



Life Customer Service Office
 3900 Burgess Place
 Bethlehem, PA 18017

Disability Customer Service Office
 700 South Street
 Pittsfield, MA 01201

- THE GUARDIAN LIFE INSURANCE COMPANY OF AMERICA
 - THE GUARDIAN INSURANCE & ANNUITY COMPANY, INC.
 - BERKSHIRE LIFE INSURANCE COMPANY OF AMERICA
- (Please check appropriate company(ies). Any insurer checked above is herein referred to as the "Company.")

Instructions To Examiner

- 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.
 - 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.
 - 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.
 - 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.
 - 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		





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- THE GUARDIAN LIFE INSURANCE COMPANY OF AMERICA 7 Hanover Square, New York, NY 10004
- THE GUARDIAN INSURANCE & ANNUITY COMPANY, INC. 1209 Orange Street, Wilmington, DE 19801
- 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.")

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 been diagnosed as having or been treated for cancer or tumor? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. In the last ten years, have you been diagnosed as having, been treated for or received a counseling for: | | |
| i. high blood pressure, chest pain or disease or disorder of the heart or circulatory system? | <input type="checkbox"/> | <input type="checkbox"/> |
| ii. diabetes or disease or disorder of the glands, bone, blood or skin? | <input type="checkbox"/> | <input type="checkbox"/> |
| iii. complications of pregnancy, infertility, or any disease or disorder of the breasts, reproductive or genital organs, prostate, kidneys, or urinary systems? | <input type="checkbox"/> | <input type="checkbox"/> |
| iv. hernia, hepatitis, or disease or disorder of the liver, gall bladder, stomach, pancreas, spleen, intestines or rectum? | <input type="checkbox"/> | <input type="checkbox"/> |
| v. arthritis, rheumatism, or disorder of the joints, limbs or muscles? | <input type="checkbox"/> | <input type="checkbox"/> |
| vi. disorder or condition of the back, neck or spine? | <input type="checkbox"/> | <input type="checkbox"/> |
| vii. allergy, asthma, sinusitis, emphysema, disease or disorder of the lungs or respiratory system, or sleep apnea? | <input type="checkbox"/> | <input type="checkbox"/> |
| viii. epilepsy, stroke, dizziness, headache, or disease or disorder of the brain, or spinal cord? | <input type="checkbox"/> | <input type="checkbox"/> |
| ix. disease or disorder of the eyes, ears, nose or throat? | <input type="checkbox"/> | <input type="checkbox"/> |
| x. anxiety, depression, mental or nervous disease or disorder, or other emotional disease or disorder? | <input type="checkbox"/> | <input type="checkbox"/> |
| xi. Chronic Fatigue Syndrome, Fibromyalgia, Epstein Barr virus or Lyme Disease? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Do you have any loss of hearing or sight, an amputation of any kind, or any physical deformity, or handicap? | <input type="checkbox"/> | <input type="checkbox"/> |
| 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? | <input type="checkbox"/> | <input type="checkbox"/> |



- Yes** **No**
7. i. Have you ever used stimulants, hallucinogens, narcotics or any other controlled substance?
- ii. Have you ever received 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 been treated by or received counseling from any physicians, medical or mental health professionals, counselors, psychotherapists, or other practitioners?**
13. Other than as previously stated on this Representations, in the last five years have you been treated by or received counseling from any 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 _____			

MEDICAL EXAMINER'S REPORT TO BE FILLED OUT IN PRIVATE

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

1. Has the Proposed Insured ever been your patient? Yes No
 If "Yes," are details included in history given? Yes No

2. Are you related to the Proposed Insured or Agent? Yes No

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

B. Build

		Males Only			
1. Height (in shoes)	Weight (Clothed)	Chest Full Inspiration	Chest Forced Expiration	Abdomen or Umbilicus	
ft. in.	lbs.	in.	in.	in.	in.
2. Did you weigh?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Did you measure?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

C. Pulse

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

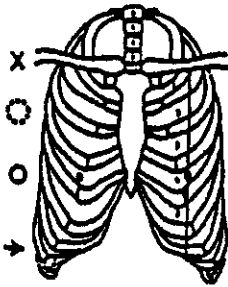
D. Blood Pressure (if above 140/90 record additional readings)

Systolic	Diastolic	5 th 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)

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



F. Do you find evidence of past or present abnormality of:

	Yes	No
1. eyes, ears, nose or throat? (If appreciate change, give measure eye impairment or hearing loss.)	<input type="checkbox"/>	<input type="checkbox"/>
2. skin, breasts, lymph nodes, thyroid or other endocrine glands?	<input type="checkbox"/>	<input type="checkbox"/>
3. lungs, pleura or respiratory tract?	<input type="checkbox"/>	<input type="checkbox"/>
4. abdomen or abdominal viscera?	<input type="checkbox"/>	<input type="checkbox"/>
5. kidneys, genitourinary tract?	<input type="checkbox"/>	<input type="checkbox"/>
6. brain or nervous system? (Include any tremor or abnormal reflexes.)	<input type="checkbox"/>	<input type="checkbox"/>
7. musculoskeletal system? (Describe deformities or limitations.)	<input type="checkbox"/>	<input type="checkbox"/>

G. Is a hernia present? (If "Yes," describe below) Yes No

H. Blood Vessels

1. Any evidence of arteriosclerosis?	<input type="checkbox"/>	<input type="checkbox"/>
2. Any varicosities?	<input type="checkbox"/>	<input type="checkbox"/>

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:

<input type="checkbox"/> my office	<input type="checkbox"/> residence of Proposed Insured
<input type="checkbox"/> agency office	<input type="checkbox"/> place of business of Proposed Insured
<input type="checkbox"/> other _____	

On this _____ 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.





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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 and 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 priort testing for Human Immunodeficiency Virus (HIV), unless such test was performed for the purpose of obtaining insurance.

I agree that this authorization shall be valid for two years from the date shown below and that a copy of the authorization shall be as valid as the original.

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

I understand that the Company or its legal representatives will use the information obtained by this authorization to determine eligibility for insurance or eligibility for benefits under an existing policy. I further understand that if I refuse to sign this authorization, the Company may not be able to process my application, or pay a claim in the case of coverage which is already in force. The Company or its legal representatives will not release any information obtained to any person or organization except to reinsurance companies, the Medical Information Bureau, Innovative Underwriters Services (a subsidiary of The Guardian Life Insurance Company of America), or other persons or organizations performing business or legal services in connection with an application, claim, or as may be lawfully permitted or required, or as I may further authorize.

I 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

