policy and to meet the conditions for waiver of premium.

You may not renew this rider after the Expiration Date.

☐ 3% Maximum Cost Of Living Adjustment Rider 1418 (Classes 6, 6M, 5, 5M, 4, 4M, 3 and 3M) – This rider adjusts the Monthly Indemnity of Your Policy at the end of each 12 months in a continuous claim to reflect any changes in the cost of living.

On the first Review Date, We will adjust the Monthly Indemnity by multiplying the Monthly Indemnity by the Cost of Living Adjustment Factor. On each subsequent Review Date while benefits are payable, We will adjust the Monthly Indemnity by multiplying the prior year's adjusted Monthly Indemnity by the Cost of Living Adjustment Factor.

The Cost of Living Adjustment Factor will never be less than 1.00 or greater than 1.03.

You may not renew this rider after the Expiration Date.

☐ Benefit Purchase Rider 1419 (Classes 6, 6M, 5, 5M, 4, 4M, 3 and 3M) – This rider gives You the opportunity to apply for additional disability income insurance in future years despite any change in Your health. We will review Your eligibility for an Increase Policy on every third Policy Anniversary while this rider is in effect. To keep this rider in effect, You must submit an application and other evidence of insurability during the Benefit Purchase Period.

You may apply for one Increase Policy between each Review Date while this rider is in effect if You have at least a 50% increase in Your Income during the first three years after the Effective Date of the Policy or since the last Review Date, or You lose Your Group Long-Term Disability Coverage and it is not subsequently replaced.

Each Increase Policy applied for during a Benefit Purchase Period or as part of a Special Benefit Purchase Option Offer will be underwritten to determine the maximum amount of Monthly Indemnity, if any, available to You. You must provide evidence of Your Income, occupation, employment and all other disability insurance with any insurer that is in force, which You have applied for, or for which You are eligible. We may require additional evidence of financial insurability, as necessary. You do not have to provide evidence of Your medical insurability.

This rider terminates when the first of the following events occurs:

- An application for an Increase Policy and required evidence of insurability is not received during the Benefit Purchase Period; or
- Less than 50% of Our offer to increase the Monthly Indemnity is accepted; or
- The initial premium for any Increase Policy is not paid; or
- The date of Your request to decrease the Monthly Indemnity of the Policy to which this rider is attached; or
- The date of Your written request to terminate this rider; or
- You attain Age 55; or
- The Policy terminates.

4. EXCLUSIONS AND LIMITATIONS OF THE POLICY – We will not pay benefits for any Disability:

- caused by, contributed to, or which results from military training, military action, military conflict, or war, whether declared or undeclared, while You are serving in the military or units auxiliary thereto, or working for contracted military services;
- during any period of time in which You are incarcerated;
- caused by, contributed to, or which results from Your commission of, or attempt to commit, a criminal offense as defined under local, state, or federal law;
- caused by, contributed to, or which results from Your being engaged in an illegal occupation;
- caused by, contributed to, or which results from the suspension, revocation or surrender of Your professional or occupational license or certification;
- caused by, contributed to, or which results from an intentionally self-inflicted Injury;
- during the first three months of Disability or the Elimination Period, if longer, that is caused by, contributed to, or which results from normal pregnancy or childbirth; or
- due to any loss We have excluded by name or specific description.

LIMITATION WHILE OUTSIDE THE UNITED STATES OR CANADA-You must be living full time in the 50 states which comprise the United States of America, the District of Columbia or Canada in order to receive benefits under the Policy, except for incidental travel or vacation; otherwise, benefits will cease. Incidental travel or vacation means being outside of the 50 states which comprise the United States of America, the District of Columbia or Canada for less than 60 days in a 12-month period. You may not recover benefits that have ceased pursuant to this limitation.

If benefits under the Policy have ceased pursuant to this limitation and You return to the 50 states that comprise the United States of America, the District of Columbia or Canada, You may become eligible to resume receiving benefits under the Policy. You must satisfy all terms and conditions of the Policy in order to be eligible to resume receiving benefits under the Policy.

If You remain outside of the 50 states which comprise the United States of America, the District of Columbia or Canada, premiums will become due beginning six months after benefits cease.

PRE-EXISTING CONDITION LIMITATION – We will not cover any loss that begins in the first two years after the Effective Date from a Pre-existing Condition.

Pre-existing Condition means a physical or mental condition:

- that was misrepresented or not disclosed in Your application; and
- for which You received professional medical advice, diagnosis or treatment within two years before the Effective Date; or
- that caused symptoms within one year before the Effective Date for which a prudent person would usually seek professional medical advice, diagnosis or treatment.

MENTAL AND/OR SUBSTANCE-RELATED DISORDERS LIMITATION – Benefits for any Disability due to a Mental and/or Substance-Related Disorder will be paid for a period not longer than the Maximum Benefit Period for Mental and/or Substance-Related Disorders as shown in the Schedule Page of the Policy.

After the Maximum Benefit Period for Mental and/or Substance-Related Disorders and subject to the Policy provisions, We will only pay benefits while You are continuously confined in a Hospital for treatment of a Disability due to a Mental and/or Substance-Related Disorder, and You are under the regular medical care of a Physician.

Under no circumstance will We pay benefits for any Disability due to a Mental and/or Substance-Related Disorder that We have excluded by name or specific description.

5. RENEWABILITY OF THE POLICY – You may renew the Policy at the end of each Premium Term until the Expiration Date. During that time, We cannot change the premium or cancel the Policy.

   After the Expiration Date, You may renew the Policy at the end of each Premium Term as long as You are not Disabled and You are Gainfully Employed Full Time for at least ten months each year and the premium is paid on time.

   Your premium will be at Our rates then in effect for persons of Your Age, Class of Risk, Occupation Class, and any special class rating that applies to the Policy. We have the right to change such premiums on a class basis on any Policy Anniversary.

Superseded Schedule Items

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Creation Date:	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
01/30/2012	Supporting Document	Outline of Coverage	01/30/2012	TDOC (12-11).pdf (Superceded)
06/29/2011	Supporting Document	Outline of Coverage	01/30/2012	TDOC (12-11).pdf (Superceded)