



**Customer Service Office
Mailing Address**
P.O. Box 26100
Lehigh Valley, PA 18002-6100

Authorization to Obtain and Release Information

THE GUARDIAN LIFE INSURANCE COMPANY OF AMERICA
THE GUARDIAN INSURANCE & ANNUITY COMPANY, INC.
BERKSHIRE LIFE INSURANCE COMPANY OF AMERICA

Name of Proposed Insured _____
Date of Birth (mm/dd/yyyy) _____

**This Authorization Is Designed to Comply with The Health Insurance Portability Act of 1996
as amended (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.

I hereby authorize the disclosure and/or release of all the information below to the Company (Company referred to herein includes The Guardian Life Insurance Company of America and/or The Guardian Insurance & Annuity Company, Inc., and/or Berkshire Life Insurance Company of America, and/or other subsidiaries and affiliates), its service providers, employees, or to its legal representatives.

Medical Records and other information. I authorize any physician, medical or mental health professional, practitioner, provider, hospital, clinic, other health or medical facility, laboratory, pharmacy, pharmacy benefit manager, therapist, health plan, benefit plan administrator, electronic health record provider, consumer reporting agency or other reporting agency, governmental agency, the Veteran's Administration, the Social Security Administration, the Department of Motor Vehicles, state agency, MIB, Inc., insurance or reinsurance company (including the Company), or employer or other company, organization, institution or person that has any records or knowledge of the Proposed Insured and/or his/her health to disclose and/or release any and all medical and non-medical information, whether in paper or in electronic format, in its possession about the Proposed Insured. 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, diagnosis, or treatment of the Proposed Insured. Non-medical information includes information such as credit reports, consumer reports, employment, occupation, payment records, financial information or records, and/or publicly accessible sources. The information outlined above may be provided by those listed above and/or compiled and interpreted by third parties.

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

I acknowledge that any agreements I have made to restrict my health information do not apply to this Authorization and I instruct any physician, health care professional, provider, hospital, clinic, health or medical facility, other health care provider or health plan, insurer, or other entity to disclose my entire medical record without restriction. I understand that the information released could contain reference to or results of Human Immunodeficiency Virus (HIV) or Antibody (Acquired Immune Deficiency Syndrome (AIDS)) or genetic testing, genetic information and may relate to the symptoms, evaluation, diagnosis, examination, treatment or prognosis of any mental or physical condition, including psychiatric, and psychological conditions, and drug or alcohol abuse.

I agree that this Authorization shall be valid for twenty-four (24) months from the date shown below. However, this time limit may be shorter if the time period permitted by applicable law in the state where the policy is delivered or issued for delivery is less. I agree that a copy of this Authorization shall be as valid as the original. I agree that if I sign this Authorization electronically, including via voice authorization, that it will be equally as effective and valid as if I signed the form through traditional means. I understand, however, that I am under no obligation to sign this document electronically.

I know that I may revoke this Authorization in writing, at any time, by sending a written request for revocation to the Chief Underwriter at the address above. 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 in connection with underwriting my application for insurance, to determine eligibility for insurance, to determine the premium for the insurance, to obtain reinsurance, to service any insurance issued, to administer coverage, to evaluate any claim for insurance benefits, to determine eligibility for benefits under an existing policy, and to conduct any other legally permissible activities that relate to any existing coverage, coverage that I have applied for, or may in the future apply for with the Company. In addition to the above, the Company or its legal representative may use the information to perform actuarial or research studies, analytics, review internal processes or experience, and/or conduct a legally permissible contestability review. 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 issued. 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. Providers of health care services may not refuse to provide treatment or payment for health care services if I refuse to sign this Authorization. The Company or its legal representatives will not release any information obtained using this Authorization to any person or organization except to reinsurance companies, MIB, Inc., Innovative Underwriters Services (a subsidiary of The Guardian Life Insurance Company of America), or other persons, agencies, companies or organizations performing business or legal services in connection with an application, claim, to perform actuarial or research studies perform analytics, or in evaluating our internal processes or experience 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). If I am applying for insurance and/or have existing coverage with the Company, information collected to determine eligibility for insurance and/or for benefits under an existing policy will be shared by the Company. I further understand that any policy issued will be delivered to the policy owner, which may be a party other than the Proposed Insured, and that this Authorization may become part of any policy issued.

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

I acknowledge that I have been given a copy of this Authorization and also acknowledge receipt of the Notice of Insurance Information Practices, which includes the Fair Credit Reporting Act Pre-Notice, the MIB Pre-Notice, and Medical Records. I also acknowledge that I or an individual authorized to act on my behalf is entitled to receive an additional copy of this authorization. Any alteration of this Authorization will not be accepted.

Signed at _____
City and State Month/Day/Year

Signature of Proposed Insured
(or parent or guardian if Insured is under 18)

Witness Signature

**Customer Service Office****Mailing Address**

P.O. Box 26100

Lehigh Valley, PA 18002-6100

NOTICE AND CONSENT FOR HIV-RELATED TESTING**The insurer identified below will be herein referred to as the "Company."**

THE GUARDIAN LIFE INSURANCE COMPANY OF AMERICA

Unless subsidiary checked below:☐ THE GUARDIAN INSURANCE & ANNUITY COMPANY, INC.☐ BERKSHIRE LIFE INSURANCE COMPANY OF AMERICA

To evaluate your insurability, the Insurer named above (the Insurer) has requested that you provide a sample of your blood, oral fluid extracted from cheek and gum tissue, or urine for testing and analysis to determine the presence of human immunodeficiency virus (HIV) antibodies. By signing and dating this form you agree that this test may be done and that underwriting decisions will be based on the test result. A series of three tests will be performed by a licensed laboratory through a medically accepted procedure.

Pre-Testing Considerations

Many public health organizations have recommended that before taking an HIV-related test a person seek counseling to become informed concerning the implications of such a test. You may wish to consider counseling, at your expense, prior to being tested.

Meaning of Positive Test Result

The test is not a test for AIDS. It is a test for antibodies to the HIV virus, the causative agent for AIDS, and shows whether you have been exposed to the virus. A positive test result does not mean that you have AIDS but that you are at significantly increased risks of developing problems with your immune system. The test for HIV antibodies is very sensitive. Errors are rare, but they do occur. Your private physician, a public health clinic, or an AIDS information organization in your city might provide you with further information on the medical implications of a positive test.

Positive HIV antibody test results will adversely affect your application for insurance. This means that your application may be declined, that an increased premium may be charged, or that other policy changes may be necessary.

Confidentiality of Test Results

All test results are required to be treated confidentially. They will be reported by the laboratory to the Insurer. The test results may be disclosed as required by law or may be disclosed to employees of the Insurer who have the responsibility to make underwriting decisions on behalf of the Insurer or to outside legal counsel who needs such information to effectively represent the Insurer in regard to your application. The results may be disclosed to a reinsurer, if the reinsurer is involved in the underwriting process. The test may be related to an insurance medical information exchange under procedures that are designed to assure confidentiality, including the use of general codes that also cover results of tests for other diseases or conditions not related to AIDS, or for the preparation of statistical reports that do not disclose the identity of any particular person.

FIRST COPY: HOME OFFICE - SECOND COPY: PROPOSED INSURED - THIRD COPY: AGENT

Notification of Test Result

If your test results are negative, no routine notification will be sent to you. If your test results are reported by the laboratory to the Insurer as being positive, you will receive written notification of such results from a physician you have designated or, in the absence of such designation, from the Texas Department of Health. Because a trained person should deliver that information so that you can understand clearly what the test result means, please list your private physician so that the Insurer can have him or her tell you the test result and explain its meaning.

Name of physician for reporting a possible positive test result: _____

Address: _____

In the event the test is positive and you are denied coverage because of that fact and you request the reason for the denial, the Insurer may require you to name a physician at that time in order to receive the information.

If the test indicates a positive result, but you do not designate a private physician, the test results will be provided to you by a representative of the Texas Department of Health

Consent

I have read and I understand this Notice and Consent for HIV-Related Testing. I voluntarily consent to the collection of sample of blood, oral fluid extracted from cheek and gum tissue, or urine from me, the testing of that sample, and the disclosure of the tests results as described above. I have read the information on this form about what a test result means.

I understand that I have the right to request and receive a copy of this authorization. A photocopy of this form will be as valid as the original.

Signature of Proposed Insured or Parent/Guardian

Name of Proposed Insured

Date Signed

Address