



**The Guardian Life Insurance
Company of America**
7 Hanover Square
New York, NY 10004

Disability Insurance Application

INSTRUCTIONS FOR COMPLETION OF THE APPLICATION

This packet contains The Guardian Life Insurance Company of America's basic application Form No. AP2-96 CA, the change application and the supplemental business applications. Completion of all appropriate parts is required from each proposed insured for personal or business disability income insurance.

The application must be completed by the agent in the presence of the proposed insured and signed by the proposed insured in the agent's presence. It is valid only for **90 days** from the date of signature of the proposed insured.

Completion by mail or telephone is not authorized.

Complete all parts of the Coverage and Premium Section and forward that section with the application to the agency.

Parts I, IIA and III must be completed even if a medical examination is required. All questions must be answered completely. **Any changes to these answers must be initialed by the proposed insured.** An agent has no authority to waive, change or limit any question on the application.

Any misrepresentation or omission made by the proposed insured, 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 or any supplement to it.

Obtain the proposed insured's signature on the authorization form that immediately follows page eight and forward it with the application to the agency.

Do not detach the conditional receipt unless you consider the proposed insured a standard risk for the type and amounts of insurance applied for **and** unless a minimum payment of at least one sixth the annual premium has been paid.

Any supplemental application must be submitted with the basic application Form No. AP2-96 CA.

for OVERHEAD EXPENSE, complete AP2-96 OE
for BUSINESS REDUCING TERM, complete AP2-96 RT
for DISABILITY BUYOUT, complete AP2-96 BO
for POLICY CHANGES, complete AP2-96 CHANGE

THE GUARDIAN LIFE INSURANCE COMPANY OF AMERICA
7 Hanover Square, New York, New York 10004

NOTICE OF INFORMATION PRACTICES
Give this notice to the proposed insured before completing the application

This notice tells you about the kinds of information we may obtain when we process your application. We will obtain or release information only with your written consent. On request, you may receive a copy of your authorization.

We treat all personal information as confidential. You have a right to access and correct our records. If you want more details about our information practices, write the Corporate Secretary here at the Guardian.

Fair Credit Reporting Act Pre-Notice

We may ask for a consumer report from a consumer reporting agency. All or part of that report may be an investigative consumer report based on interviews with people who know you. Such a report includes information about your character, general reputation, personal characteristics or mode of living, except as may be related directly or indirectly to your sexual orientation. You may ask to be interviewed in connection with this report. If you want more information about the nature and scope of this kind of investigation, write the Disability Selection Department here at the Guardian.

At your request, our underwriters will tell you if we have asked for a consumer report or an investigative consumer report. If we have, we will tell you the name and address of the consumer reporting agency from which we have requested the report. You may then contact that agency for further information about its report and your rights under federal or state law. In New York State, for example, a consumer has the right to inspect and obtain a copy of the report from such an agency.

Medical Information Bureau Pre-Notice

The Medical Information Bureau is a nonprofit membership organization of life insurance companies. The Bureau provides an information exchange for its members. On the request of any of its member companies to which you apply for life or disability insurance, or to which you make a claim for benefits, the Bureau will supply the inquiring company with the information in its files.

The Guardian or our reinsurers may make a brief report of objective findings about you to the Bureau. We will not report what action we have taken on your application.

If you so request of the Bureau, it will arrange to disclose the information it may have in your file. If you question the accuracy of the information in the Bureau's file, you may contact the Bureau and seek to correct the information according to the procedures set forth in the Federal Fair Credit Reporting Act. The Bureau's address is Post Office Box 105, Essex Station, Boston, MA 02112, telephone 617/426-3660.

Medical Records

We may request information from health care providers or others who have records of your medical history, mental or physical condition, or treatment.

Personal Information Telephone Interview

We may phone you to verify or supplement information you have given us. The call will be made from our underwriting office or from a consumer reporting agency acting for us.

COVERAGE AND PREMIUM SECTION
For Agent Use Only

Proposed Insured _____ Occupational class _____
 Agency Name and Code _____ Soliciting Agent Name _____
 DIS Code _____ Soliciting Agent Social Security No. _____
 Agent Name _____ Code _____ %
 Agent Name _____ Code _____ %
 Agent Name _____ Code _____ %

Did the proposed insured voluntarily ask about disability insurance? Yes No

How long have you known the proposed insured? _____

Telephone interview – If more information is needed, a Guardian representative may call the proposed insured. Show the most convenient time and place for such a call weekdays between the hours of 9:00 AM and 9:00 PM *local time*.

Area code _____ Number _____ Ext. _____ Home Business Time _____ AM PM

COVERAGE APPLIED FOR

	Policy Form No.	Monthly Indemnity	SIS Benefit (optional)	Elimination Period	Benefit Period	FIO Benefit (optional)	COLA Benefit (optional)
Personal Policy	_____	\$ _____	\$ _____	_____	_____	\$ _____	_____ %
Overhead Policy	_____	\$ _____		_____	_____	\$ _____	
Reducing Term Policy	_____	\$ _____		_____	_____		
		Lump Sum or Downpayment	Monthly Benefit Limit	Monthly Benefits Paid for	Maximum Buyout Benefit	Elimination Period	FIO Benefit (optional)
Buyout Policy	_____	\$ _____	\$ _____	_____ months	\$ _____	_____	\$ _____

Other Optional Benefits

- Residual Disability (regular) Automatic Increase (overhead) Group Disability Replacement \$ _____
 Residual Disability (2 yr. cap) Partial Disability Salary Replacement (overhead) \$ _____
 Automatic Increase (personal) Unemployment Premium Waiver

Premiums Quoted

	Personal*	Overhead	Reducing Term	Buyout
Total Annual Premium (s)	\$ _____	\$ _____	\$ _____	\$ _____
Term Premium	\$ _____	\$ _____	\$ _____	\$ _____

* Level or Graded

Premium Mode

- Annual Semiannual Quarterly Guard-O-Matic** Monthly (list billed only)

** If the case is Guard-O-Matic (GOM), be sure that the premium is correct and that you submit an R223, a void check and debit for premium (minimum deposit of two monthly premiums), in states where applicable.

Send Premium Notices to: Residence Business List Bill Account _____
 P.O. or Mail Box #

 City, State, Zip Code

Multi-Life or List Bill Plans

Indicate if the policy applied for is part of any of the following plans:

Check all that apply

- Multi-Life (2 or more) employer sponsored case
- Qualified Sick Pay Plan (QSPP) – (only the proposed insured may be an owner or loss payee in a QSPP)
- List Bill Plan – All policies must have a common billing date and premium mode.
 - New List Bill Plan – You must request the same list bill date for all policies.

List Bill Name

Address

List Bill Date

- Add to List Bill Plan – Show the list bill date (the next premium due date) of the existing policies.

List Bill Name and Number

List Bill Date

SPECIAL INSTRUCTIONS: Use this space to request special underwriting or issue considerations.

- a. Preliminary term requested: _____
- b. Special date of issue requested: _____
- c. Names of other insureds whose applications should be handled concurrently:

Medical Examination

- A medical examination has been arranged with the following examiner or examining service:

Name _____

Address _____

4. Occupation of the Proposed Insured

(a) Occupation _____ Job Title _____

(b) Nature of Business _____

(c) Describe, **in order of importance**, all major duties of your occupation. Include all physical activities that are performed in connection with the major duties of your occupation.

Description of Specific Duties	% of Time Devoted to Each Duty
_____	_____
_____	_____
_____	_____
_____	_____

(d) How many hours per week are you at work in this occupation? _____ hours

(e) Number of years in this occupation _____ with this employer _____

(f) Former occupation, if changed within two years _____

(g) Do you have any other part- or full-time jobs? Yes No

If yes, describe _____

(h) Do you supervise any employees? Yes No If yes, how many? _____ full time _____ part time

(i) If an owner, percentage owned _____% Years owned _____

Type of business entity: Sole Proprietor Partnership S Corp C Corp

Other (Describe) _____

Number of employees? _____ full time _____ part time

(j) Have you ever had a professional license suspended, revoked, or is such license under review, or have you been disbarred? Yes No If yes, explain:

5. Other Insurance Coverage of the Proposed Insured

Type of Insurance: DI = Disability Income OE = Overhead Expense BY = Buyout MD = Medical
Category: IND = Individual G = Group A = Association
Status: I = Inforce AP = Applied For, or Date of Eligibility

(a) List all personal and business disability income insurance and all medical insurance now in force, applied for, or eligible for in all companies, including the Guardian. **If none, check here:**

Insurer	Type: DI, OE, BY or MD	Category: IND, G or A	Status: I, AP or Date of Eligibility	Basic Monthly Indemnity	Social Insurance Benefit	Automatic Increase Option	Future Increase Option	Check if Employer Pays Premium
				\$	\$	%	\$	
				\$	\$	%	\$	
				\$	\$	%	\$	
				\$	\$	%	\$	
				\$	\$	%	\$	
				\$	\$	%	\$	
				\$	\$	%	\$	

(b) Will the new Guardian policy replace any personal or business disability income insurance? Yes No

If yes, list below:

When issuing any insurance as a result of this application, the Guardian will rely on the fact that the proposed insured can and will permanently terminate the coverage listed below by the next premium due date following the delivery of the Guardian policy. If the coverage listed below is not terminated by the date shown or if it is terminated and later reinstated, any policy issued will be rescinded and all premiums will be returned. The Guardian may contact any listed insurer after the date shown to confirm that the coverage has been permanently terminated.

Insurer	Type: DI, OE or BY	Category: IND, G or A	Group or Association Name	Policy Number	Amount to be Replaced	Next Premium Due Date and Mode
					\$	
					\$	
					\$	
					\$	
					\$	
					\$	

(c) Within the past five years, have you had disability income, accident, medical insurance or life insurance declined, postponed, modified, rated or cancelled? Yes No

If yes, explain and give company name, dates and reason, if known:

6. Personal Financial Information of the Proposed Insured

Earned Income means the compensation that you receive for work or personal services, **after business expenses**, but before any other deductions, as reported for federal income tax purposes on IRS Form 1040. Earned income does not include unearned or passive income and it is not Adjusted Gross Income.

Unearned or passive income includes, but is not limited to, income from dividends, interest, investments, rentals, royalties, retirement plans or from business interests as an inactive owner.

Fill in the amounts that are shown on your federal income tax forms and supporting schedules. Do not enter any amounts that are not reported to the IRS. If IRS Form 1040 has not been filed for the year shown, explain in **Remarks section**. If a joint return, furnish appropriate financial documentation for the proposed insured.

Explain any special circumstances that may affect your earned income in the **Remarks section**.

	Annualized Rate of Current Income	Actual Filed Most Recent Calendar Year	Actual Filed Two Calendar Years Ago
	Jan 1 - Dec 31 Year _____	Jan 1 - Dec 31 Year _____	Jan 1 - Dec 31 Year _____
(a) Earned Income			
1. Salary or Wages from Form W2			
2. Sole Proprietor Net Profit from 1040 Schedule C			
3. Share of Partnership or S Corp Non-passive Income from 1040 Schedule E			
4. Qualified Pension Plan contributions or Qualified Profit Sharing contributions or 401K contributions that would cease if the proposed insured were disabled			
5. Bonus, Commission or other Earned Income from the occupation described in 4.(a) of Part I (explain in Remarks section)			
6. Other Earned Income from any other full- or part-time work (explain in Remarks section)			
TOTAL EARNED INCOME (Must be completed)			
(b) Unearned Income , including passive income. If none, check here. <input type="checkbox"/> None			

PART IIA – HEALTH AND PERSONAL HISTORY OF THE PROPOSED INSURED

(Complete even if medical examination is required)

7. (a) Height _____ ft. _____ in.
(b) Weight _____ lbs.
(c) Has there been a weight change of more than 15 pounds in the past year? Yes No
If yes, explain: _____

8. In the last 12 months have you used tobacco in any form? Yes No
If yes, explain: _____

9. Within the past 10 years, have you had, been treated for or received counseling for:
- | | Yes | No |
|--|--------------------------|--------------------------|
| (a) high blood pressure, chest pain or disorder of the heart or circulatory system? | <input type="checkbox"/> | <input type="checkbox"/> |
| (b) diabetes, cancer, tumor, or disorder of the glands, bone, blood or skin? | <input type="checkbox"/> | <input type="checkbox"/> |
| (c) complications of pregnancy, infertility, or any disorder of the breasts, reproductive or genital organs, prostate, kidneys, or urinary system? | <input type="checkbox"/> | <input type="checkbox"/> |
| (d) hernia, hepatitis or disorder of the liver, gall bladder, stomach, intestines or rectum? | <input type="checkbox"/> | <input type="checkbox"/> |
| (e) arthritis, rheumatism, or disorder of the joints, limbs or muscles? | <input type="checkbox"/> | <input type="checkbox"/> |
| (f) disorder or condition of the back, neck or spine? | <input type="checkbox"/> | <input type="checkbox"/> |
| (g) allergy, asthma, sinusitis, emphysema, or disorder of the lungs or respiratory system? | <input type="checkbox"/> | <input type="checkbox"/> |
| (h) epilepsy, stroke, dizziness, headache, or disorder of the brain or spinal cord? | <input type="checkbox"/> | <input type="checkbox"/> |
| (i) disorder of the eyes, ears, nose or throat? | <input type="checkbox"/> | <input type="checkbox"/> |
| (j) anxiety, depression, nervousness, stress, mental or nervous disorders, or other emotional disorders? | <input type="checkbox"/> | <input type="checkbox"/> |
| (k) Chronic Fatigue Syndrome, Epstein Barr virus or Lyme disease? | <input type="checkbox"/> | <input type="checkbox"/> |
10. (a) Have you ever used stimulants, hallucinogens, narcotics or any controlled substance other than as prescribed by a physician?
- | | | |
|--|--------------------------|--------------------------|
| | <input type="checkbox"/> | <input type="checkbox"/> |
|--|--------------------------|--------------------------|
- (b) Have you ever had or been advised to have counseling or treatment for alcohol or drug use?
- | | | |
|--|--------------------------|--------------------------|
| | <input type="checkbox"/> | <input type="checkbox"/> |
|--|--------------------------|--------------------------|
11. 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) or AIDS Related Complex (ARC)?
- | | | |
|--|--------------------------|--------------------------|
| | <input type="checkbox"/> | <input type="checkbox"/> |
|--|--------------------------|--------------------------|
12. (a) Are you currently taking prescribed medication?
- | | | |
|--|--------------------------|--------------------------|
| | <input type="checkbox"/> | <input type="checkbox"/> |
|--|--------------------------|--------------------------|
- (b) Are you currently taking non-prescription medication?
- | | | |
|--|--------------------------|--------------------------|
| | <input type="checkbox"/> | <input type="checkbox"/> |
|--|--------------------------|--------------------------|
13. Do you have any loss of hearing or sight, an amputation of any kind, or any physical deformity, impairment or handicap?
- | | | |
|--|--------------------------|--------------------------|
| | <input type="checkbox"/> | <input type="checkbox"/> |
|--|--------------------------|--------------------------|
14. Are you now pregnant?
- | | | |
|--|--------------------------|--------------------------|
| | <input type="checkbox"/> | <input type="checkbox"/> |
|--|--------------------------|--------------------------|
15. Within the past five years, have you had a sickness or injury for which you have made a claim or for which you will make a claim?
- | | | |
|--|--------------------------|--------------------------|
| | <input type="checkbox"/> | <input type="checkbox"/> |
|--|--------------------------|--------------------------|
16. Within the past five years, have you had a physical examination or check-up of any kind; been advised to have surgery or any diagnostic tests that were not performed, except HIV tests; or consulted a physician, medical or mental health professional, counselor or other practitioner for any condition not listed in this Part IIA?
- | | | |
|--|--------------------------|--------------------------|
| | <input type="checkbox"/> | <input type="checkbox"/> |
|--|--------------------------|--------------------------|
17. Within the past 12 months, have you had **symptoms** of any condition listed in this Part IIA for which you **have not** sought medical attention or advice?
- | | | |
|--|--------------------------|--------------------------|
| | <input type="checkbox"/> | <input type="checkbox"/> |
|--|--------------------------|--------------------------|

PART III – REPRESENTATIONS OF THE PROPOSED INSURED AND OWNER

- No money has been paid as a deposit for disability income insurance with this application.
- A deposit of \$_____ has been paid for:
 - proposed personal disability income insurance in the amount of \$_____ per month; and/or
 - proposed overhead expense disability insurance in the amount of \$_____ per month;
 in exchange for the receipt providing conditional coverage.
- Additional disability income insurance has been applied for in the amount of \$_____ but no deposit has been paid for this amount of insurance.
- A list bill date or a special date has been requested and a deposit has been paid. In making this request, I understand that I may be waiving certain rights and guarantees under the conditional receipt given in exchange for my premium deposit.

I have read my answers to the foregoing questions. I declare that they were taken in the presence of the agent and are complete and true to the best of my knowledge and belief.

I understand and agree as follows:

1. This application (pages one through eight), any supplement to it, and Part II, if required, shall form a part of any policy issued. The Guardian will rely on all written statements in these pages if it issues a policy to me. Upon delivery of such policy, I will review it and if not satisfied, I will return it to the Guardian within 10 days of the date of delivery for a prompt refund of premium. 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.
2. An agent cannot accept any person for insurance; nor waive a complete answer to any part of this application; nor make contracts; nor waive any other rights or requirements of the Guardian.
3. No information acquired by any representative of the Guardian shall bind the Guardian unless it shall have been set out in writing in this application.
4. No waiver or change in the terms of the policy applied for will be valid unless it is set out in writing and signed by the president, a vice president or a secretary of the Guardian in the home office.
5. If a premium has been paid for insurance in exchange for the conditional receipt bearing the same number as this application, insurance will be in force as set out in the terms of such receipt.
6. Except as provided in the conditional receipt, no insurance shall take effect unless and until: the policy has been delivered to and accepted by me; the full first premium has been paid during my lifetime; and there has been no change in my health, income level, status of employment or occupation from that shown in my application.

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Signed at _____, this _____ day of _____ year _____

Signature of proposed insured

Signature of owner if other than proposed insured. If owner is a business entity, signature and title of authorized person.

Title

I certify that I have taken this application in the presence of the proposed insured and that I have truly and accurately recorded on this application the information supplied by the proposed insured.

Signature of licensed agent

License Number(s)

Agent's Name

State(s) where licensed



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, 7 Hanover Square, New York, NY 10004
 - THE GUARDIAN INSURANCE & ANNUITY COMPANY, INC., 3900 Burgess Place, Bethlehem, PA 18017
 - BERKSHIRE LIFE INSURANCE COMPANY OF AMERICA, 700 South Street, Pittsfield, MA 01201
- (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

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, preferred provider organization, health maintenance organization, point of service health care coverage, or pharmacy, pharmacy benefit manager, consumer reporting agency, the Medical Information Bureau, insurance or reinsurance company, employer, or laboratory that has any records or information of me or my health to release medical and non-medical information in its possession about me or my minor children, to the Company or its legal representatives. Non-medical information shall include data about my driving record; civil action or bankruptcy court records; hazardous sport or aviation activity; use of alcohol or drugs, employment information, business pursuits, documentation of earned and unearned income; any claim of eligibility for disability income benefits; and other applications for insurance. 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 me or my minor children. I understand that the information released 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 or the diagnosis and treatment of Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) by a medical professional. Medical information does not include information about prior testing for Human Immunodeficiency Virus (HIV), unless such test was performed for the purpose of obtaining insurance.

I agree that for purposes of collecting information in connection with an application for insurance, 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. For the purpose of collecting information in connection with a claim for benefits under an accident and sickness insurance policy, this authorization will be valid for the term of coverage of the policy. For the purpose of collecting information in connection with a claim for benefits under a life insurance policy, the authorization is valid for the duration of the claim.

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 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
Personal Representative

Personal Representative's Authority or
Relationship to Proposed Insured

Witness Signature

**DO NOT DETACH UNLESS A MINIMUM OF ONE SIXTH OF THE ANNUAL PREMIUM
IS PAID AT TIME APPLICATION IS SIGNED**

CONDITIONAL RECEIPT FROM THE GUARDIAN LIFE INSURANCE COMPANY OF AMERICA

7 Hanover Square, New York, NY 10004

THIS RECEIPT CONTAINS LIMITATIONS. READ IT CAREFULLY.
NO AGENT CAN CHANGE THE TERMS OF THIS RECEIPT.

A deposit of \$ _____ has been received from _____ for:

- personal disability income insurance in the amount of \$ _____ per month; and/or
 overhead expense disability insurance in the amount of \$ _____ per month.

Such insurance is applied for in an application with the same date and number as this receipt on the life of _____, the proposed insured.

Conditions for Insurance:

- (1) The effective date of insurance under this receipt shall be the latest of the following dates:
- the date of the application; or
 - the date of the medical examination (as shown on Part II of the application); or
 - the date requested by the proposed insured at the time of application.

Such insurance shall be in force only for such proportional part of a year as the above payment bears to the full annual premium.

- (2) The proposed insured must be acceptable at standard premium rates under our underwriting rules and practices for the policy(ies) and amount of benefits applied for, with no restriction and no change in coverage. Information required by the Guardian to determine insurability must be received at its home office within 60 days of the date of this receipt.

If these conditions are not met, the Guardian shall have no liability under this receipt except to return the payment made.

- (3) If the proposed insured has a change in health while this conditional receipt is in effect and before the application has been approved or rejected, then the Guardian shall determine whether the proposed insured is insurable only as of the effective date of insurance under this receipt.
- (4) This receipt is not valid unless it has been signed by the licensed Guardian agent. No waiver or change in the terms of this receipt will be valid unless it is set out in writing and signed by the president, a vice president, or a secretary of the Guardian in the home office.
- (5) If the check or draft given in exchange for this receipt is dishonored when it is first presented, this receipt shall be null and void.

Signed at _____, this _____ day of _____ year _____

Signature of licensed agent

Agent's Name (please print)

I certify that I have read the terms of this receipt and have had them explained to me by the agent. I understand that the insurance applied for shall not be effective unless and until all of the conditions of this receipt are met.

Signature of proposed insured

Signature of owner if other than proposed insured

**ALL PREMIUM CHECKS MUST BE MADE PAYABLE TO THE GUARDIAN.
DO NOT MAKE CHECK PAYABLE TO THE AGENT OR LEAVE PAYEE BLANK.
CASH IS UNACCEPTABLE — THIS RECEIPT MAY NOT BE GIVEN IN EXCHANGE FOR CASH.**

THE GUARDIAN LIFE INSURANCE COMPANY OF AMERICA
7 Hanover Square, New York, New York 10004

SUPPLEMENTAL APPLICATION FOR
DISABILITY OVERHEAD EXPENSE INSURANCE

Proposed Insured _____

Loss Payee of overhead expense policy _____ Tax ID _____

Owner of overhead expense policy _____ Tax ID _____

A. INFORMATION ABOUT BUSINESS OR PROFESSIONAL ENTITY

1. Name of business entity: _____
2. Nature of business: _____
3. Type of business entity: Sole Proprietor Partnership
 S Corp C Corp
 Other (describe) _____
4. (a) Date organized: _____ (b) Total number of employees: _____
5. Has the business entity or any of its principals been in receivership or bankruptcy in the past five years?
 Yes No If yes, give full details and date of discharge from receivership or bankruptcy.

B. MONTHLY EXPENSES OF THE BUSINESS ENTITY

List below on a **monthly** basis, the total tax-deductible expenses of the business entity. Do not include salaries of other principals or members of your profession.

Regular lease, rental or mortgage payments on business premises	\$ _____
Rental, mortgage or realty taxes	_____
Employees' salaries (number of employees _____)	_____
Utilities	_____
Installment payments for furniture and equipment	_____
Premiums for business insurance	_____
Accounting, billing and collection fees	_____
Professional or trade dues or subscriptions	_____
Postage	_____
Business laundry	_____
Janitorial and maintenance services	_____
Other fixed expenses: _____	_____
_____	_____
_____	_____

Total monthly expenses \$ _____

Your share of the total monthly expenses is _____%

I declare that the above statements are true and complete to the best of my knowledge and belief.

Signed at _____, this _____ day of _____ year _____

Signature of proposed insured

Signature of owner if other than proposed insured. If owner is a business entity, signature and title of authorized person.

Title

Signature of licensed agent

THE GUARDIAN LIFE INSURANCE COMPANY OF AMERICA
7 Hanover Square, New York, New York 10004

SUPPLEMENTAL APPLICATION FOR
BUSINESS REDUCING TERM DISABILITY INSURANCE

Proposed Insured _____
Loss Payee of reducing term policy _____ Tax ID _____
Owner of reducing term policy _____ Tax ID _____

A. INFORMATION ABOUT BUSINESS OR PROFESSIONAL ENTITY

- Name of business entity: _____
- Nature of business: _____
- Type of business entity: Sole Proprietor Partnership
 S Corp C Corp
 Other (describe) _____
- (a) Date organized: _____ (b) Total number of employees: _____
- Has the business entity or any of its principals been in receivership or bankruptcy in the past five years?
 Yes No If yes, give full details and date of discharge from receivership or bankruptcy.

B. INFORMATION ABOUT THE ECONOMIC NEED FOR THIS INSURANCE

- The insurance applied for will cover the following business obligation:
 business loan purchase agreement employment contract
 other (describe) _____
- Names of all debtors or guarantors:

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

- Date obligation took effect: _____ Date obligation will end: _____
- Explain the reason that the obligation was incurred:

- Periodic payment in the amount of \$ _____ is to be made each month each _____ months
- Total amount owed by all parties: Principal \$ _____
Interest, if any _____
Total _____

of which the proposed insured's the proposed owner's share is _____% and \$ _____ each month.

I declare that the above statements are true and complete to the best of my knowledge and belief.

Signed at _____, this _____ day of _____ year _____

Signature of proposed insured

Signature of owner if other than proposed insured. If owner is a business entity, signature and title of authorized person.

Title

Signature of licensed agent

THE GUARDIAN LIFE INSURANCE COMPANY OF AMERICA
7 Hanover Square, New York, New York 10004

SUPPLEMENTAL APPLICATION FOR
DISABILITY BUYOUT INSURANCE

Proposed Insured _____

Loss Payee(s) of buyout policy

Name Tax ID

Name Tax ID

Name Tax ID

Name Tax ID

Owner(s) of buyout policy

Name Tax ID

Name Tax ID

Name Tax ID

Name Tax ID

A. INFORMATION ABOUT BUSINESS ENTITY

1. Name of business entity: _____
2. Nature of business: _____
3. Type of business: Partnership S Corp
 C Corp Other (describe) _____
4. Date business organized: _____
5. Has the business entity or any of its principals been in receivership or bankruptcy in the past five years?
 Yes No If yes, give full details and date of discharge from receivership or bankruptcy.

B. INFORMATION ABOUT BUY-SELL AGREEMENT

1. Status of buy-sell agreement: in force and dated _____
 date to be drafted by _____
2. Type of buy-sell agreement (in force or to be drafted):
 stock redemption cross purchase entity purchase
 other (describe) _____

3. Complete for all principals under buy-sell agreement (in force or to be drafted)

Principal	Age	% of Ownership	Other buy-sell insurance in force or applied for		
			Company	Amount	Indicate Life or DI

C. VALUATION OF THE BUSINESS ENTITY

1. Valuation Formula

Please select one of the formulas below to be used in valuing the business entity. The formula chosen will be used to determine the amount of coverage available and, at time of claim, in determining the amount of benefits payable.

(a) For a commercial business organization

- Salary x 1
- Net worth
- Capitalization of earnings: Average net earnings x a multiple of _____

(b) For a professional or personal service organization

- Your share of net worth plus _____ x your personal income
- CPA and law firms only:** Your share of net worth plus _____ x gross income of the business

(c) For any type of organization

- _____ x your personal income
 - Another valuation method is preferred (describe) _____
-

2. Determination of Values

Based on the valuation formula chosen above, provide the following information:

	Current Year Estimated	Most Recent Calendar Year	Two Calendar Years Ago
	Jan 1 - Dec 31 Year _____	Jan 1 - Dec 31 Year _____	Jan 1 - Dec 31 Year _____
(a) Total Assets			
(b) Goodwill*			
(c) Total Liabilities			
(d) Net Worth (a + b - c)			
(e) Gross Income of the Business**			
(f) Average Net Earnings**			
(g) Earned Income**			

* Goodwill may be included for a commercial business only.

** These amounts are those that were actually filed with the IRS for the year(s) indicated. If forms were not filed with the IRS, explain here:

I declare that the above statements are true and complete to the best of my knowledge and belief.

Signed at _____, this _____ day of _____ year _____

Signature of proposed insured

Signature of owner if other than proposed insured. If owner is a business entity, signature and title of authorized person.

Title

Signature of licensed agent

THE GUARDIAN LIFE INSURANCE COMPANY OF AMERICA
7 Hanover Square, New York, New York 10004

Insured _____ Agency Name/Code _____

Policy No.(s) _____ Agent's Name and Code _____

CHANGE APPLICATION FOR DISABILITY INCOME INSURANCE

COMPLETE ONLY IN THE PRESENCE OF THE PROPOSED INSURED – PRINT all entries in ink. Complete all appropriate parts of AP2-96 as indicated below and give the insured AP2-96 FCRA if C-AUTH-2003 CA-1 is required.

1. **Add, increase or change** benefits. Complete Part I – questions 4, 5 and 6, Parts IIA, III and C-AUTH-2003 CA-1. If action requested is on a special age basis, preliminary inquiry to Disability Policyholder Service in addition to underwriting approval is required.

- Increase** benefit period to _____.
- Shorten** elimination period to _____.
- Add** optional benefit rider(s): Residual Partial COLA - _____%.
- Add** SIS benefit of \$ _____ and **reduce** monthly indemnity to \$ _____.
- Remove** SIS benefit and **increase** monthly indemnity to \$ _____.
- Under buyout policy, **increase** monthly benefit to \$ _____ and/or lump sum to \$ _____.
- Under overhead expense policy, **increase** monthly benefit to \$ _____.

2. **Exercise** an increase option from FIO rider. Indicate amount to be exercised \$ _____. Complete Part I – questions 5(a), 5(b) and 6, Part III and C-AUTH-2003 CA-1. If exercising an option from an overhead expense or buyout policy, complete the appropriate business supplement.

3. **Reduce or remove** benefits

- Reduce** monthly indemnity to \$ _____.
- Decrease** benefit period to _____.
- Increase** elimination period to _____.
- Reduce** benefits under optional benefit rider _____ to _____.
- Remove** optional benefit rider(s) _____.

4. **Change** occupational class to _____. Complete Part I – question 4, Part III and C-AUTH-2003 CA-1.

5. **Remove** exclusionary/impairment rider or rating. Complete Part I – question 4, Parts IIA, III and C-AUTH-2003 CA-1.

6. **Change** to nonsmoker premiums. Complete Part IIA – question 8, Parts III and C-AUTH-2003 CA-1.

7. **Change** premiums from graded to level.

8. **Convert** benefits on an original age basis to Form _____.

9. **Other** (please explain) _____.

Signed at _____, this _____ day of _____ year _____

Signature of insured

Signature of owner if other than insured. If owner is a business entity, signature and title of authorized person.

Title



**The Guardian Life Insurance
Company of America**
Administrative Office:
777 East Magnesium Road
Spokane, Washington 99208

DATING INFORMATION

(To be given to the applicant with the initial application for all policies applied for on a non-prepaid basis or where backdating or special dating is being requested.)

Backdating is the process of dating a policy earlier than the date the policy is issued. For example, a policy may be backdated to provide the policyowner with a lower insurance age and thus a lower premium. Special dating is the process of dating a policy on a specific date. Absent backdating or special dating, the policy will generally be dated the date it is physically issued. However, if the date of policy issue is the 29th, 30th or 31st of the month, the policy will be dated the 1st of the following month.

Premium is charged from the date the policy is dated. If you request backdating or special dating, or if the policy is delivered after its issue date, you may be required to pay premium for a period of time during which no insurance is in effect. The amount of such premium may depend on the time it takes to underwrite, issue, and deliver a policy to you. You may reduce our processing time and the amount of such premium by providing all information we request (including, for example, supplemental medical information) as quickly as possible and by accepting policy delivery promptly.

You are not required to pay premium under an insurance policy for a period of time during which that policy does not provide coverage. However, you may wish to waive this right in order to obtain the benefits of backdating or special dating.

Coverage will not take effect under the policy unless and until such time as you have taken delivery of the policy, paid the first premium and there has been no change in the proposed insured's health, income level, status of employment and/or occupation as stated in the application. If you would like the benefit of backdating or special dating but do not wish to waive your right not to pay premium for a period of time during which no insurance is in effect, you may opt to pay the first premium with the application in exchange for a Conditional Receipt. Doing so may reduce or eliminate the period of time for which you pay a premium without insurance being in effect. Certain restrictions apply to use of a Conditional Receipt. Ask your insurance representative to explain this option fully to you before you pay any money with your application.

Signed at _____ on _____
City/State month – day – year

Applicant

Witness

Insurance Representative

One copy to: APPLICANT INSURER