Guardian®

Medical Supplement for Individual Life And Disability Insurance - Part II

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

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

Health and Personal History of Proposed Insured

SECTION A: Proposed Insured Information

1. First Name _____ MI _____ Last Name _____

2. Date of Birth (mm/dd/yyyy) _____

SECTION B: Primary Doctor Information

Please provide information about the primary care doctor you last consulted within the past 5 years. If you have consulted more than one primary care doctor within the past 5 years, please provide complete details in the Additional Details section.

1. Primary Care Doctor _____

2. Street Address _____

City _____ State _____ Zip _____

3. Phone _____ **4.** Date Last Seen (mm/dd/yyyy) _____

5. Reason ☐ Routine Physical ☐ Check-up ☐ Other *If reason for visit is "Other," please explain.* _____

_____

6. What treatment or medication was given or recommended? _____

7. Was your primary care doctor the last physician seen? ☐ Yes ☐ No *If "No," please complete the following:*

a. Doctor Last Seen _____

b. Street Address _____

City _____ State _____ Zip _____

c. Phone _____ **d.** Date Last Seen (mm/dd/yyyy) _____

e. Reason _____

f. What treatment or medication was given or recommended? _____

SECTION C: Proposed Insured's Health/Medical History

If you answer "Yes" to any of the questions below, please provide details in the Additional Details section.

1. Height _____ ft _____ in **2.** Weight _____ lbs

3. Have you lost more than 10 lbs in the past year? ☐ Yes ☐ No *If "Yes," please provide the following information:*

a. Reason for change in weight: ☐ Diet ☐ Exercise ☐ Illness ☐ Pregnancy (women only)

☐ Other _____

b. How much weight have you lost in the past year? _____ lbs

4. In the past 10 years, have you been diagnosed with, treated for, tested positive for, been given medical advice by a member of the medical profession or received a consultation or counseling for:

a. any cancer or tumor? ☐ Yes ☐ No

b. high blood pressure, heart murmur, irregular heartbeat, palpitations, heart attack, coronary artery disease, chest pain, or any other disease or disorder of the heart, blood vessels or circulatory system? ☐ Yes ☐ No

c. high blood sugar, high cholesterol, diabetes, thyroid disorder or any disease or disorder of the blood (except HIV), skin, glands or endocrine system? ☐ Yes ☐ No

d. disease or disorder of the kidney, bladder or urinary systems (including blood or protein in the urine)? ☐ Yes ☐ No

e. any disease or disorder of the prostate, breasts, reproductive system (including infertility) or genital organs or complications of pregnancy? ☐ Yes ☐ No

f. Crohn's disease or colitis, blood in stool, hepatitis or any disease or disorder of the liver, colon, pancreas, spleen, stomach, intestines, esophagus, rectum, gall bladder or hernia or surgery for weight loss? ☐ Yes ☐ No

g. arthritis, chronic pain, auto-immune or connective tissue disorder, multiple sclerosis, Parkinson's disease or tremor? ☐ Yes ☐ No

h. any disease, disorder or condition of the back, neck, spine/spinal cord, joints, limbs or bones? ☐ Yes ☐ No

i. asthma, emphysema, chronic obstructive pulmonary disease, shortness of breath, disease or disorder of the lungs or respiratory system, allergies or any sleep disorder including sleep apnea? ☐ Yes ☐ No

j. seizure disorder, stroke, transient ischemic attack (TIA), memory loss, Alzheimer's disease, dizziness, headache or disease or disorder of the brain? ☐ Yes ☐ No

k. any disease or disorder of the eyes, vision, ears, hearing, nose or throat? ☐ Yes ☐ No

l. anxiety, depression, stress, attention deficit disorder (ADD), post-traumatic stress disorder (PTSD) or any other mental, nervous, eating or emotional disorder? ☐ Yes ☐ No

m. chronic fatigue syndrome, fibromyalgia, neuritis, neuralgia, narcolepsy, insomnia, restless leg syndrome, Epstein Barr virus, Lyme Disease, muscle weakness or any disease or disorder of the muscles, nerves or nervous system? ☐ Yes ☐ No

5. Have you had an amputation of any kind or any physical deformity, handicap or impairment that has been diagnosed by a member of the medical profession? ☐ Yes ☐ No

6. Within the past 10 years, have you received any speech, physical or occupational therapy? ☐ Yes ☐ No

7. Within the past 10 years, have you tested positive, been diagnosed by or received treatment from a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or Human Immunodeficiency Virus (HIV)? ☐ Yes ☐ No

8. Are you currently taking prescription medication or have been prescribed any medication within the past 6 months that was not already disclosed? ☐ Yes ☐ No

SECTION C: Proposed Insured's Health/Medical History (continued)

9. Are you currently taking non-prescription medication or supplements? ☐ Yes ☐ No

10. Describe your complete use of tobacco or tobacco products below. This includes, but is not limited to: cigarettes, cigars, pipes, chewing tobacco, snuff, hookah, nicotine gum, nicotine patch and electronic delivery devices. *If additional space is needed, please provide in the Additional Details section.*

Type of Product	Quantity	Frequency	Date Last Used (mm/dd/yyyy)
Cigarettes		☐ Daily ☐ Weekly ☐ Monthly ☐ Yearly	
Cigars		☐ Daily ☐ Weekly ☐ Monthly ☐ Yearly	
Pipes		☐ Daily ☐ Weekly ☐ Monthly ☐ Yearly	
Chewing Tobacco		☐ Daily ☐ Weekly ☐ Monthly ☐ Yearly	
Other _____		☐ Daily ☐ Weekly ☐ Monthly ☐ Yearly	
☐ I have never used tobacco products.			

11. Describe your complete use of alcohol below. This includes, but is not limited to: beer, wine and liquor. *If additional space is needed, please provide in the Additional Details section.*

Note: Alcohol types and equivalent amounts: 1 Beer = 12 oz. 1 Wine = 4 oz. 1 Liquor = 1 oz.

Type of Product	Quantity	Frequency	Date Last Used (mm/dd/yyyy)
Beer		☐ Daily ☐ Weekly ☐ Monthly ☐ Yearly	
Wine		☐ Daily ☐ Weekly ☐ Monthly ☐ Yearly	
Liquor		☐ Daily ☐ Weekly ☐ Monthly ☐ Yearly	
Other_____		☐ Daily ☐ Weekly ☐ Monthly ☐ Yearly	
☐ I have never used alcohol.			

12. Describe your use of marijuana, in any form, in the last 5 years below. If you have not used marijuana in the last 5 years, check here ☐.

a. Purpose: ☐ Recreational/Social ☐ Medicinal *If purpose is medicinal, please provide the below information:*

i. Reason for Use: _____

ii. Prescribing Doctor's Name: _____

b. Date Last Used (mm/dd/yyyy): _____

c. Frequency: _____ times per: ☐ day ☐ week ☐ month ☐ year

13. **Age 15 and over:** In the past 10 years, have you used stimulants, cocaine, heroin, morphine, hallucinogens, methamphetamines, narcotics, opioids or any other illicit drug or controlled substance except as prescribed by a member of the medical profession? *If "Yes," complete the Alcohol and Drug Usage Supplement.* ☐ Yes ☐ No

14. **Age 15 and over:** In the past 10 years, have you had or been advised to have counseling or treatment for alcohol or drug use or been advised by a member of the medical profession to limit your use of alcohol or drugs? This includes both prescription and non-prescription drugs. *If "Yes," complete the Alcohol and Drug Usage Supplement.* ☐ Yes ☐ No

15. **Age 15 and over:** Are you now pregnant? *If "Yes," expected delivery date*: _____ ☐ Yes ☐ No

SECTION C: Proposed Insured's Health/Medical History (continued)

16. Are you currently receiving or within the last 5 years, have you had a sickness, injury or any other condition for which you received or applied for any disability benefits including worker's compensation, social security disability insurance or any other form of disability insurance? ☐ Yes ☐ No

17. Within the past 5 years, have you had a physical exam, check-up of any kind or diagnostic tests performed that were not previously disclosed, except for HIV or AIDS tests? ☐ Yes ☐ No

18. Within the past 5 years, have you been advised by a member of the medical profession to have surgery or any diagnostic tests that were *not* performed, except for HIV or AIDS tests? ☐ Yes ☐ No

19. Do you have an appointment scheduled within the next 6 months to seek medical attention, excluding routine physicals? ☐ Yes ☐ No

20. Other than as previously stated on this application, are you currently or in the past 5 years have you received medical advice, counseling, or treatment for any medical, surgical, psychological, or psychiatric condition from a medical professional or have you been a patient in a hospital, clinic, rehabilitation center or other medical facility? ☐ Yes ☐ No

21. Age 6 and below and Life coverage only:

a. Was the Proposed Insured born prematurely (gestational age less than 37 weeks)? ☐ Yes ☐ No
If "Yes," provide gestational age: _____

b. Was the Proposed Insured's birth weight less than 5 pounds? ☐ Yes ☐ No

c. Has the Proposed Insured ever been evaluated, tested, treated for or diagnosed with any growth or developmental delays or failure to thrive? ☐ Yes ☐ No

SECTION D: Family History

1. To the best of your knowledge, have any immediate family members (father, mother or sibling) died before age 60 from cardiovascular disease or cancer? ☐ Yes ☐ No

2. To the best of your knowledge, have any immediate family members (father, mother or sibling) been diagnosed by a member of the medical profession before age 60 with cardiovascular disease or cancer? ☐ Yes ☐ No

3. Have any immediate family members been diagnosed or treated by a member of the medical profession for diabetes, mental illness or a hereditary condition of the brain, muscles, nervous system, eyes or kidneys? ☐ Yes ☐ No

4. Complete the chart below for all immediate family members (father, mother or sibling). The Gender column only needs to be completed for siblings. *If additional space is needed, please provide in the Additional Details section.*

Family Member	Gender Male (M) or Female (F)	Age of Onset	Age if Living	Age at Death	Condition and/or Cause of Death (if applicable)
Father	NA				
Mother	NA				
Sibling	☐ M ☐ F				
Sibling	☐ M ☐ F				
Sibling	☐ M ☐ F				
Sibling	☐ M ☐ F				
Sibling	☐ M ☐ F				

SECTION E: Additional Details

Provide all details to any "Yes" answers, identifying each detail by question number. Include, if applicable, all dates, diagnoses, stage or severity of diagnoses, known symptoms, tests performed, treatment (recommended or received), medications (types and amounts), surgeries, length of disability, days of work missed, job restrictions or modifications due to injury or sickness, physical limitations and the names and addresses of all treatment providers including, but not limited to, physicians, medical or mental health professionals, counselors, psychotherapists, chiropractors, acupuncturists, practitioners or hospitals, clinics or other medical or mental health facilities. For additional space use the Supplement to the Application for Insurance.

SECTION F: Signatures

I understand and agree that the statements and answers in this application: (1) are written as made by me; (2) to the best of my knowledge and belief are full, complete and true; and (3) shall be a part of the contract of insurance, if issued.

Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

Signed at _____ _____

City and State | Month/Day/Year

_____ _____

Signature of Witness | Signature of Proposed Insured

Guardian

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

Report on Physical Measurements

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

Please print.

SECTION A: Proposed Insured Information

First Name _____ MI _____ Last Name _____

Date of Birth (mm/dd/yyyy) _____

Are you related to the Proposed Insured or Producer? ☐ Yes ☐ No

How long have you known the Proposed Insured? _____

Has the Proposed Insured ever been your patient? ☐ Yes ☐ No

Are you examining the Proposed Insured concurrently for another company? ☐ Yes ☐ No

SECTION B: Build

1. Height (in shoes) _____ ft _____ in

2. Weight (clothed) _____ lbs

3. Did you weigh? ☐ Yes ☐ No

4. Did you measure? ☐ Yes ☐ No

5. Males Only:
Chest Full Inspiration _____ in
Chest Forced Expiration _____ in
Abdomen or Umbilicus _____ in

SECTION C: Pulse and Blood Pressure

1.

Pulse	Rate	Number of Irregularities
At Rest		
Immediately after exercise		
Two minutes after exercise		

2.

Blood Pressure	Reading 1	Reading 2	Reading 3
Systolic			
Diastolic			

Note: If Reading 1 is above 140/90, please record additional readings.

SECTION D: Certification

Name of Doctor or Paramedical Facility _____

Street Address _____

City _____ State _____ Zip _____

I certify that:

- I have carefully examined the Proposed Insured named above.
- The examination was made in private at: ☐ Residence of Proposed Insured ☐ Agency Office ☐ My Office ☐ Place of Business of Proposed Insured ☐ Other _____
- The examination took place on (mm/dd/yyyy) _____ at _____ ☐ a.m. ☐ p.m.
- This examination is for: ☐ Life Insurance ☐ Disability Insurance ☐ Other _____
- Photo ID Verified ☐ Yes ☐ No

_____
Signature of Medical Examiner

Examiner: Please give name of producer/broker or agency requesting this examination:

_____ _____
Producer/Broker Address

If not appointed examiner for the Company, please complete below:

State in which licensed: _____ Date of License: _____ License # _____

IMNB0018000230201

Guardian®

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

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

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

Guardian®

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

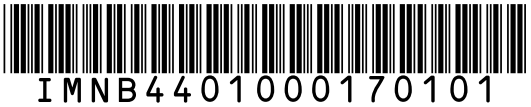
The test is not a test for AIDS. It is a test for antibodies to the HIV virus, the causative agent for AIDS, and shows whether you have been exposed to the virus. A positive test result does not mean that you have AIDS but that you are at significantly increased risks of developing problems with your 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