AUTHORIZATION

This application form, recorded Authorizations and any amendments shall be the basis for the policy.

The insurance, if approved by Guardian Life Insurance Company of America(Guardian), will be in force only when issued by Guardian Life Insurance Company of America. The premium must be paid when due. A change in my eligibility or the proposed dependent(s) after the completion of the application form and before the delivery of the contract may affect my eligibility for insurance with the company. I understand and agree that any information I provide through this application form process may be shared with persons necessary to facilitate issuing coverage, including but not limited to my agent or broker. I understand that I have a right to receive a copy of this authorization.

I understand that this authorization is required in order to enable Guardian Life Insurance Company of America to make eligibility or application determinations relating to me and/or my dependent(s). If I refuse to sign or revoke this authorization, Guardian Life Insurance Company of America may refuse to consider this application for insurance. I understand that I may revoke this authorization at any time by notifying Guardian Life Insurance Company of America in writing of my desire to revoke. Such revocation must be sent by certified mail to the following address: 1[P.O. Box 659020, Sacramento, CA 95865]. Such revocation will not be valid if Guardian Life Insurance Company of America has taken action in reliance on the authorization. Unless an earlier date is required by law, this authorization expires upon the earliest of the following events: 30 days after denial of this application, or if insured, 30 days after no longer being insured by Guardian Life Insurance Company of America. But in no event will this authorization be in effect for longer than 24 months from the date signed.

I agree that a photocopy of this authorization shall be valid for two years from the date signed.

I acknowledge receiving the notification regarding the Abbreviated Notice of Insurance Information Practices and the Outline of Coverage for dental Insurance, if required.

I acknowledge that I have read the completed application form. I attest that all statements and answers on this application form are complete, true and correct. I understand and acknowledge that any fraudulent statement or material misrepresentation or omission on the application form, recorded Authorizations and/or any amendments may result in claim denial or contract rescission, subject to the Incontestability provision of the policy.

I acknowledge and consent to receiving electronic copies of applicable insurance related document, in lieu of paper copies, to the extent permitted by applicable law. I may change this election only by providing 30 days prior written notice.