ARIZONA — September 1, 2006

This replaces Application Instructions BG01AI(07/05)-AZ, and has been updated to include the revised HIPAA Authorization Form.

State Variations

- **Suitability Standards and Rate Stabilization Apply**

  For complete details on the completion of the Long Term Care Insurance Personal Worksheet and The Company's Suitability Standards, see the following Guidelines Regarding Suitability Standards for LTC Insurance.

- At time of application, when the Outline of Coverage is given to the applicant, the agent must fill in the premium amounts for the policy and each optional rider applied for, where indicated in the Outline.

Submission Guidelines

NOTE: **Minnesota and Texas residents** must complete applications for their resident state (see the LTCI Quick Reference Guide under "Contract State and Required Forms").

- Calculate the premium based on the age of the applicant as of nearest birthdate. For joint coverage, calculate the premium based on the older applicant's age (age nearest birthdate).
- Current date the application and check. To save applicant's age (we will backdate up to 60 days), request this in the Special Request section of the application.
- If the applicant answers "**Yes**" to any part of **Question 1**, any inability to perform ADL's or IADL's may indicate a functional or cognitive limitation, which is not an acceptable risk. Consult your Underwriting Guide (**BG01UG(06/04)**).
- If the applicant answers "**Yes**" to any part of **Question 2**, they are not an acceptable risk. **Do not submit the application**.
- If the applicant answers "**Yes**" to any other health question, consult your Underwriting Guide (**BG01UG(06/04)**) to confirm eligibility and risk class.
- Submit the application with at least one month's premium. We will not process COD applications (unless submitted as list bill under a pre-approved employer or association group).
- Complete a New Business Transmittal (**BG01NBT(07/05)**) and return with application forms, attaching a check as indicated.
- **Replacement Guidelines** - The replacement question on the application (Question 15) must be answered "Yes" in **any** of the following situations if, on the date of the application:
  - The applicant has existing in-force long term care insurance, medical or health insurance coverage which the applicant will not keep if we issue a policy.
  - The applicant has existing in-force long term care insurance, medical or health insurance coverage with a paid-to-date that is within 65 days of the application date.
  - With respect to joint coverage: (1) one applicant has no existing in-force long term care insurance, medical, or health insurance coverage with a paid-to-date that is within 65 days of the application date but the other one does; or (2) both applicants have existing in-force long term care insurance, medical, or health insurance coverage with a paid-to-date that is within 65 days of the application date.
  - The applicant is applying for a new long term care insurance policy with Berkshire Life Insurance Company of America (internal replacement) and will not keep the original policy if the new one is issued.

  NOTE: When Question 13 on the application indicates that there is existing coverage and the replacement question is answered "No," agents must consider our maximum coverage limitations when choosing the Daily Benefit applied for.

Application Instructions

- O Leave the "*Notice of Privacy Practices*" (**BG01N-PRV(06/04)**) with applicant(s).
- O Leave the "*Shopper's Guide to Long Term Care Insurance*" with applicant(s).
- O Leave the "*Important Notice to Persons on Medicare*" (**BG01N-MED(06/04)**) with applicant(s).
- O Leave the "*Long Term Care Insurance Potential Rate Increase Disclosure*" (**BG01N-PRI(06/04)-AZ**) with applicant(s).
- O Leave the "*Things You Should Know...*" (**BG01N-SUT(06/04)**) with applicant(s).
- O Complete and return the Personal Worksheet (**BG01WRK(06/04)**) with the application (Refer to the following "*Guidelines Regarding Suitability Standards for LTC Insurance*" when completing this worksheet).
- O Complete the Outline of Coverage (**BG01OC(06/04)-AZ**) and leave with applicant(s).
- O Complete all questions on the application (**BG01A(06/04)-AZ**). For joint coverage, the younger applicant completes the Joint Coverage section. **Please include an illustration to verify benefits and premiums**.
- O Complete the Agent's Certification (**BG01AC(06/04)**) and submit with the application.
- O Have the applicant(s) sign both copies of the Authorization for Disclosure, Receipt and Use of Personal Health Information (**BG01AUT(06/05)-AZ**). Leave one copy with applicant(s), submit one copy with the application.
- O Complete and leave the Disclosure Statement and Conditions of Coverage (**BG01AD(06/04)**) with applicant(s).
- O When either applicant is replacing other coverage as marked on the application, complete the Notice to Applicant Regarding Replacement (**BG01N-REP(06/04)**). Leave one copy with the applicant(s), submit the other copy with the application.
- O When the applicant will not be the owner of the policy, complete the Supplemental Application for Policy Ownership (**BG01AO(06/04)**).
- O When the applicant is requesting monthly bank withdrawal, complete the Automatic Payment Authorization (**BG01APA(06/04)**). Leave one copy with the applicant(s), submit the other copy and a voided check with the application.

GUIDELINES REGARDING SUITABILITY STANDARDS FOR LTC INSURANCE

State law requires both the agent and the Company to assist the applicant in determining the suitability of a potential purchase of long term care insurance. It is therefore very important that you read, understand, and implement the procedures outlined in this instruction. It will allow you to determine that your sale will meet the required suitability standards.

There are two additional forms that are required for each sale:

1. The first form is **BG01N-SUT(06/04)** and is titled "Things You Should Know Before You Buy Long Term Care Insurance." You must review this form with each applicant and it should help you finalize the sale.
2. The second form is **BG01WRK(06/04)**, "Long Term Care Insurance Personal Worksheet." This worksheet must be filled out by the applicant with your assistance.

   The first section - Premium Information, requires you to complete the policy form number and fill in the anticipated premium. Point out the policy's renewability provision to the applicant and the possibility of a future rate increase.

   The second section - Questions Related To Your Income, requires you to check a box in each of two lines. In the first line of this section, the source of premium payments needs to be indicated. In the second line of this section, affordability of the policy needs to be indicated.

   The third section - What Is Your Annual Income? Requires you to check a box in each of two lines. In the first line of this section, the annual income of the applicant needs to be indicated. In the second line of this section, the expectation for change in income needs to be indicated.

   This section also requires you to analyze the applicant's ability to afford the premiums based on income. To do this, you must multiply the applicant's income by 7% (0.07). If this amount is less than the annual premium, then either family members must be paying the premium or savings must be the premium source with assets from the next section in the "Over $50,000" bracket. Otherwise, the proposed sale does not meet the suitability standards.

   The fourth section - Will You Buy Inflation Protection? Requires you to answer "Yes" or "No" and explain the difference between future costs and the daily benefit selected.

   The fifth section - What Elimination Period Are You Considering? Requires you to indicate the number of days, approximate cost for that period of care and discuss how the applicant plans to pay for this care.

   The sixth section - Questions Related To Your Savings and Investments. The first line of this section requires you to check a box indicating the value of the applicant's assets (excluding the applicant's home) and the next line requires the applicant to indicate the expected change in these assets. If the assets are less than $30,000, the sale does not meet suitability standards.

   The seventh section - Comparison to Current Coverage. If the insured has current coverage you are replacing, you must analyze the insured's current coverage and indicate (by checking the appropriate box) why the replacement is suitable. In addition, the premium for the applicant's existing coverage must be entered on the line provided.

   The eighth section - Disclosure Statement, requires the applicant to certify that the answers in the worksheet are accurate, or that the applicant declines to provide the financial information. It also requires the applicant to acknowledge that you have reviewed the form with them and that the applicant understands that premium rates may be increased in the future.

We will send the attached letter if we determine that the proposed purchase may not be suitable for the applicant. If the attached letter is sent, the applicant must respond again within 60 days, or we will not underwrite the coverage and the file will be closed.

The next part of this section requires the agent to certify that the importance of this form has been properly explained to the applicant.

The last part of this section **must** be completed if the applicant's proposed purchase does not meet suitability standards. The applicant will have to provide a compelling reason for the company to consider the risk if the applicant does not meet the required suitability standards.

The ninth section - Authorization to Process Application, must be signed if the applicant declines to provide the financial information.

SUMMARY - In general, the purchase of a long term care policy will not be considered suitable if:

- Premiums for the proposed policy are more than 7% of applicant's income, unless the applicant's assets are greater than $50,000 or another premium source (such as family members) is indicated; or
- Applicant's assets (savings and investments) are under $30,000.

SAMPLE LONG TERM CARE INSURANCE SUITABILITY LETTER

Dear [Applicant]:

Your recent application for long term care insurance included a "Personal Worksheet," which asked questions about your finances and your reasons for buying long term care insurance. For your protection, State law requires us to consider this information when we review your application. This prevents issuing a policy to those who may not need coverage.

Your answers on the worksheet indicate that long term care insurance may not meet your financial needs. We suggest that you review the information provided along with your application, including the booklet "Shopper's Guide to Long Term Care Insurance" and the page titled "Things You Should Know Before Buying Long Term Care Insurance." Your State Insurance Department also has information about long term care insurance and may be able to refer you to a counselor free of charge who can help you decide whether to buy this policy.

Your state requires that we confirm your request to proceed before we can continue to underwrite your application. We need to hear from you within the next 60 days to complete the underwriting of your application. If we do not hear from you within the next 60 days, we cannot issue you a policy and your file will be closed. You should understand that you will not have any coverage until you respond to this letter, we approve your application and issue you a policy.

Please check one box and return in the enclosed envelope.

☐ Yes, I wish to purchase this coverage. Please continue the review of my application.

☐ No. I have decided not to purchase long term care coverage at this time.

_____ _____

APPLICANT'S SIGNATURE DATE

Please return to:
Berkshire Life Insurance Company of America
Long Term Care Administrative Office
P.O. Box 4243
Woodland Hills, CA 91365-4243 *by [Date]*

Berkshire Life Insurance Company of America
Home Office: Pittsfield, Massachusetts
Long Term Care Administrative Office
Post Office Box 4243
Woodland Hills, CA 91365-4243
888-505-8743

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The terms of this Notice of Privacy Practices apply to **Berkshire Life Insurance Company of America** and its long term care insurance products. The organization will share personal health information of applicants and insureds as necessary to carry out treatment, payment, and health care operations as permitted by law.

We are required by law to maintain the privacy of your personal health information and to provide you with notice of our legal duties and privacy practices with respect to your personal health information. We are required to abide by the terms of this Notice so long as it remains in effect. We reserve the right to change the terms of this Notice of Privacy Practices as necessary and to make the new Notice effective for all personal health information maintained by us. Copies of revised notices will be mailed to all insureds then covered and copies may be obtained by mailing a **written request** to us.

USES AND DISCLOSURES OF YOUR PERSONAL HEALTH INFORMATION

Your Authorization. Except as outlined below, we will not use or disclose your personal health information for any purpose unless you have signed a form authorizing the use or disclosure. You have the right to revoke that authorization in writing unless we have taken any action in reliance on the authorization.

Uses and Disclosures for Payment. We will make uses and disclosures of your personal health information as necessary for payment purposes. For instance, we may use information regarding treatment and services provided to you in order to process and pay claims, to determine whether services are required as covered under the terms of your policy.

Uses and Disclosures for Health Care Operations. We will use and disclose your personal health information as necessary, and as permitted by law, for our health care operations which may include business management, quality improvement and assurance, enrollment, underwriting, reinsurance, compliance, auditing, rating, and other functions related to your application or policy.

Family and Friends Involved In Your Care. With your approval, we may from time to time disclose your personal health information to designated family, friends, and others who are involved in your care or in payment for your care in order to facilitate that person's involvement in caring for you or paying for your care. If you are unavailable, incapacitated, or facing an emergency medical situation, and we determine that a limited disclosure may be in your best interest, we may share limited personal health information with such individuals without your approval. If you have designated a person to receive information regarding payment of the premium on your long term care policy, we will inform that person when your premium has not been paid. We may also disclose limited personal health information to a public or private entity that is authorized to assist in disaster relief efforts in order for that entity to locate a family member or other persons that may be involved in some aspect of caring for you.

Business Associates. Certain aspects and components of our services are performed through contracts with outside persons or organizations, such as licensed insurance agents, third party administration services, auditing, actuarial services, legal services, etc. At times it may be necessary for us to provide certain of your personal health information to one or more of these outside persons or organizations who assist us with our health care operations. In all cases, we require these business associates to appropriately safeguard the privacy of your information.

Communications With You. We may communicate with you regarding your claims, premiums, or other things connected with your application or policy. You have the right to request and we will accommodate reasonable requests by you to receive communications regarding your personal health information from us by alternative means or at alternative locations, if you inform us in writing that disclosure of such information would otherwise endanger you. For instance, if you wish messages to not be left on voice mail or sent to a particular address, we will accommodate reasonable requests. You may request such confidential communication by sending a **written request** to us.

Other Health-Related Products or Services. We may, from time to time, use your personal health information to determine whether you might be interested in or benefit from treatment alternatives or other health-related programs, products or services which may be available to you as an insured. For example, we may use your personal health information to identify whether you have a particular illness, and contact you to advise you that a disease management program to help you manage your illness better is available to you as an insured. We will not use your information to communicate with you about products or services which are not health-related without your written permission.

Information Received Prior to Issuance of a Policy. We may request and receive from you and your health care providers personal health information prior to the issuance of a policy to you. We will use this information to determine whether you are eligible for a policy and to determine your premium rate. We will protect the confidentiality of that information in the same manner as all other personal health information we maintain and, if the policy is not issued, we will not use or disclose the information about you we obtained for any other purpose.

Research. In limited circumstances, we may use and disclose your personal health information for research purposes. For example, a research organization may wish to compare outcomes of patients by payer source and will need to review a series of records that we hold. In all cases where your specific authorization has not been obtained, your privacy will be protected by strict confidentiality requirements applied by an institutional review board or privacy board which oversees the research or by representations of the researchers that limit their use and disclosure of insured information.

Other Uses and Disclosures. We are permitted or required by law to make certain other uses and disclosures of your personal health information without your authorization.

- We may release your personal health information for any purpose required by law;
- We may release your personal health information as required by law if we believe you to be a victim of abuse, neglect, or domestic violence;
- We may release your personal health information if required by law to a government oversight agency conducting audits, investigations, or civil or criminal proceedings;
- We may release your personal health information if required to do so by a court or administrative ordered subpoena or discovery request; in most cases you will have notice of such release;
- We may release your personal health information to law enforcement officials as required by law to report wounds and injuries and crimes;
- We may release your personal health information for certain research purposes when such research is approved by an institutional review board with established rules to ensure privacy; and
- We may release your personal health information if you are a member of the military as required by armed forces services; we may also release your personal health information if necessary for national security or intelligence activities.

RIGHTS THAT YOU HAVE

Access to Your Personal Health Information. You have the right to copy and/or inspect much of the personal health information that we retain on your behalf. All requests for access must be made in writing and signed by you or your representative. We will charge you $5.00 if you request a copy of the information. We will also charge for preparing a summary of the requested information if you request such summary. You may obtain an access request form by sending a **written request** to us.

Amendments to Your Personal Health Information. You have the right to request in writing that personal health information that we maintain about you be amended or corrected. We are not obligated to make all requested amendments but will give each request careful consideration. All amendment requests, in order to be considered by us, must be in writing, signed by you or your representative, and must state the reasons for the amendment/correction request. If an amendment or correction you request is made by us, we may also notify others who work with us and have copies of the uncorrected record if we believe that such notification is necessary. You may obtain an amendment request form by sending a **written request** to us.

Accounting for Disclosures of Your Personal Health Information. You have the right to receive an accounting of certain disclosures made by us of your personal health information after June 30, 2004. Requests must be made in writing and signed by you or your representative. You may obtain an accounting request form by sending a **written request** to us.

Restrictions on Use and Disclosure of Your Personal Health Information. You have the right to request restrictions on certain of our uses and disclosures of your personal health information for treatment, payment, or health care operations by notifying us of your request for a restriction in writing. You may obtain a restriction request form by sending a **written request** to us. We are not required to agree to your restriction request but will attempt to accommodate reasonable requests when appropriate and we retain the right to terminate an agreed-to restriction if we believe such termination is appropriate. In the event of a termination by us, we will notify you of such termination. You also have the right to terminate, in writing or orally, any agreed-to restriction by sending a **written request** to us.

Complaints. If you believe your privacy rights have been violated, you can file a complaint with: **Berkshire Life Insurance Company of America, Long Term Care Administrative Office, ATTN: CORPORATE PRIVACY OFFICER, P.O. Box 4243, Woodland Hills, CA 91365-4243, Phone: 888-505-8743.** You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services in Washington D.C. in writing within 180 days of a violation of your rights. There will be no retaliation for filing a complaint.

FOR FURTHER INFORMATION AND WRITTEN REQUESTS

For all **written requests** described above, if you have questions or need further assistance regarding this Notice, please contact: **Berkshire Life Insurance Company of America, Long Term Care Administrative Office, ATTN: CORPORATE PRIVACY OFFICER, P.O. Box 4243, Woodland Hills, CA 91365-4243, Phone: 888-505-8743.**

You retain the right to obtain a paper copy of this Notice of Privacy Practices, even if you have requested such copy by e-mail or other electronic means.

EFFECTIVE DATE

This Notice of Privacy Practices is effective June 30, 2004.

Berkshire Life Insurance Company of America
Home Office: Pittsfield, Massachusetts
Long Term Care Administrative Office
Post Office Box 4243
Woodland Hills, CA 91365-4243
888-505-8743

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

Federal law requires us to inform you that this insurance duplicates Medicare benefits in some situations.

- This is long term care insurance that provides benefits for covered nursing home and home care services.
- In some situations Medicare pays for short periods of skilled nursing home care, limited home health services and hospice care.
- This insurance does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Neither Medicare nor Medicare Supplement insurance provides benefits for most long term care expenses.

Before You Buy This Insurance

✓ Check the coverage in **all** health insurance policies you already have.

✓ For more information about long term care insurance, review the *Shopper's Guide to Long Term Care Insurance*, available from the insurance company.

✓ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.

✓ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

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LONG TERM CARE INSURANCE
POTENTIAL RATE INCREASE DISCLOSURE FORM

1. **Premium Rate:** The premium rate that is applicable to you and the coverage you have applied for is shown on the application.
2. **The premium for the policy and any riders that are issued to you will be shown on the Policy Schedule of your policy. This rate will be in effect unless and until the Company requests a premium rate increase and it is filed in the state in which your policy was issued.**
3. **Rate Schedule Adjustments:**

   Premium rate or rate schedule adjustments will be effective on the next anniversary date following the date the rate increase is filed in the state.
4. **Potential Rate Revisions:**

   This policy is Guaranteed Renewable. This means that the rates for this product may be increased in the future. Your rates can NOT be increased due to your increasing age or declining health, but your rates may go up based on the experience of all policyholders with a policy similar to yours.

   If you receive a premium rate or premium rate schedule increase in the future, you will be notified of the new premium amount and you will be able to exercise at least one of the following options:

   - Pay the increased premium and continue your policy in force as is.
   - Reduce your policy benefits to a level such that your premiums will not increase. (Subject to state law minimum standards.)
   - Exercise your nonforfeiture option if purchased. (This option is available for purchase for an additional premium.)
   - Exercise your contingent nonforfeiture option.* (This option may be available to you if you do not purchase a separate nonforfeiture option.)

***Contingent Nonforfeiture**

If the premium rate for your policy goes up in the future and you didn't buy a nonforfeiture option you may be eligible for contingent nonforfeiture. Here's how to tell if you are eligible:

You will keep some long term care coverage, if:

- Your premium after the increase exceeds your original premium by the percentage shown (or more) in the following table; and
- You lapse (not pay more premiums) within 120 days of the increase.

The amount of coverage (i.e., new lifetime maximum benefit amount) you will keep will equal the total amount of premiums you've paid since your policy was first issued. If you have already received benefits under the policy, so that the remaining maximum benefit amount is less than the total amount of premiums you've paid, the amount of coverage will be that remaining amount.

Except for this reduced lifetime maximum benefit amount, all other policy benefits will remain at the levels attained at the time of the lapse and will not increase thereafter.

Should you choose this Contingent Nonforfeiture option, your policy, with this reduced maximum benefit amount will be considered "paid-up" with no further premiums due.

Example:

- You bought the policy at age 65 and paid the $1,000 annual premium for 10 years, so you have paid a total of $10,000 in premium.
- In the eleventh year, you receive a rate increase of 50%, or $500 for a new annual premium of $1,500, and you decide to lapse the policy (not pay any more premiums).
- Your "paid-up" policy benefits are $10,000 (provided you have at least $10,000 of benefits remaining under your policy.)

Contingent Nonforfeiture **Cumulative Premium Increase Over Initial Premium That Qualifies for Contingent Nonforfeiture** (Percentage Increase is cumulative from the date of original issue. It does NOT represent a one-time increase)	
Issue Age	**Percent Increase Over Initial Premium**
40-44	150%
45-49	130%
50-54	110%
55-59	90%
60	70%
61	66%
62	62%
63	58%
64	54%
65	50%
66	48%
67	46%
68	44%
69	42%
70	40%
71	38%
72	36%
73	34%
74	32%
75	30%
76	28%
77	26%
78	24%
79	22%
80	20%
81	19%
82	18%
83	17%
84	16%
85	15%

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Things You Should Know Before You Buy Long-Term Care Insurance

Long-Term Care Insurance

- A long-term care insurance policy may pay most of the costs for your care in a nursing home. Many policies also pay for care at home or other community settings. Since policies can vary in coverage, you should read this policy and make sure you understand what it covers before you buy it.
- You should **not** buy this insurance policy unless you can afford to pay the premiums every year. Remember that the company can increase premiums in the future.
- The personal worksheet includes questions designed to help you and the company determine whether this policy is suitable for your needs.

Medicare

- Medicare does **not** pay for most long-term care.

Medicaid

- Medicaid will generally pay for long-term care if you have very little income and few assets. You probably should **not** buy this policy if you are now eligible for Medicaid.
- Many people become eligible for Medicaid after they have used up their own financial resources by paying for long-term care services.
- When Medicaid pays your spouse's nursing home bills, you are allowed to keep your house and furniture, a living allowance, and some of your joint assets.
- Your choice of long-term care services may be limited if you are receiving Medicaid. To learn more about Medicaid, contact your local or state Medicaid agency.

Shopper's Guide

- Make sure the insurance company or agent gives you a copy of a book called the National Association of Insurance Commissioners' "Shopper's Guide to Long-Term Care Insurance". Read it carefully. If you have decided to apply for long-term care insurance, you have the right to return the policy within 30 days and get back any premium you have paid if you are dissatisfied for any reason or choose not to purchase the policy.

Counseling

- Free counseling and additional information about long-term care insurance are available through your state's insurance counseling program. Contact your state insurance department or department on aging for more information about the senior health insurance program in your state.

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Long Term Care Insurance
Personal Worksheet

People buy long term care insurance for many reasons. Some don't want to use their own assets to pay for long term care. Some buy insurance to make sure they can choose the type of care they get. Others don't want their family to have to pay for care or don't want to go on Medicaid. But long term care insurance may be expensive and may not be right for everyone.

By state law, the insurance company must fill out part of the information on this worksheet and **ask** you to fill out the rest to help you and the company decide if you should buy this policy.

Premium Information

Policy Form Numbers: _____

The premium for the coverage you are considering will be $ _____ per _____ .

Type of Policy: Guaranteed Renewable

The Company's Right To Increase Premiums

The Company has a right to increase premiums on this policy form in the future, provided it raises rates for all policies in the same class in this state.

Rate Increase History

The company has sold long term care insurance since 2004 and has sold this policy since 2004. The company has never raised its rates for any long term care policy it has sold in this state or any other state.

Questions Related To Your Income

How will you pay each year's premium?

O From my income O From my Savings/Investments O My family will pay

O Have you considered whether you could afford to keep this policy if the premiums went up, for example, by 20%?

What Is Your Annual Income? (check one)

O Under $10,000 O $10-20,000 O $20-30,000 O $30-50,000 O Over $50,000

How do you expect your income to change over the next 10 years? (check one)

O No change O Increase O Decrease

If you will be paying premiums with money received only from your own income, a rule of thumb is that you may not be able to afford this policy if the premiums will be more than 7% of your income.

Turn the Page

Will You Buy Inflation Protection? (check one) O Yes O No

If not, have you considered how you will pay for the difference between future costs and your daily benefit amount?

O From my income O From my Savings/Investments O My family will pay

The national average annual cost of care in 2001[1] was: $56,000 in a nursing home; $22,476 in an assisted living facility and $14,000 for home health care, but these figures vary across the country. In ten years the national average annual cost would be about $91,280 in a nursing home; $36,636 in an assisted living facility and $22,820 for home health care, if costs increase 5% annually.

What Elimination Period Are You Considering? Number of Days _____ Approximate cost $ _____ for that period of care.

How are you planning to pay for your care during the elimination period? (check one)

O From my income O From my Savings/Investments O My family will pay

Questions Related To Your Savings and Investments

Not counting your home, about how much are all of your assets (savings and investments) worth? (check one)

O Under $20,000 O $20,000-30,000 O $30,000-50,000 O Over $50,000

How do you expect your assets to change over the next ten years? (check one)

O Stay about the same O Increase O Decrease

If you are buying this policy to protect your assets and your assets are less than $30,000, you may wish to consider other options for financing your long term care.

Comparison To Current Coverage

If you have existing long term care coverage and you intend to add to or replace your current coverage, please indicate your reason for doing so (check one):

O Additional or different benefits (please specify): _____

O No change in benefits, but lower premiums

O Fewer benefits and lower premiums

O Other (please specify): _____

Premium for your current long term care coverage: $ _____ per _____ .

[1] 2003 NAIC Shopper's Guide

Continued on Next Page

Disclosure Statement

(Check One)

O The answers to the questions above describe my financial situation.

Or

O I choose not to complete this information. However, I still want the Company to consider my application (complete Authorization to Process Application below).

O I acknowledge that the agent (below) has reviewed this form with me including the premium, premium rate increase history and potential for premium increase in the future. I understand the above disclosures. **I understand that the rates for this policy may increase in the future.** *(This box must be checked in order to consider your application for Long Term Care.)*

Signed: _____ _____

(Applicant) (Date)

_____ _____

(Joint Applicant) (Date)

O I explained to the applicant the importance of completing this information.

Signed: _____ _____

(Agent) (Date)

_____

(Agent's Printed Name)

In order for us to process your application, please return this signed statement to Berkshire Life Insurance Company of America, along with your application.

My agent has advised me that this policy does not appear to be suitable for me. However, I still want the Company to consider my application.

Signed: _____ _____

(Applicant) (Date)

_____ _____

(Joint Applicant) (Date)

The Company may contact you to verify your answers.

This confidential information will be used only to determine your suitability for long term care insurance and may not be used for any other purpose or disseminated outside of the Company or agency.

Authorization to Process Application

My agent has explained to me that my personal financial circumstances are an important consideration in determining whether or not long term care insurance is an appropriate purchase for me.

My agent has also given me a copy of "*Things You Should Know Before You Buy Long Term Care Insurance*" and has explained the importance of completing the Long Term Care Insurance Personal Worksheet.

I hereby confirm that I have chosen not to complete the Long Term Care Insurance Personal Worksheet. Nevertheless, I request that you continue to process my application for long term care insurance.

Signed: _____ _____

(Applicant) (Date)

_____ _____

(Joint Applicant) (Date)

Berkshire Life Insurance Company of America
Home Office: Pittsfield, Massachusetts
Long Term Care Administrative Office
Post Office Box 4243
Woodland Hills, CA 91365-4243
888-505-8743

OUTLINE OF COVERAGE FOR LONG TERM CARE INSURANCE POLICY FORM BG01P(06/04)-AZ

NOTICE TO BUYER: This policy may not cover all of the costs associated with long term care incurred by the buyer during the period of coverage. The buyer is advised to review carefully all policy limitations.

Caution: The issuance of this Long Term Care Insurance Policy is based upon your responses to the questions in your application. A copy of your application is enclosed. If responses are incorrect or untrue, the Company may have the right to deny benefits or rescind your policy. The best time to clear up any questions is now, before a claim arises! If, for any reason, any of your answers are incorrect, contact us at the address shown above.

The policy is an individual policy of insurance.

PURPOSE OF OUTLINE OF COVERAGE

This outline of coverage provides a very brief description of the important features of the policy. You should compare this outline of coverage to outlines of coverage for other policies available to you. This is not the insurance contract, but only a summary of coverage. Only the individual policy contains governing contractual provisions. This means that the policy sets forth in detail the rights and obligations of both you and the Company. Therefore, if you purchase this coverage, or any other coverage, it is important that you READ YOUR POLICY CAREFULLY!

FEDERAL TAX CONSEQUENCES

THE POLICY IS INTENDED TO BE A FEDERALLY TAX-QUALIFIED LONG TERM CARE INSURANCE CONTRACT AS DEFINED UNDER SECTION 7702B(b) OF THE INTERNAL REVENUE CODE OF 1986, as amended. You should consult with your attorney, accountant, or tax advisor regarding the tax implications of purchasing this long term care insurance.

TERMS UNDER WHICH THE POLICY MAY BE RETURNED AND PREMIUM REFUNDED

If you are not satisfied with your policy, you have 30 days to return it to us or any authorized agent or agency for a full refund of any premium you have paid within 30 days. Upon your death (last of your deaths under joint coverage), we will refund any unearned premium for the policy on a pro-rata basis. We will make this refund within 30 days of our receipt of proof of your death. If you cancel the policy after 30 days, any unearned premium will be refunded to you on a pro-rata basis. If you purchase the optional Return of Premium Rider, all or a portion of the premiums paid for the policy and riders will be returned to your beneficiary upon your death (last of your deaths under joint coverage).

If your application for this policy is denied, we will refund any premium paid with the application within 30 days of the date of denial.

THIS IS NOT MEDICARE SUPPLEMENT COVERAGE

If you are eligible for Medicare, review the *Guide to Health Insurance for People with Medicare* available from us. Neither Berkshire Life Insurance Company of America nor its agents represent Medicare, the federal government or any state government.

LONG TERM CARE COVERAGE

Policies of this category are designed to provide coverage for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, Maintenance or Personal Care Services provided in a setting other than an acute care unit of a hospital, such as in a nursing home, in the community or in the home.

The policy provides coverage for Qualified Long Term Care Services in the form of an expense-incurred benefit for covered long term care expenses, subject to policy Elimination Periods, Limitations and Exclusions described below.

BENEFITS PROVIDED BY THE POLICY

Covered Services

The policy provides benefits for Qualified Long Term Care Services performed in a nursing facility or an assisted living facility and Maintenance or Personal Care Services performed in an assisted living facility. Benefits are also provided for Facility Bed Reservation, Respite Care Services and an Alternative Plan of Care. In addition, you may select coverage under the policy for Home and Community Care Services, including benefits for home health care, adult day care, hospice services and Caregiver Training. An Emergency Response System benefit is also available when Home and Community Care Services are selected.

Elimination Period

This is the number of days you must satisfy the conditions on Eligibility for Payment of Benefits and receive either Facility Care Services or Home and Community Care Services (if covered under the policy) before we will begin paying benefits. You may choose an Elimination Period of 0, 30, 90 or 180 days. Once you have satisfied the Elimination Period, no future Elimination Period is required. Days may be accumulated under separate claims in order to satisfy the Elimination Period. The Elimination Period applies to each insured individually under joint coverage.

Benefit Amount

You may choose an unlimited Benefit Amount for Lifetime coverage, or a lesser amount determined by multiplying the Daily Benefit selected by the Benefit Period selected (1,825 days (5 years), 1,460 days (4 Years) or 1,095 days (3 Years)). The result will be your Benefit Amount for all benefits payable under the policy. Under joint coverage, the policy provides for a separate Benefit Amount for each insured.

Coverage Outside the United States

Benefits are payable for Qualified Long Term Care Services received outside the United States or its territories, or Canada for up to 30 days per calendar year. The benefit payable under the policy will be the actual daily charges you incur for covered services, up to the Daily Benefit you select. Benefits paid are subtracted from the Benefit Amount.

Facility Care Services Benefit

Benefits are payable for Qualified Long Term Care Services (including skilled, intermediate or custodial nursing care) provided to you in a nursing facility or assisted living facility and Maintenance or Personal Care Services performed in an assisted living facility. The benefit payable under the policy will be the actual daily Facility Care Services charges you incur, up to the Daily Benefit you select. You may choose a Daily Benefit of up to $300 per day. Premium rates will vary according to the Daily Benefit you select. Benefits paid are subtracted from the Benefit Amount.

Facility Bed Reservation Benefit

This benefit is payable if you are receiving Facility Care Services benefits under the policy, you incur a temporary absence from the facility and are charged by the nursing facility or assisted living facility to reserve your accommodations. The benefit payable will be the actual daily charges you incur for the reservation, up to the Daily Benefit selected. This benefit is payable for a maximum of 30 days per calendar year. Benefits paid are subtracted from the Benefit Amount.

Home and Community Care Services Benefit

This benefit will only be covered under the policy if it is selected by you and shown on the Policy Schedule page of the policy. Benefits are payable for home health care provided through a qualified Home Health Care Agency or Independent Home Health Caregiver, in a setting other than a hospital, nursing facility or assisted living facility. Home health care includes professional nursing care by or under the supervision of an RN or other licensed nurse; care by a qualified Home Health Aide; therapeutic care services by or under the supervision of a speech, occupational, physical, or respiratory therapist, licensed or certified under state law, if any; services provided by a registered dietician or homemaker services. Benefits are also payable for adult day care, hospice services and Caregiver Training.

The benefit payable under the policy will be the actual Home and Community Care Services charges you incur, up to the Daily Benefit you select. Premium rates will vary according to the Daily Benefit you select. Benefits paid are subtracted from the Benefit Amount.

Emergency Response System

This benefit is payable if you are receiving Home and Community Care Services benefits under the policy. We will reimburse you for charges you incur for use of this system, up to $50 per month. This will include a device or system installed in your residence that provides you with a means of communication to request assistance in the event of a medical emergency. Benefits paid are subtracted from the Benefit Amount.

Caregiver Training Benefit

If Home and Community Care Services are selected, this benefit provides for training by a health care professional to an informal caregiver. The informal caregiver may be an unpaid member of your Family, a friend or neighbor.

The benefit payable under the policy will be the actual Caregiver Training charges incurred, up to a Maximum Lifetime Caregiver Training Benefit that is equal to 5 times the Daily Benefit selected. You need not satisfy the Elimination Period to receive this benefit; however, use of the benefit does not count toward satisfaction of the Elimination Period for any other benefits payable under the policy. Benefits paid are subtracted from the Benefit Amount.

Respite Care Services Benefit

Benefits are payable for Qualified Long Term Care Services provided on a short term basis to relieve Family or friends who are the primary caregivers in your residence. Such services may be provided in your home, a nursing facility, assisted living facility or through a community based program.

The benefit payable under the policy will be the actual daily Facility Care Services or if selected, Home and Community Care Services charges incurred, up to the Daily Benefit chosen. The Respite Care Services Benefit is payable for a maximum of 30 days per calendar year. You need not satisfy the Elimination Period to receive this benefit; however, use of the benefit does not count toward satisfaction of the Elimination Period for any other benefits payable under the policy. Benefits paid are subtracted from the Benefit Amount.

Alternative Plan of Care Benefit

If you are Chronically Ill an Alternative Plan of Care is available, if agreed to by you, your Licensed Health Care Practitioner and us. The Maximum Lifetime Alternative Plan of Care payable under the policy is equal to 50 times the Daily Benefit selected. The Alternative Plan of Care benefit amount agreed upon, divided by the Daily Benefit selected, equals the number of subsequent days for which we will not pay additional benefits for Home and Community Care Services or Facility Care Services under the policy. This number of subsequent days will be considered to have been paid by the Alternative Plan of Care benefit amount agreed to. An Alternative Plan of Care provides for Qualified Long Term Care Services not specifically shown as being available under the policy including: equipment purchases or rentals; permanent or temporary modifications to your residence (such as ramps or rails), or care services not normally covered under Home and Community Care Services. The Alternative Plan of Care is not available for providing Home and Community Care Services benefits on policies providing benefits for Facility Care Services only. We reserve the right to make the final decision on any request for the Alternative Plan of Care Benefit. Benefits paid are subtracted from the Benefit Amount.

Optional Personal Care Advisor

An Optional Personal Care Advisor will be available if requested by you to assist you with questions regarding such matters as: Eligibility for Payment of Benefits; appropriate level of care; availability of facilities and other care and service resources in your area; or any other questions you may have about a claim for benefits. You may contact your Personal Care Advisor by calling the toll-free number which will be shown on the Policy Schedule page of the policy. You are not required to use these services in order to file a claim, there is no cost to you for their use and no benefits will be deducted from the Benefit Amount.

Optional Care Coordination

At your request, if you need Care Coordination assistance related to filing a claim, you may call the toll-free number which will be shown on the Policy Schedule page of the policy and we will arrange for a care coordinator to contact you.

The care coordinator will be an RN and will: assess and coordinate appropriate care and services; provide assistance in the development of a Plan of Care; if you wish, maintain a continuing role in the arrangement and monitoring of services and assist with necessary claims documentation. You are not required to use these services in order to file a claim, there is no cost to you for their use and no benefits will be deducted from the Benefit Amount.

Definitions

Activities of Daily Living:

- Bathing: Washing oneself by sponge bath; or in either a tub or shower, including the task of getting into or out of the tub or shower.
- Continence: The ability to maintain control of bowel and bladder function; or, when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene (including caring for catheter or colostomy bag).
- Dressing: Putting on and taking off all items of clothing and any necessary braces, fasteners, or artificial limbs.
- Eating: Feeding oneself by getting food into the body from a receptacle (such as a plate, cup or table) or by a feeding tube or intravenously.
- Toileting: Getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.
- Transferring: Moving into or out of a bed, chair or wheelchair.

Family means you or your spouse and those related to you or your spouse; including a parent, sibling, child, grandparent or grandchild (including any of his or her in-laws, step or legally adopted relatives).

Hands-On Assistance means the physical assistance of another person without which you would be unable to perform the Activity of Daily Living.

Home Health Aide means a person, other than an RN or nurse, who provides Maintenance or Personal Care Services through a Home Health Care Agency. A Home Health Aide must be licensed or certified under state law, if any, and acting within the scope of his or her license or certification at the time the treatment or service is performed.

Home Health Care Agency means a hospital, agency, or other provider licensed or certified under state law, if any, to provide Home Health Care.

Independent Home Health Caregiver means a person who is approved by us; and

- is independently employed and not associated with a Home Health Care Agency;
- provides care within the scope of his or her employment in the performance of Qualified Long Term Care Services; and
- is licensed or certified under state law, if any, and acting within the scope of his or her license at the time the treatment or service is performed.

Licensed Health Care Practitioner means:

- a physician;
- a registered nurse; or
- a licensed social worker.

The Licensed Health Care Practitioner must not be a member of your Family.

Maintenance or Personal Care Services means any care provided primarily to give needed assistance to you as a result of your being Chronically Ill (including protection of your health and safety due to a Severe Cognitive Impairment).

Plan of Care means a written plan prescribed by a Licensed Health Care Practitioner developed in consultation with you, based upon an assessment indicating you are Chronically Ill. The Plan of Care will recommend the necessary services to be performed. In addition, it will specifically identify the frequency and type of services most suitable to meet your needs, as well as the most appropriate providers for such services. The Plan of Care is updated as your needs change.

Qualified Long Term Care Services means necessary diagnostic, preventive, therapeutic, curing, treating, mitigating and rehabilitative services and Maintenance or Personal Care Services, which are required by you when you are Chronically Ill and are provided pursuant to a Plan of Care.

Severe Cognitive Impairment means your deterioration or loss of intellectual capacity, which requires Substantial Supervision by another person to protect yourself or others from threats to health and safety. It is measured by clinical evidence and standardized tests that reliably measure your impairment in:

- short or long term memory;
- your orientation as to person (such as who you are), place (such as your location) and time (such as day, date and year); and
- deductive or abstract reasoning.

A Severe Cognitive Impairment includes Alzheimer's disease and similar forms of irreversible dementia.

Single Claim Period means a claim for benefits under the policy that is not interrupted by a period of 180 consecutive days. If you do not satisfy the conditions on Eligibility for Payment of Benefits (because you have recovered and you are no longer receiving benefits under the policy) for 180 consecutive days or longer, a new Single Claim Period will be established.

Stand-By Assistance means the presence of another person within arm's reach of you that is necessary to prevent, by physical intervention, injury to you while you are performing the Activity of Daily Living.

Substantial Assistance means Hands-On or Stand-By Assistance.

Substantial Supervision means continual supervision by another person to protect you or others from threats to health or safety (such as may result from wandering) when you have a Severe Cognitive Impairment. Such supervision may include cueing by verbal prompting, gestures or other similar demonstrations.

Eligibility for Payment of Benefits

You will satisfy the conditions on Eligibility for Payment of Benefits if you are a Chronically Ill individual, which means that within the previous 12 months you have been certified by a Licensed Health Care Practitioner as: being unable to perform, without Substantial Assistance, at least two Activities of Daily Living for an expected period of at least 90 days due to loss of functional capacity; or having a Severe Cognitive Impairment.

The expected 90-day period for loss of functional capacity does not establish a waiting period beyond any Elimination Period selected before benefits become payable under the policy.

LIMITATIONS OR CONDITIONS ON ELIGIBILITY FOR PAYMENT OF BENEFITS

Non-Eligible Facilities

A nursing facility does not include a hospital, convalescent home, board and rest home, home for the aged, residential care facility, domiciliary and retirement care facility, training center or government or veteran's facility or any other facility where the patient is not required to pay. An assisted living facility does not include a hospital.

No benefits will be paid under the policy for confinement in:

- Non-eligible facilities; or
- an unlicensed facility (if licensing is required in your state).

No benefits will be paid and the Elimination Period will not be satisfied for any confinement, care, treatment or service(s):

- provided to you by a person in your Family;
- provided outside of the United States or its territories, or Canada, except as described under Coverage Outside the United States in the Policy Benefits section of this Policy;
- for which you have no financial liability or that is provided at no charge in the absence of insurance;
- provided in facilities operated primarily for the treatment of alcoholism or drug addiction; or

- provided in facilities operated primarily for the treatment of mental or nervous disorders. However, this shall not operate to exclude coverage for loss which results from Alzheimer's or any other demonstrable organic disease such as senile dementia.

Non-Duplication of Benefits

Benefits are not payable under the policy for expenses incurred to the extent that such expenses are reimbursable under Medicare or would be so reimbursable but for the application of a deductible or coinsurance amount; or for any other state or federal worker's compensation plan, or other governmental program (except Medicaid).

For purposes of satisfying the Elimination Period, days on which you satisfy the conditions on Eligibility for Payment of Benefits, but coverage is excluded due to the Non-Duplication of Benefits provision, will count toward satisfaction of the Elimination Period.

Payment of Benefits

While the policy is in force, you will receive benefits if:

- you satisfy Eligibility for Payment of Benefits;
- you have satisfied any applicable Elimination Period shown on the Policy Schedule page of the policy;
- you receive services covered under the policy pursuant to a Plan of Care;
- you are not receiving any other benefits covered under the policy;
- you have not been paid benefits that exceed the Benefit Amount or if shown on the Policy Schedule page of the policy, the Maximum Benefit Amount With Restoration of Benefits;
- your claim is properly filed according to the requirements described in the policy; and
- your claim is not subject to any Limitations and Exclusions contained in the policy.

THE POLICY MAY NOT COVER ALL EXPENSES ASSOCIATED WITH YOUR LONG TERM CARE NEEDS.

RELATIONSHIP OF COST OF CARE AND BENEFITS

Because the costs of long term care services will likely increase over time, you should consider whether and how the benefits of this plan may be adjusted. The benefit levels of the basic policy will not increase over time. For an additional premium payment, you may purchase one of the optional Inflation Protection Riders described below.

TERMS UNDER WHICH THE POLICY MAY BE CONTINUED IN FORCE OR DISCONTINUED

RENEWABILITY: THE POLICY IS GUARANTEED RENEWABLE. This means you have the right, subject to the terms of the policy, to continue the policy as long as you pay your premiums on time. Berkshire Life Insurance Company of America cannot change any of the terms of the policy on its own, except that, in the future, IT MAY INCREASE THE PREMIUM YOU PAY.

Waiver of Premium

Premiums for the policy and attached riders will be waived after you (either insured under joint coverage) have been confined in a nursing facility or assisted living facility for a period of 90 days and you satisfy the conditions on Eligibility for Payment of Benefits. The 90 days need not be consecutive, but must be satisfied during a Single Claim Period. We will return any unearned premium to you on a pro-rata basis. Premium paid during the 90-day period described above will be considered unearned and also returned to you. The premium will be waived until you no longer satisfy the conditions on Eligibility for Payment of Benefits (because you have recovered and you are no longer confined in a nursing facility or assisted living facility). Premium payments will then again become due. Any new Single Claim Period will require satisfaction of a new 90-day waiting period for Waiver of Premium, as described above. For an additional premium payment, an optional Waiver of Premium Rider is also available, as described below.

ALZHEIMER'S DISEASE AND OTHER ORGANIC BRAIN DISORDERS

Subject to Eligibility for Payment of Benefits, Payment of Benefits, any Limitations and Exclusions described above, the policy provides coverage if you are clinically diagnosed as having Alzheimer's disease or related degenerative and dementing illnesses.

PREMIUM

10-Year and Paid-up at 65 Premium Payment Options

These options provide that at the end of the premium payment period if each required premium has been paid, the policy will automatically be renewed for the rest of your life with no further premium payments required. During the premium payment period, premiums will be subject to change as described under "TERMS UNDER WHICH THE POLICY MAY BE CONTINUED IN FORCE OR DISCONTINUED" on the sixth page of this outline of coverage.

Long Term Care Insurance Policy

Elimination Period: O 0 Days O 30 Days O 90 Days O 180 Days

Daily Benefit ($50 - $300): $ _____

Benefit Period: O Lifetime O 1,825 Days (5 Years) O 1,460 Days (4 Years) O 1,095 Days (3 Years)

The following are the Annual Premiums for the coverage you have applied for:

Comprehensive coverage is Facility Care Services plus Home and Community Care Services (HCCS)

	Premium
Select only one of the following coverage combinations:	
O Facility Care Services Only	$ _____
O Facility Care Services Only with Indemnity Benefit Rider	$ _____
O Comprehensive	$ _____
O Comprehensive with Indemnity Benefit Rider	$ _____
O Comprehensive with Personal Caregiver Rider *(Available only with Preferred Plus Rate Class and Lifetime Premium Payment Option)*	$ _____
O Comprehensive with Monthly Benefit Rider *(One of the Compound Inflation Protection Riders must also be selected)*	$ _____
Inflation Protection Riders (select only one):	
O Compound 5%	$ _____
O Compound 3%	$ _____
Nonforfeiture Benefit Rider:	
O Shortened Benefit Period Nonforfeiture	$ _____
Additional Riders:	
O Return of Premium	$ _____
O Waiver of Premium Benefit *(Not available with Facility Care Services Only coverage)*	$ _____
O Restoration of Benefits *(Not available with Lifetime Benefit Period)*	$ _____
O Paid-Up Survivor *(Available only with joint coverage and Lifetime Premium Payment Option)*	$ _____
Premium Payment Options: O Lifetime	
O 10-Year Premium	$ _____
O Paid-Up At Age 65 Premium **(Available to age 55)**	$ _____
TOTAL ANNUAL PREMIUM:	$ _____

ADDITIONAL FEATURES

Medical Underwriting

Your insurability for the policy will be determined by the answers given in your application and any other authorized medical information we obtain regarding your current state of health.

Modes of Premium Payment

Premiums may be paid on an annual, semi-annual or quarterly basis, or by monthly automatic premium plan. We will change the mode of premium payment if we receive a proper written request at our Long Term Care Administrative Office before the premium due date. The amount of each modal premium is calculated by multiplying the annual policy premium by the applicable modal factors. Modal Factors are: Semi-Annually (0.52), Quarterly (0.27) and Monthly (0.088). The modal premiums will be shown on the Policy Schedule page of the policy.

Grace Period

Except for the first premium, you will have 31 days after each due date to pay the premium due. The policy remains in force during the Grace Period.

Unintentional Lapse

If your premium is not paid by the 30th day of the Grace Period, we will provide written notice to you and any individuals designated by you to receive notice of non-payment of premium. Notice will be sent at least 30 days before cancellation of your coverage. If your premium is not paid within 35 days after notice is sent, the policy will lapse for non-payment of premium.

Nonforfeiture Benefits

If you choose not to select the following optional nonforfeiture rider, a contingent benefit upon lapse will be available if: (a) the policy lapses as described under the Grace Period and Unintentional Lapse provisions of the policy; and (b) the premium rates for the policy are substantially increased. The benefit provided will be in the form of a Shortened Benefit Period as described below.

OPTIONAL RIDERS (available for an additional premium payment)

Shortened Benefit Period Nonforfeiture

The rider provides a benefit when the policy remains in force for at least 3 years and lapses due to nonpayment of premium. Coverage will continue and benefits will be payable based on the Daily Benefit in effect on the date of lapse. The new Benefit Amount payable under the rider will become equal to the greater of: (a) the total of premiums paid for the policy and all riders; or (b) 30 times the Daily Benefit in effect at the time of lapse. Any benefits paid after the policy lapses will be subtracted from this new Benefit Amount.

Return of Premium

The rider provides that if the policy remains in force and lapses due to your death (last of your deaths under joint coverage), the total of premiums paid, reduced by the total of benefits received, will be paid to your beneficiary.

Indemnity Benefit

The rider will pay the full Daily Benefit selected for Facility Care Services and Home and Community Care Services (if covered under the policy), regardless of the actual expenses incurred by you.

Waiver of Premium

The rider will waive premiums for the policy and any attached riders after you (either insured under joint coverage) have selected and received Home and Community Care Services for 90 days (regardless of the number of visits in a day). The 90 days need not be consecutive but must be satisfied during a Single Claim Period. We will return any unearned premium to you on a pro-rata basis. Premium paid during the 90-day period described above will be considered unearned and also returned to you. The premium will be waived until you no longer satisfy the conditions on Eligibility for Payment of Benefits (because you have recovered and you are no longer receiving Home and Community Care Services, and you

are not confined in a nursing facility or assisted living facility). Premium payments will then again become due. Any new Single Claim Period will require satisfaction of a new 90-day waiting period for Waiver of Premium, as described above.

The waiting period for Waiver of Premium under the policy for confinement in a nursing facility or assisted living facility is 90 days. If you receive fewer than 90 days of Home and Community Care Services and do not qualify for Waiver of Premium under the rider, we will credit any day on which you receive Home and Community Care Services during a Single Claim Period toward satisfaction of the 90-day waiting period for Waiver of Premium under the policy.

Monthly Benefit

The rider will pay the actual Home and Community Care Services charges incurred on a monthly basis during any calendar month, up to 31 times the Daily Benefit selected for Home and Community Care Services. Benefits paid are subtracted from the Benefit Amount.

Personal Caregiver

The rider will pay the full Daily Benefit for services covered under the policy when Home and Community Care Services are selected, regardless of the actual expenses incurred by you. This applies to each benefit for which you qualify. In addition, a personal caregiver benefit is payable for Home and Community Care Services. This benefit will be equal to the full Daily Benefit selected for Home and Community Care Services, regardless of the actual charges incurred by you. Further, the personal caregiver benefit is payable to you regardless of who provides the Home and Community Care Services, including any non-professional caregiver, any unpaid Family member, or your friends. Benefits paid are subtracted from the Benefit Amount.

Restoration of Benefits

The rider will restore the Benefit Amount if, claims paid during a Single Claim Period have not exceeded the Benefit Amount, the policy remains in force and for a period of 180 consecutive days, you do not satisfy the conditions on Eligibility for Payment of Benefits under the policy (because you have recovered and you are not receiving any benefits). We will restore benefits up to a Maximum Benefit Amount of twice the Benefit Amount selected. Under joint coverage, if only one of you has exhausted the Maximum Benefit Amount with Restoration of Benefits, coverage will continue for the remaining insured.

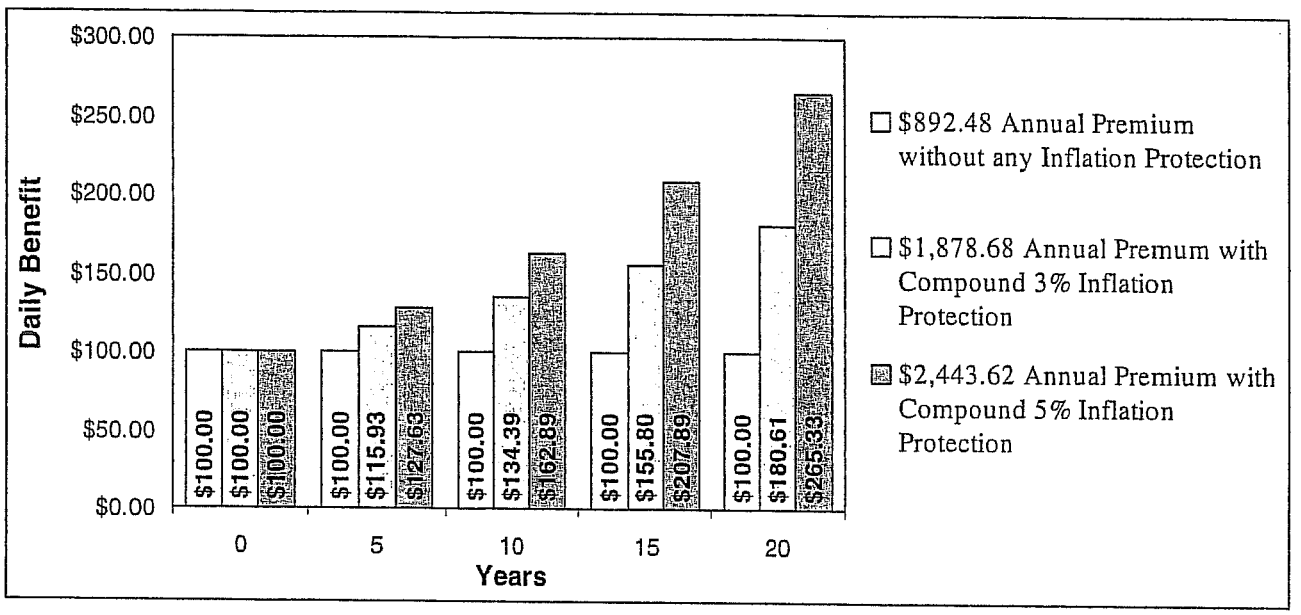
Paid-up Survivor Benefit

The rider provides that the policy to which the rider is attached will be paid-up and no further premium payments will be required for the policy or any attached riders after both of the following have occurred: (a) the end of the 10th policy year; and (b) the date of death of either insured. In the event one insured dies prior to the end of the 10th policy year, the remaining insured will pay the individual premium rate that would have been charged at the original issue age and risk class for the balance of the 10-year period, after which the policy will be paid-up and no further premiums due.

Inflation Protection

The riders provide that on each policy anniversary date, we will increase the Daily Benefit and Benefit Amount payable under the policy. The Compound 5% or 3% Inflation Protection Riders increase the Daily Benefit by 5% or 3% of the previous year's dollar amount. The remaining Benefit Amount is also increased by 5% or 3%. Under both riders, the Daily Benefit and Benefit Amount will continue to increase annually while you are receiving benefits under the policy.

The following graph compares the benefits and premiums between a policy with both a Compound 5% and 3% Inflation Protection Rider and a policy without either rider. For purposes of illustration, the sample shown is for a policy with a 1,095-day (3-year) Benefit Period for Facility Care Services and Home and Community Care Services, issued at age 60, a 90-day Elimination Period, and a $100.00 Daily Benefit.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Daily Benefit
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$134.39
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$100.00
$155.80
$207.89
$100.00
$180.61
$265.33
0
5
10
15
20
Years
$892.48 Annual Premium without any Inflation Protection
$1,878.68 Annual Premum with Compound 3% Inflation Protection
$2,443.62 Annual Premium with Compound 5% Inflation Protection

Berkshire Life Insurance Company of America
Home Office: Pittsfield, Massachusetts
Long Term Care Administrative Office
Post Office Box 4243
Woodland Hills, CA 91365-4243
888-505-8743

APPLICATION FOR LONG TERM CARE INSURANCE

(PLEASE PRINT)

BG01A(06/04)-AZ

Applicant Information

Applicant (First Name, Middle Initial, Last Name)			Sex O M O F	Birthplace (City, State)
Social Security Number	Height	Weight	Birthdate	Age as of Nearest Birthday
Residence Address (Street, City, State, Zip)				Phone Work: ( ) Home: ( ) Other: ( ) Acceptable times to call: O Day O Evening O Sat/Sun
Billing Address — If different (Name, Street, City, State, Zip)				

Health Questions

1. During the past 24 months, have you:

Yes	No		
O	O	a)	needed assistance or supervision with dressing, eating, bathing, toileting, transferring, or walking?
O	O	b)	used a wheelchair, walker, brace or cane?
O	O	c)	used oxygen equipment, received kidney dialysis or required a catheter?
O	O	d)	received home health care services, physical or other rehabilitative therapy?
O	O	e)	experienced amnesia, confusion, forgetfulness or memory loss?
O	O	f)	experienced dizziness, fainting, weakness or chronic fatigue?
O	O	g)	experienced falling, unstable gait, paralysis or loss of balance?
O	O	h)	been confined to a nursing facility, assisted living facility, or home for the aged?

2. During the past 10 years, have you been medically diagnosed with or treated for:

Yes	No			Yes	No		
O	O	a)	AIDS or positive HIV status?	O	O	d)	Hepatitis C?
O	O	b)	Alzheimer's Disease or dementia?	O	O	e)	Multiple Sclerosis?
O	O	c)	Amyotrophic Lateral Sclerosis?	O	O	f)	Parkinson's Disease or Parkinsonism?

3. During the past 10 years, have you been medically advised or treated for:

Yes	No			Yes	No		
O	O	a)	high blood pressure?	O	O	i)	seizures or other neurological disorder?
O	O	b)	heart disorder?	O	O	j)	alcohol or drug dependency or abuse?
O	O	c)	circulatory disorder?	O	O	k)	arthritis or osteoporosis?
O	O	d)	diabetes?	O	O	l)	depression or other psychiatric disorder?
O	O	e)	emphysema or other chronic lung disorder?	O	O	m)	breast, prostate or other genito-urinary disorder?
O	O	f)	cancer; internal or melanoma?	O	O	n)	glaucoma or macular degeneration?
O	O	g)	stroke?	O	O	o)	liver disease or disorder?
O	O	h)	TIA (transient ischemic attack)?				

If you answered "Yes" to any of Questions 1-3, provide full details below. Additional details may be provided on page 4:

Ques. No.	Date From	Date To	Describe Condition and Treatment	Name of Physician or Care Facility

Berkshire Life Insurance Company of America, Pittsfield, MA is a wholly owned stock subsidiary of The Guardian Life Insurance Company of America, New York, NY.

Health Questions (continued)

4. **Provide the name, address and phone number of your primary care physician (PCP). Additional details may be provided on page 4:**

_____

_____

Date last seen: _____ Reason For visit: _____

5. **Provide the names of all medical specialists (other than your PCP) consulted within the last 2 years. Additional details may be provided on page 4:**

Name / Phone number	Specialty	Reason for visit	Medication / treatment prescribed

6. **During the past 12 months have you:**

Yes No

O O a) smoked cigarettes?

O O b) received disability benefits? If "Yes", details:

_____

O O c) been advised to have any surgery that has not yet been performed? If "Yes", details:

_____

O O d) been declined by another company for a policy providing nursing home or home health care coverage? If "Yes", details: _____

O O e) taken prescription medication? If "Yes", list all medications:

_____

Additional Questions

Yes No

O O 7. **Due to any mental or physical disability that you now have or have had in the past, is any person or institution authorized to act on your behalf?**

O O 8. **Are you actively at work? If "Yes", hours per week:** _____

9. **Occupation:** _____ **If retired, date of retirement:** _____

10. **With whom do you currently live?** O Spouse O Family O Alone O Other: _____

11. **Type of residence?** O House or Condo O Apartment O Retirement Community O Other

Information About Your Insurance Coverage

Yes No

O O 12. **Are you covered by Medicaid? (This does not mean Medicare)**

O O 13. **Do you have a policy, certificate or application with this or any other company providing long term care insurance (including a health care service contract or health maintenance organization contract)?**

O O 14. **Did you have another long term care insurance policy or certificate in force during the last twelve (12) months?**

If that policy lapsed, when did it lapse? _____

O O 15. **Do you intend to replace any of your long term care, medical or health insurance coverage with this policy?**

If you answered "Yes" to any of Questions 13-15, provide full details below and complete required replacement forms. Additional details may be provided on page 4:

Ques. No.	Company	Issue Date	Type	Daily Benefit	Paid-to-Date

COMPLETE THIS PAGE FOR JOINT COVERAGE APPLICANT ONLY

Applicant Information

Applicant (First Name, Middle Initial, Last Name)			Sex O M O F	Birthplace (City, State)
Social Security Number	Height	Weight	Birthdate	Age as of Nearest Birthday
Phone Work: ( ) Home: ( ) Other: ( ) Acceptable times to call: O Day O Evening O Sat/Sun				Relationship to Primary Applicant

Health Questions

1. During the past 24 months, have you:

Yes	No		
O	O	a)	needed assistance or supervision with dressing, eating, bathing, toileting, transferring, or walking?
O	O	b)	used a wheelchair, walker, brace or cane?
O	O	c)	used oxygen equipment, received kidney dialysis or required a catheter?
O	O	d)	received home health care services, physical or other rehabilitative therapy?
O	O	e)	experienced amnesia, confusion, forgetfulness or memory loss?
O	O	f)	experienced dizziness, fainting, weakness or chronic fatigue?
O	O	g)	experienced falling, unstable gait, paralysis or loss of balance?
O	O	h)	been confined to a nursing facility, assisted living facility, or home for the aged?

2. During the past 10 years, have you been medically diagnosed with or treated for:

Yes	No			Yes	No		
O	O	a)	AIDS or positive HIV status?	O	O	d)	Hepatitis C?
O	O	b)	Alzheimer's Disease or dementia?	O	O	e)	Multiple Sclerosis?
O	O	c)	Amyotrophic Lateral Sclerosis?	O	O	f)	Parkinson's Disease or Parkinsonism?

3. During the past 10 years, have you been medically advised or treated for:

Yes	No			Yes	No		
O	O	a)	high blood pressure?	O	O	i)	seizures or other neurological disorder?
O	O	b)	heart disorder?	O	O	j)	alcohol or drug dependency or abuse?
O	O	c)	circulatory disorder?	O	O	k)	arthritis or osteoporosis?
O	O	d)	diabetes?	O	O	l)	depression or other psychiatric disorder?
O	O	e)	emphysema or other chronic lung disorder?	O	O	m)	breast, prostate or other genito-urinary disorder?
O	O	f)	cancer; internal or melanoma?	O	O	n)	glaucoma or macular degeneration?
O	O	g)	stroke?	O	O	o)	liver disease or disorder?
O	O	h)	TIA (transient ischemic attack)?				

If you answered "Yes" to any of Questions 1-3, provide full details below. Additional details may be provided on page 4:

Ques. No.	Date From	Date To	Describe Condition and Treatment	Name of Physician or Care Facility

COMPLETE THIS PAGE FOR JOINT COVERAGE APPLICANT ONLY

Health Questions (continued)

4. Provide the name, address and phone number of your primary care physician (PCP). Additional details may be provided on page 4:

_____

_____

Date last seen: _____ Reason For visit: _____

5. Provide the names of all medical specialists (other than your PCP) consulted within the last 2 years. Additional details may be provided on page 4:

Name / Phone number	Specialty	Reason for visit	Medication / treatment prescribed

6. During the past 12 months have you:

Yes No

O O a) smoked cigarettes?

O O b) received disability benefits? If "Yes", details:

_____

O O c) been advised to have any surgery that has not yet been performed? If "Yes", details:

_____

O O d) been declined by another company for a policy providing nursing home or home health care coverage? If "Yes", details: _____

O O e) taken prescription medication? If "Yes", list all medications:

_____

Additional Questions

Yes No

O O **7. Due to any mental or physical disability that you now have or have had in the past, is any person or institution authorized to act on your behalf?**

O O **8. Are you actively at work? If "Yes", hours per week:** _____

9. Occupation: _____ **If retired, date of retirement:** _____

10. With whom do you currently live? O Spouse O Family O Alone O Other: _____

11. Type of residence? O House or Condo O Apartment O Retirement Community O Other

Information About Your Insurance Coverage

Yes No

O O **12. Are you covered by Medicaid? (This does not mean Medicare)**

O O **13. Do you have a policy, certificate or application with this or any other company providing long term care insurance (including a health care service contract or health maintenance organization contract)?**

O O **14. Did you have another long term care insurance policy or certificate in force during the last twelve (12) months?**

If that policy lapsed, when did it lapse? _____

O O **15. Do you intend to replace any of your long term care, medical or health insurance coverage with this policy?**

If you answered "Yes" to any of Questions 13-15, provide full details below and complete required replacement forms. Additional details may be provided on page 4:

Ques. No.	Company	Issue Date	Type	Daily Benefit	Paid-to-Date

Coverage Applied For

Comprehensive coverage is Facility Care Services plus Home and Community Care Services (HCCS)

Select only one of the following coverage combinations:

- O Facility Care Services Only
- O Facility Care Services Only with Indemnity Benefit Rider
- O Comprehensive
- O Comprehensive with Indemnity Benefit Rider
- O Comprehensive with Personal Caregiver Rider *(Available only with Preferred Plus Rate Class and Lifetime Premium Payment Option)*
- O Comprehensive with Monthly Benefit Rider *(One of the Compound Inflation Protection Riders must also be selected)*

Inflation Protection Riders (select only one):

- O Compound 5%
- O Compound 3%

Nonforfeiture Rider:

- O Shortened Benefit Period Nonforfeiture

Additional Riders:

- O Return of Premium
- O Waiver of Premium *(Not available with Facility Care Services Only coverage)*
- O Restoration of Benefits *(Not available with Lifetime Benefit Period)*
- O Paid-Up Survivor *(Available only with joint coverage and Lifetime Premium Payment Option)*

Daily Benefit Applied For ($50-$300): $ _____

Elimination Period:

O 0 Days O 30 Days O 90 Days O 180 Days

Benefit Period:

O Lifetime O 1,825 Days (5 Years) O 1,460 Days (4 Years) O 1,095 Days (3 Years)

Required Benefit Rejection

If Inflation Protection or Nonforfeiture Benefits **ARE NOT SELECTED** you must initial in boxes below:

REJECTION of Inflation Protection Riders — I have reviewed the Outline of Coverage and the graph that compares the benefits and premiums of the policy with and without the Inflation Protection Riders and I have chosen to **reject** the riders.

Initial here: ☐ Primary Applicant ☐ Joint Applicant

REJECTION of Nonforfeiture Rider — I have reviewed the Outline of Coverage that describes the Shortened Benefit Period Nonforfeiture Rider and I have chosen to **reject** the rider.

Initial here: ☐ Primary Applicant ☐ Joint Applicant

Premium Information

Primary Applicant Rate Class:

O Preferred Plus O Preferred O Standard

Joint Applicant Rate Class:

O Preferred Plus O Preferred O Standard

Premium Payment Options (select only one):

- O Lifetime Premium
- O 10-Year Premium
- O Paid-Up At Age 65 Premium (**Available to age 55**)

Payment Mode and Amount (select only one):

O Annual O Semi-Annual O Quarterly O Monthly Automatic Payment Plan

O **List Billing (select mode as shown below):**

O Annual O Semi-Annual O Quarterly O Monthly

Approved Employer or Association Group?

O Yes O No If "Yes", Group Identification Code or Name: _____

Paid with Application $	**Beneficiary Name and Relationship**
Special Request / Requested Effective Date	

Unintentional Lapse

PROTECTION AGAINST UNINTENTIONAL LAPSE

I understand that I have the right to designate at least one person other than myself to receive notice of lapse or termination of this long term care insurance policy for non-payment of premium. I understand that notice will not be given until thirty (30) days after a premium is due and unpaid. **Check applicable box:**

O I elect NOT to designate any person to receive such notice.

O I designate the following person to receive notice prior to cancellation of my policy for non-payment of premium:

Name: _____ Telephone Number: _____

Address: _____
Street City State Zip Code

Relationship: _____

Additional Information

ADDITIONAL INFORMATION

Provide additional details for any "yes" answers, or for questions 4 and 5. Include the question number and indicate whether details pertain to **Primary** or **Joint** Applicant.

Representations of the Applicant(s)

CAUTION: If your answers on this application are incorrect or untrue, Berkshire Life Insurance Company of America may have the right to deny benefits or rescind your policy.

Those parties who sign below agree and acknowledge that:

1. This application and any other supplements to the application will form the basis for, and become part of and attached to, any policy issued.
2. All of the statements that are part of the application and any other supplements to the application are correctly recorded, and are complete and true to the best of the knowledge and belief of those persons who made them.
3. No agent, broker or medical examiner has any right to accept risks, make or change contracts, or to waive or modify any of Berkshire Life Insurance Company of America's rights or requirements.
4. The Effective Date of the Policy is the date from which premiums are calculated and become due. No insurance shall take effect unless and until this application is approved by Berkshire Life Insurance Company of America, a policy is issued during the lifetime of the applicant(s), the initial premium payment has been made and, as of the Effective Date of the Policy, the health status of the applicant(s) remains insurable under Berkshire Life Insurance Company of America's underwriting standards.
5. By paying premiums on a basis more frequently than annually, the total premium payable during one year's time will be greater than if the premium were paid annually. That is, the cost of paying annualized periodic premiums will be more than the cost of paying one annual premium.
6. I have received an Outline of Coverage, NAIC Shopper's Guide, Disclosure Statement including Notice of Insurance Information Practices, Potential Rate Increase Disclosure Form, and Notice of Privacy Practices.

Signatures

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

✘ _____
Signature of Applicant

✘ _____
Signature of Joint Applicant

Agent's Certification

THIS AGENT'S CERTIFICATION IS TO BE USED WITH THE APPLICATION ON:

_____ Print Applicant's Name

_____ Print Joint Applicant's Name

Yes No

1. How well do you know the Applicant(s)?

O Known well for ____ years
O Known slightly for ____ years
O Met very recently
O Relative? _____

O O **2a. To the best of your knowledge, is the insurance applied for intended to replace any long term care, medical or health insurance in force with this or any other company?**

2b. List any other health insurance policies that you have sold to the applicant(s):

(a) Which of the policies listed above are still in force, if any?

(b) Which of the policies listed above sold in the past five (5) years are no longer in force, if any?

O O **3. Did you ask the applicant(s) all the questions face to face and witness their signature(s)?**
If "No", provide details: _____

O O **4. Did you deliver to the applicant(s) the Outline of Coverage, the required Disclosures, including the Notice of Insurance Information Practices, the NAIC Shopper's Guide and the Notice of Privacy Practices?**

Licensed Agent's Name	Agent's Code	Split Percentage	Manager/GA Code
		%	__ __-__ __
		%	__ __-__ __
		%	__ __-__ __

I represent that to the best of my knowledge and belief the information provided in the application is complete, accurate and correctly recorded; and there is nothing adversely affecting the insurability of the applicant(s) other than as indicated in the application. I have reviewed the current health insurance coverage of the applicant(s) and find that the coverage of the type and amount applied for is appropriate for the needs of the applicant(s). Further, if this is a replacement, I have reviewed the current health insurance coverage of the applicant(s) and find that this replacement is appropriate for the needs of the applicant(s). I represent that I am duly licensed in the state in which the application was signed.

_____ Type or Print Agent's Name

X _____ Signature of Soliciting Agent

_____ Soliciting Agent's Code

_____ Soliciting Agent's Social Security Number

_____ Date

Berkshire Life Insurance Company of America
Home Office: Pittsfield, Massachusetts
Long Term Care Administrative Office
Post Office Box 4243
Woodland Hills, CA 91365-4243
888-505-8743

AUTHORIZATION FOR DISCLOSURE, RECEIPT AND USE OF PERSONAL HEALTH INFORMATION

This Authorization complies with the HIPAA Privacy Rule

"I", "me", "my", "you" and "your" means each Applicant signing this Authorization.

AUTHORIZATION FOR DISCLOSURE

I authorize any licensed physician or licensed health care practitioner, hospital, clinic, medical facility, health care provider, insurance company or health plan that has provided treatment, payment or health care services to me or any other insurance company to which I have applied for insurance coverage ("My Providers"), to disclose my entire medical record and any knowledge of my past or present health or medical condition to Berkshire Life Insurance Company of America, its reinsurers and any third party administrator designated by Berkshire Life Insurance Company of America ("the Company"). This includes any information relating to HIV, AIDS and any sexually transmitted diseases, mental illness, the use of drugs, alcohol and tobacco, but excludes psychotherapy notes. Psychotherapy notes mean notes recorded (in any medium) by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the individual's medical record. Psychotherapy notes exclude the following information that is subject to disclosure under this Authorization: medication prescription and monitoring; counseling session start and stop times; the modalities and frequencies of treatment furnished; results of clinical tests; and any summary of the following items: diagnosis; functional status; the treatment plan; symptoms; prognosis; and progress to date.

By my signature below, I terminate any agreements I have made with My Providers to restrict information in my medical records or any knowledge of my past or present health or medical condition and I instruct My Providers to release and disclose my entire medical record and other records or knowledge of me or my health without restriction.

AUTHORIZATION FOR RECEIPT AND USE

I authorize the employees and business associates of the Company, its reinsurers and any third party administrator designated by the Company who are responsible for the processing of my application for long term care insurance to receive and use any information I have provided on my application form or provided by me during the course of a personal interview with me and to receive and use any information provided by other parties under the above Authorization For Disclosure for the purpose of determining my eligibility to obtain coverage under the long term care insurance policy for which I have applied, and to determine the rates and terms which apply to any policy issued.

I understand that the information which will be provided under this Authorization is necessary for the Company to determine my eligibility for coverage under the long term care insurance policy I have applied for and that the Company will condition the review of my application for long term care insurance on my providing this Authorization. I also understand that my application may be denied if I refuse to provide this Authorization.

REDISCLOSURE OF INFORMATION

I understand that if the person or entity that receives information provided pursuant to this Authorization is not subject to federal privacy regulations, the information may be redisclosed and will no longer be protected by the federal privacy regulations. In the case of this Authorization, however, the information described above will be received by an insurance company which is covered by the federal privacy regulations, and will not be used or redisclosed except as described above or required by law, and the information will continue to be protected under the federal privacy regulations.

REVOCATION OF AUTHORIZATION

I understand that I may revoke this Authorization in writing at any time by sending a written revocation to: *Berkshire Life Insurance Company of America, ATTN: Privacy Administrator, P.O. Box 4243, Woodland Hills, CA 91365-4243.* I also understand that any such revocation will not be effective to the extent that action has been taken by the Company in reliance on this Authorization or the extent that the Company has a legal right to contest a claim under the policy which I have applied for or to contest the policy itself.

EXPIRATION OF AUTHORIZATION

This Authorization will be valid for 24 months from the date of my signature below, except with respect to information relating to HIV, in which case this authorization will be valid for 180 days from the date of my signature below. A copy of this Authorization is as valid as the original.

You or your authorized representative is entitled to receive a copy of this Authorization.

Applicant's Name (Please Print)	**Date of Birth**
Applicant's Signature	**Date**
Joint Applicant's Name (Please Print)	**Date of Birth**
Joint Applicant's Signature	**Date**

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This Authorization complies with the HIPAA Privacy Rule

"I", "me", "my", "you" and "your" means each Applicant signing this Authorization.

AUTHORIZATION FOR DISCLOSURE

I authorize any licensed physician or licensed health care practitioner, hospital, clinic, medical facility, health care provider, insurance company or health plan that has provided treatment, payment or health care services to me or any other insurance company to which I have applied for insurance coverage ("My Providers"), to disclose my entire medical record and any knowledge of my past or present health or medical condition to Berkshire Life Insurance Company of America, its reinsurers and any third party administrator designated by Berkshire Life Insurance Company of America ("the Company"). This includes any information relating to HIV, AIDS and any sexually transmitted diseases, mental illness, the use of drugs, alcohol and tobacco, but excludes psychotherapy notes. Psychotherapy notes mean notes recorded (in any medium) by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the individual's medical record. Psychotherapy notes exclude the following information that is subject to disclosure under this Authorization: medication prescription and monitoring; counseling session start and stop times; the modalities and frequencies of treatment furnished; results of clinical tests; and any summary of the following items: diagnosis; functional status; the treatment plan; symptoms; prognosis; and progress to date.

By my signature below, I terminate any agreements I have made with My Providers to restrict information in my medical records or any knowledge of my past or present health or medical condition and I instruct My Providers to release and disclose my entire medical record and other records or knowledge of me or my health without restriction.

AUTHORIZATION FOR RECEIPT AND USE

I authorize the employees and business associates of the Company, its reinsurers and any third party administrator designated by the Company who are responsible for the processing of my application for long term care insurance to receive and use any information I have provided on my application form or provided by me during the course of a personal interview with me and to receive and use any information provided by other parties under the above Authorization For Disclosure for the purpose of determining my eligibility to obtain coverage under the long term care insurance policy for which I have applied, and to determine the rates and terms which apply to any policy issued.

I understand that the information which will be provided under this Authorization is necessary for the Company to determine my eligibility for coverage under the long term care insurance policy I have applied for and that the Company will condition the review of my application for long term care insurance on my providing this Authorization. I also understand that my application may be denied if I refuse to provide this Authorization.

REDISCLOSURE OF INFORMATION

I understand that if the person or entity that receives information provided pursuant to this Authorization is not subject to federal privacy regulations, the information may be redisclosed and will no longer be protected by the federal privacy regulations. In the case of this Authorization, however, the information described above will be received by an insurance company which is covered by the federal privacy regulations, and will not be used or redisclosed except as described above or required by law, and the information will continue to be protected under the federal privacy regulations.

REVOCATION OF AUTHORIZATION

I understand that I may revoke this Authorization in writing at any time by sending a written revocation to: *Berkshire Life Insurance Company of America, ATTN: Privacy Administrator, P.O. Box 4243, Woodland Hills, CA 91365-4243.* I also understand that any such revocation will not be effective to the extent that action has been taken by the Company in reliance on this Authorization or the extent that the Company has a legal right to contest a claim under the policy which I have applied for or to contest the policy itself.

EXPIRATION OF AUTHORIZATION

This Authorization will be valid for 24 months from the date of my signature below, except with respect to information relating to HIV, in which case this authorization will be valid for 180 days from the date of my signature below. A copy of this Authorization is as valid as the original.

You or your authorized representative is entitled to receive a copy of this Authorization.

Applicant's Name (Please Print)	**Date of Birth**
Applicant's Signature	**Date**
Joint Applicant's Name (Please Print)	**Date of Birth**
Joint Applicant's Signature	**Date**

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NOTICE OF INSURANCE INFORMATION PRACTICES AND CONDITIONS OF COVERAGE

DISCLOSURE STATEMENT

NOTICE OF INSURANCE INFORMATION PRACTICES — To evaluate your application, we will need some personal information about you. It may be necessary to obtain some of that information from sources other than yourself. For your protection, you have a qualified right to learn what information we obtain about you. You also have the right to request correction of any erroneous information. The information we obtain about you will be used by Berkshire Life Insurance Company of America to determine eligibility for insurance and/or benefits under an existing policy and for other business purposes in connection with the insurance relationship. A detailed description of our information practices is contained in the Notice of Privacy Practices furnished to you with your application.

CONDITIONS OF COVERAGE

I/We _____ the applicant(s) have applied for a long term care insurance policy from Berkshire Life Insurance Company of America (the Company) and have submitted $_____ to the Company. The minimum amount of premium which may accompany an application is a monthly premium amount. It is understood and agreed that no liability is created or assumed by the Company, except for the refund of any premium amount submitted, unless and until a long term care insurance policy becomes effective. If approved, the effective date will be stated in the policy issued to the applicant(s).

The insurance applied for will become effective and in force only if:

1. This application is approved by the Company; and
2. A policy is issued during the lifetime of the applicant(s); and
3. The initial premium payment has been paid; and
4. Until the effective date of the policy as set by the Company, the health status of the applicant(s) remains insurable under the Company's underwriting standards.

Requests for a specific effective date are honored at the Company's discretion in accordance with its published guidelines on policy dating upon the conclusion of the underwriting review.

Should the applicant(s) be determined uninsurable based on the Company's underwriting standards, or if the Company is unable to obtain required underwriting information within 90 days, the amount submitted will be returned to the applicant(s). Should the amount submitted not be honored by the applicant's bank, the Company will discontinue consideration of the application.

No agent or broker has the authority to waive or alter any of the terms or conditions of the application for insurance or these Conditions of Coverage.

ALL PREMIUM CHECKS MUST BE MADE PAYABLE TO BERKSHIRE LIFE INSURANCE COMPANY OF AMERICA. DO NOT MAKE CHECK PAYABLE TO THE AGENT, AGENCY, OR LEAVE PAYEE BLANK.

I/We have read and understand the Conditions of Coverage.

Signed at _____ _____
City, State Date

_____ _____
Applicant's Signature Joint Applicant's Signature

_____ _____
Licensed Agent's Signature Date

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Home Office: Pittsfield, Massachusetts
Long Term Care Administrative Office
Post Office Box 4243
Woodland Hills, CA 91365-4243
888-505-8743

NOTICE TO APPLICANT REGARDING REPLACEMENT OF INDIVIDUAL ACCIDENT AND SICKNESS OR LONG TERM CARE INSURANCE

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE

According to your application, you intend to lapse or otherwise terminate existing accident and sickness or long term care insurance and replace it with an individual policy to be issued by Berkshire Life Insurance Company of America. Your new policy provides 30 days within which you may decide, without cost, whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy. You should review this new coverage carefully, comparing it with all accident and sickness or long term care insurance coverage you now have and terminate your present policy only if, after due consideration, you find that purchase of this long term care coverage is a wise decision.

STATEMENT TO APPLICANT BY AGENT (BROKER OR OTHER REPRESENTATIVE)

(Use additional sheets as necessary)

I have reviewed your current medical or health or long term care insurance coverage. I believe the replacement of insurance involved in this transaction materially improves your position. My conclusion has taken into account the following considerations, which I call to your attention:

1. If you are replacing existing long term care insurance coverage, you may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.
2. If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before your sign it, reread it carefully to be certain that all information has been properly recorded.

_____ _____
(Signature of agent, broker or other representative) *(Typed name of agent or broker)*

_____
(Typed address of agent or broker)

The above "Notice to Applicant" was delivered to me on:

_____ _____
(Date) *(Applicant's signature)*

_____ _____
(Date) *(Joint Applicant's signature)*

Berkshire Life Insurance Company of America
Home Office: Pittsfield, Massachusetts
Long Term Care Administrative Office
Post Office Box 4243
Woodland Hills, CA 91365-4243
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NOTICE TO APPLICANT REGARDING REPLACEMENT OF INDIVIDUAL ACCIDENT AND SICKNESS OR LONG TERM CARE INSURANCE

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE

According to your application, you intend to lapse or otherwise terminate existing accident and sickness or long term care insurance and replace it with an individual policy to be issued by Berkshire Life Insurance Company of America. Your new policy provides 30 days within which you may decide, without cost, whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy. You should review this new coverage carefully, comparing it with all accident and sickness or long term care insurance coverage you now have and terminate your present policy only if, after due consideration, you find that purchase of this long term care coverage is a wise decision.

STATEMENT TO APPLICANT BY AGENT (BROKER OR OTHER REPRESENTATIVE)

(Use additional sheets as necessary)

I have reviewed your current medical or health or long term care insurance coverage. I believe the replacement of insurance involved in this transaction materially improves your position. My conclusion has taken into account the following considerations, which I call to your attention:

1. If you are replacing existing long term care insurance coverage, you may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.
2. If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before your sign it, reread it carefully to be certain that all information has been properly recorded.

_____ _____
(Signature of agent, broker or other representative) *(Typed name of agent or broker)*

_____
(Typed address of agent or broker)

The above "Notice to Applicant" was delivered to me on:

_____ _____
(Date) *(Applicant's signature)*

_____ _____
(Date) *(Joint Applicant's signature)*

Berkshire Life Insurance Company of America
Home Office: Pittsfield, Massachusetts
Long Term Care Administrative Office
Post Office Box 4243
Woodland Hills, CA 91365-4243
888-505-8743

Automatic Payment Authorization

I (We) hereby authorize **Berkshire Life Insurance Company of America**, hereinafter called COMPANY, to debit my (our) financial institution named below, hereinafter called BANK, and to initiate an electronic funds transfer from my (our) O checking O savings account indicated below on or about the 15th of each month to pay premiums that become due for my (our) insurance policy issued by COMPANY.

Bank Name _____

Address _____

City _____

State _____ Zip _____

Routing Number _____

Account No. _____

This authority is to remain in effect until I (we) notify COMPANY or BANK to terminate it and COMPANY or BANK has reasonable time to act on its termination; or until COMPANY or BANK has sent me (or either of us) ten (10) days written notice of termination of this arrangement.

_____
DEPOSITOR NAME(S) AS SHOWN ON BANK RECORDS

Date _____ Signed _____

Date _____ Signed _____

IMPORTANT: Please attach two (2) months' premium and a voided check for the above account, except for the following:

California - Please attach one (1) month's premium and a voided check.

New Hampshire - For all Clients ages 65 and over, please attach one (1) month's premium and a voided check.

Berkshire Life Insurance Company of America

David L. Kalib
Secretary

TO BANK: As provided above, your depositor has authorized us to initiate debits to, and you to debit, the above account as specified. So that you may comply with this authorization, we agree that these arrangements shall be subject to the Automated Clearing House rules, as they may be in effect from time to time, and we recognize your status as a participating bank.

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Berkshire Life Insurance Company of America, Pittsfield, MA is a wholly owned stock subsidiary of The Guardian Life Insurance Company of America, New York, NY

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

"I", "me", "my" means each Applicant signing this Authorization.

This authorization is at the request of the individual or individuals whose names appear below.

In the event my application for insurance is not approved or if my policy is issued at a rate or with benefits other than as applied for ("Adverse Underwriting Decision"), I authorize Berkshire Life Insurance Company of America (Berkshire Life) to disclose the specific reasons for the Adverse Underwriting Decision to my agent or broker and/or to his or her marketing organization. I understand that Berkshire Life will not condition eligibility for coverage, underwriting or risk rating determination, or payment of benefits on any provision of this authorization. **I understand that this disclosure may involve specific, protected health information regarding me. I also understand that authorizing this disclosure is optional and I am not required to sign this authorization.**

REDISCLOSURE OF INFORMATION

I understand that if the person(s) or organization(s) that receives information provided pursuant to this authorization is not subject to federal privacy regulations, the information may be redisclosed and will no longer be protected by the federal privacy regulations.

REVOCATION OF AUTHORIZATION

As described in Berkshire Life Insurance Company of America's Notice of Privacy Practices, I understand that I may revoke this authorization in writing at any time by sending a written revocation to: Berkshire Life Insurance Company of America, Long Term Care Administrative Office, ATTN: PRIVACY ADMINISTRATOR, P.O. Box 4243, Woodland Hills, CA 91365-4243. I also understand that any such revocation will not be effective to the extent that action has been taken by Berkshire Life in reliance on this authorization or the extent that Berkshire Life has a legal right to contest a claim under the policy which I have applied for or to contest the policy itself.

EXPIRATION OF AUTHORIZATION

This authorization will be valid for 24 months from the date of my signature below.

A copy of this authorization is as valid as the original.

_____
Applicant's Name (Please Print)

_____ _____
Applicant's Signature **Date**

_____
Joint Applicant's Name (Please Print)

_____ _____
Joint Applicant's Signature **Date**