GUARDIAN℠

Life Customer Service Office
6255 Sterner's Way
Bethlehem, PA 18017-9464

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.")

Instructions To Examiner

1. Please print the Proposed Insured's name and birth date legibly at the top of Part 2 and obtain his/her signature at the bottom of Part 2 and on the Authorization at the end of this form.

2. The person authorized to perform the examination must personally ask each question and record the Proposed Insured's answer. Each "yes" answer must be adequately explained; dates, durations, diagnosis, treatment, results, and names of doctors should be included.

3. The agent is not permitted to be present during an examination. It is not expected that the examination findings will be discussed with the agent or the Proposed Insured or an opinion expressed on the Proposed Insured's insurability.

4. Please complete the fee voucher below (Life only). Do not detach. This will serve as your bill to the Company. Payment will be made from the applicable Customer Service Office for reasonable and customary fees.

5. At the request of our local agency, the examination and any test results* may be mailed to the agency, attention: NEW BUSINESS ADMINISTRATOR. In the absence of such request, all material should be mailed to the applicable Customer Service Office listed above. In no case is this information to be given to the agent. Information which you regard as especially confidential may be reported directly to the Medical Director at the above Customer Service Office by separate letter.

* X-rays should be mailed to the Medical Department of the Company at the applicable address shown at the top.

FEE VOUCHER:

Proposed Insured's Name (Please Print)		Date of Birth	Agent's Name		Agency
Examination Fee $	Authorized ECG $	Special Tests – X-Ray $		Other (specify) $	Total Fee $
Name of Doctor or Paramedical Facility					**IMPORTANT** IRS NUMBER MUST BE PROVIDED FOR PAYMENT: IRS OR EMPLOYER I.D. NUMBER:
Number and Street Address					
City	State	Zip Code	Picture ID verified?		

HOME OFFICE USE ONLY

Policy Number	Amount	Underwriter & Date

IMNB3600000230201

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Representations to the Medical Examiner (Part 2)

This application is to be attached to and made part of the policy.

PROPOSED INSURED INFORMATION

Please print:

1a. First Name_____ MI _____ Last Name_____

b. Date of Birth (mm/dd/yyyy) __ __ /__ __ /__ __ __ __

c. Name and Address of your personal physician. If none, so state.

_____

_____

d. Date and reason last consulted_____

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

f. Weight change past year: ☐ Gain ☐ Loss _____ lbs.
Reason for change:_____

(If you answer "Yes" to questions 2-15, provide details in item #16 on the next page.)

		Yes	No
2.	Have you ever had or been treated for cancer or tumor?	☐	☐
3.	In the last ten years, have you had, been treated for or received a consultation or counseling for:		
	i. high blood pressure, chest pain or disorder of the heart or circulatory system?	☐	☐
	ii. diabetes or disorder of the glands, bone, blood or skin?	☐	☐
	iii. complications of pregnancy, infertility, or any disorder of the breasts, reproductive or genital organs, prostate, kidneys, or urinary systems?	☐	☐
	iv. hernia, hepatitis, or disorder of the liver, gall bladder, stomach, pancreas, spleen, intestines or rectum?	☐	☐
	v. arthritis, rheumatism, or disorder of the joints, limbs or muscles?	☐	☐
	vi. disorder or condition of the back, neck or spine?	☐	☐
	vii. allergy, asthma, sinusitis, emphysema, disorder of the lungs or respiratory system, or sleep apnea?	☐	☐
	viii. epilepsy, stroke, dizziness, headache, or disorder of the brain, or spinal cord?	☐	☐
	ix. disorder of the eyes, ears, nose or throat?	☐	☐
	x. anxiety, depression, nervousness, stress, mental or nervous disorder, or other emotional disorder?	☐	☐
	xi. Chronic Fatigue Syndrome, Fibromyalgia, Epstein Barr virus or Lyme Disease?	☐	☐
4.	Do you have any loss of hearing or sight, an amputation of any kind, or any physical deformity, impairment or handicap?	☐	☐
5.	Within the past ten 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?	☐	☐
6.	i. Are you currently taking prescribed medication?	☐	☐
	ii. Are you currently taking non-prescription medication?	☐	☐

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		Yes	No
7.	i. Have you ever used stimulants, hallucinogens, narcotics or any other controlled substance?	☐	☐
	ii. Have you ever had or been advised to have counseling or treatment for alcohol or drug use? ..... (If yes, complete the Alcohol and Drug Usage Supplement.)	☐	☐
8.	Are you now pregnant? ..... *If yes, expected delivery date:* _____	☐	☐
9.	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?	☐	☐
10.	Within the past five years, have you had a physical exam or check-up of any kind?	☐	☐
11.	Within the past five years, have you been advised to have surgery or any diagnostic tests that were not performed, except for HIV tests?	☐	☐
12.	Within the past 12 months, have you had symptoms of any condition listed, except those conditions listed in question 5, for which you **have not sought medical attention or advice**?	☐	☐
13.	Other than as previously stated on this Representations, in the last five years have you received medical advice from physicians, medical or mental health professionals, counselors, psychotherapists, or other practitioners, or have you been a patient in a hospital, clinic, sanatorium, or other medical facility?	☐	☐
14.	i. Have you smoked cigarettes in the past 24 months?..... (If you have quit, date last used: _____.)	☐	☐
	ii. Have you used tobacco in any form in the last 12 months?	☐	☐
	If "No," have you used tobacco in any form in the last 24 months?	☐	☐
	If "No," have you used tobacco in any form in the last 48 months? ..... (If you have quit, date last used: _____.)	☐	☐
	iii. Do you currently use a nicotine patch or nicotine gum?	☐	☐
15.	Do you have a family history of: diabetes, cancer, high blood pressure, heart disease, mental illness or suicide?	☐	☐

	Age if Living	Cause of Death	Age at Death
FATHER			
MOTHER			
BROTHERS and SISTERS			
No. Living _____			
No. Deceased_____			

16. **DETAILS OF "YES" ANSWERS. IDENTIFY QUESTION & NUMBER. CIRCLE APPLICABLE ITEMS:**
Give 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, practitioners or hospitals. Additional paper may be attached if necessary to explain details.

I understand and agree that the statements and answers in this Representations to the Medical Examiner are written as made by me; to the best of my knowledge and belief are full, complete and true; and that they shall be a part of the contract of insurance, if issued.

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

_____ _____
Witness Signature of Proposed Insured

MEDICAL EXAMINER'S REPORT TO BE FILLED OUT IN PRIVATE

A. How long have you known the Proposed Insured? _____

	Yes	No
1. Has the Proposed Insured ever been your patient?	☐	☐
If "Yes," are details included in history given?	☐	☐
2. Are you related to the Proposed Insured or Agent?	☐	☐
3. Are you examining the Proposed Insured concurrently for another company?	☐	☐

B. Build

1. Height (in shoes)	Weight (Clothed)	Males Only: Chest Full Inspiration	Chest Forced Expiration	Abdomen or Umbilicus
ft. in.	lbs.	in.	in.	in.

2. Did you weigh? ☐ Yes ☐ No
Did you measure? ☐ Yes ☐ No

C. Pulse

	Rate	Number of Irregularities
At rest		
Immediately after exercise		
Two minutes after exercise		

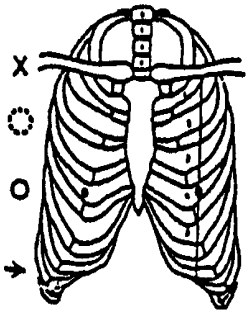
D. Blood Pressure (if above 140/90, record additional readings)

Systolic			
Diastolic 5th Phase			

E. Heart Is there any:

Enlargement ☐ Yes ☐ No Dyspnea ☐ Yes ☐ No
Murmur(s) ☐ Yes ☐ No Edema ☐ Yes ☐ No
(describe below - if more than one, describe separately)

	First Murmur	Second Murmur	
Location	☐	☐	Indicate
Constant	☐	☐	
Inconstant	☐	☐	
Transmitted	☐	☐	Apex by
Localized	☐	☐	
Systolic	☐	☐	
Presystolic	☐	☐	Murmur area by
Diastolic	☐	☐	Point of greatest
Soft (Gr. 1-2)	☐	☐	intensity by
Mod. (Gr. 3-4)	☐	☐	
Loud (Gr. 5-6)	☐	☐	
After exercise:	☐	☐	Transmission by
Increased	☐	☐	
Absent	☐	☐	
Unchanged	☐	☐	Your comments
Decreased	☐	☐	and impression?



F. Do you find evidence of past or present abnormality of:	Yes	No
1. eyes, ears, nose or throat? (If appreciable change, give measured eye impairment or hearing loss.)	☐	☐
2. skin, breasts, lymph nodes, thyroid or other endocrine glands?	☐	☐
3. lungs, pleura or respiratory tract?	☐	☐
4. abdomen or abdominal viscera?	☐	☐
5. kidneys, genitourinary tract?	☐	☐
6. brain or nervous system? (Include any tremor or abnormal reflexes.)	☐	☐
7. musculoskeletal system? (Describe deformities or limitations.)	☐	☐
G. Is a hernia present? (If "Yes," describe below.)	☐	☐
H. Blood Vessels		
1. Any evidence of arteriosclerosis?	☐	☐
2. Any varicosities?	☐	☐

Details or Remarks

Lab testing is required. Use proper kit and send to the Lab.

I certify that I have carefully examined _____ whose signature is affixed to the foregoing declarations and that examination was made in private at: ☐ my office ☐ residence of Proposed Insured ☐ agency office ☐ place of business of Proposed Insured ☐ other _____

On this _____ (Day) day of _____ (Month), _____ (Year) at _____ (Time) ☐ a.m. ☐ p.m.

This examination is for: ☐ Life Insurance ☐ Disability Insurance ☐ Other Purposes _____

Signed: _____ (Medical Examiner)

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

_____ (Agent/Broker) _____ (Address)

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

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

This Report Must Bear Date Examination Actually Made And Under No Circumstances Any Other.

C-MED-2003

IMNB0000000230201

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Authorization to Obtain and Release Information

Name of Proposed Insured _____ Date of Birth _____

Address of Proposed Insured _____

This Authorization Is Designed To Comply With The HIPAA Privacy Rule

This Authorization applies to the Proposed Insured named above. It can only be signed by the Proposed Insured, or the parent or legal guardian of the Proposed Insured in the case of a minor under the age of 18.

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

Medical Records and other information. I authorize any physician, medical or mental health professional, practitioner, hospital, clinic, other health facility, pharmacy, pharmacy benefit manager, consumer reporting agency, the Social Security Administration, MIB, Inc., insurance or reinsurance company, or employer or other organization, institution or person that has any records or knowledge of the Proposed Insured or his/her health to release any and all medical and non-medical information in its possession about the Proposed Insured, to the Company or its legal representatives. Medical information means all information in the possession of or derived from providers of health care regarding the medical history, pharmaceutical history, mental or physical condition, or treatment of the Proposed Insured. I understand that the information released could contain reference to or results of HIV Antibody (AIDS) testing, and may relate to the symptoms, evaluation, diagnosis, examination, treatment or prognosis of any mental or physical condition, including psychiatric, and psychological conditions, and drug or alcohol abuse.

I agree that this authorization shall be valid for two years from the date shown below and that a copy of the authorization shall be as valid as the original. I agree that if I sign this authorization electronically, that it will be equally as effective and valid as if I signed the form through traditional means. I understand, however, that I am under no obligation to sign this document electronically.

I know that I may revoke this authorization in writing, at any time, by sending a written request for revocation to the Guardian Corporate Secretary at 7 Hanover Square, New York, NY 10004-2616, or the Berkshire Corporate Secretary at 700 South Street, Pittsfield, MA 01201. I understand that a revocation is not effective to the extent that the Company and/or any of the entities listed above has already relied on this authorization, or to the extent that the Company has a legal right to contest a claim under an insurance policy or to contest the policy itself.

I understand that the Company or its legal representatives will use the information obtained by this authorization to determine eligibility for insurance or eligibility for benefits under an existing policy. I further understand that if I refuse to sign this authorization, the Company may not be able to process my application, or pay a claim in the case of coverage which is already in force. The Company or its legal representatives will not release any information obtained to any person or organization except to reinsurance companies, MIB, Inc., Innovative Underwriters Services (a subsidiary of The Guardian Life Insurance Company of America), or other persons or organizations performing business or legal services in connection with an application, claim, or as may be lawfully permitted or required, or as I may further authorize. I understand that any information disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal regulations governing privacy (such as the HIPAA Privacy Rule).

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

I acknowledge that I have been given a copy of this authorization and also acknowledge receipt of the Notice of Insurance Information Practices, which includes the Fair Credit Reporting Act Pre-Notice, the Medical Information Bureau Pre-Notice, and Medical Records. I also acknowledge that I or an individual authorized to act on my behalf is entitled to receive a copy of this authorization form.

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

_____ _____
Signature of Proposed Insured or Parent/Legal Guardian Witness Signature