GUARDIAN® The Guardian Life Insurance Company of America

Group Term Accelerated Life Benefit Summary and Disclosure Statement

Group Life Claims, PO Box 26035, Lehigh Valley, PA 18002-6035 **Customer Service: 800-525-4542; Fax: (610) 807-8266**
Email Address: group_life_claims@GuardianLife.com

This Disclosure Statement provides a brief summary of the important features of an Accelerated Life Benefit; it does not alter any of the contract's provisions. The actual contract provisions set forth its full details and conditions.

EFFECT OF AN ACCELERATED LIFE BENEFIT PAYMENT ON GROUP TERM LIFE INSURANCE

The coverage will remain in force and premiums must be paid on the full amount of group term life insurance for which you were insured on the day before you applied for the accelerated life benefit. However, an accelerated life benefit payment will reduce the remaining group term life insurance amount in proportion to the amount of the accelerated proceeds. The remaining amount of group term life insurance for which you are covered after receiving an accelerated life benefit payment is subject to any increases or cutbacks that would otherwise apply to your insurance. Applicable cutbacks are applied to the amount of group term life insurance for which you were insured on the day before you applied for the accelerated life benefit. You may be required to provide proof of insurability for increased amounts. If required, we must approve that proof in writing before you are covered for the new amount.

The amount of an accelerated life benefit payment will be computed as set forth in the detailed statement on file with each state insurance department. The amount of an accelerated life benefit payment will be less than the amount of accelerated proceeds. If the life proceeds are assigned, you cannot apply for an accelerated life benefit.

TAX CONSEQUENCES

Unlike conventional life insurance proceeds, an accelerated life benefit payment may be taxable. A qualified personal tax adviser should be consulted before requesting an accelerated life benefit payment.

GOVERNMENT ENTITLEMENTS

Your eligibility for public assistance programs, such as medical assistance (Medicaid), aid to families with dependent children, and Supplemental Security Income ("SSI") may be affected by having an accelerated life benefit as part of your life insurance certificate or by receiving an accelerated life benefit payment. Exercising the option to receive an accelerated life benefit payment and receiving such payment before applying for these programs, or while other government benefits are being received, may affect initial or continued eligibility. The appropriate social services agency (for example, the Medicaid Unit of the local Department of Public Welfare and Social Security Administration Office) should be consulted for more information concerning how receipt of an accelerated life benefit payment will affect the eligibility of the recipient and/or the recipient's spouse or dependents.

LIMITS OF THE ACCELERATED LIFE BENEFIT

The accelerated life benefit is **not** health, nursing home, or long term-care insurance, and it is not intended or designed to eliminate your need for such coverage. There are no restrictions or limits on the use of an accelerated life benefit payment. An accelerated life benefit payment may not be enough to cover your medical, nursing home or other bills.

DEFINITIONS

Accelerated Proceeds: The portion of the group term life insurance requested by the owner.
Maximum Benefit Amount: The amount of certificate death proceeds which can be accelerated.
Proof: This includes certification by a licensed, qualified physician who has examined the insured.
Terminally Ill: This means that the insured is expected to die within six months.

GG-014393 (6/08)

ACKNOWLEDGMENT

I hereby acknowledge that I have received and read this Accelerated Life Benefit Summary and Disclosure Statement.

_____ _____
Signature of Insured Date

_____
Group Plan Number

The Guardian Life Insurance Company of America

PLEASE SEND THIS FORM WITH YOUR APPLICATION FOR AN ACCELERATED LIFE BENEFIT TO GUARDIAN. KEEP A PHOTOCOPY FOR YOUR RECORDS.

The minimum benefit amount is the lesser of: a) 50% of the in-force group term life amount; or b) $10,000. The maximum benefit amount is the lesser of: a) 50% of the in-force group term life amount; or b) $100,000.

The accelerated life benefit payment will be available to the employee in a lump sum.

AMOUNT OF ACCELERATED LIFE BENEFIT PAYMENT

The amount of an accelerated life benefit payment will be discounted to the present value of a benefit payable six months later based on the maximum adjustable policy loan interest rate (in accordance with the laws of your state), the amount of the accelerated proceeds and a processing fee where allowed by state (see below).

PROCESSING FEE

A processing fee in accordance with the laws of your state will be required **ONLY** if an accelerated life benefit payment is made. The processing fee will be no more than $250. This charge is directly associated with Guardian's administrative costs for processing an accelerated life benefit payment.

COST

There is no additional premium charged to add an Accelerated Life Benefit provision to a group life insurance contract.

SAMPLE ILLUSTRATION

Here is a generic example of how an accelerated life benefit payment affects your group term life insurance.

Assumptions

1. Employee's in-force group term life insurance amount is $100,000
2. After 10 years, insured requests accelerated proceeds of $30,000

Illustration

The following table illustrates the status before and after the accelerated life benefit payment is made:

	Before	After
In-force group term life amount:	$100,000	$70,000

Amount of Accelerated Life Benefit Payment:

Discount:	$1,500.00
Processing fee:	$ 150.00

The amount of the accelerated life benefit payment is computed as follows: Accelerated proceeds less adjustment for discount, less processing fee:

$$\$30,000 - \$1,500 - \$150 = \$28,350$$

***These adjustments are based on a hypothetical situation only. They will be determined as described in the actuarial memorandum on file with each state insurance department.**

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Accelerated Group Life Benefit Application

Group Life Claims, PO Box 26035, Lehigh Valley, PA 18002-6035 Customer Service: 800-525-4542, Fax: (610) 807-8266
Email Address: Group_Life_Claims@GuardianLife.com

Processing Fee: A processing charge not to exceed $150.00 will be required ONLY if an accelerated benefit payment is made. This charge is directly associated with Guardian's administrative costs for processing an accelerated benefit payment.

Accelerated Benefit: The amount of the Accelerated Life Benefit for which the eligible employee may apply is based on the amount of such employee's group term life insurance for which the individual is insured on the date they apply for the benefits.

Premium Payments: Premium payments for the full amount of your Life Benefit will remain the same and will not decrease as a result of receiving an Accelerated Benefit.

The employee certifies that they have read and understand the above statement.

✖ Employee's Signature: Date:

Employee's Section

1. Plan Number G-

2. Planholder/Employer Name

3a. Current Inforce Life Amount $ _____

3b. Indicate Amount Requested $ _____

4. Employee's Name 5. Date of Birth 6. Employee's Social Security Number

7. Employee's Address 8. Employee's Telephone Number

9. Nature of Injury/Sickness

List name and address of any Hospitals or Institutions where you have or are being treated or confined for this present condition either as an in or out-patient:

Name	Address	Dates of Confinements

List all Physicians who have treated you either as an in or out-patient for this condition:

Name	Address	Dates of Treatment

INDICATE MODE OF PAYMENT

Unless the insured selected a payment option while the insured was living, you have the right to choose how payment of the death proceeds will be made to you. If the amount payable to you is more than $10,000.00, our usual method of payment is to open an account in your name at State Street Bank giving you complete control and immediate access to all of your funds. If the amount of proceeds is lower than above, a single check will be payable to you. The other settlement options listed below remain available while the account is active and meet the requirements of the account (see page 2 for more information).

☐ Place proceeds into the Guardian Asset Account, GAA

☐ Installment payments

☐ Other manner of payment: _____

✖ Signature of Employee: Date:

*Additional paper can be used if necessary

(Please see reverse side)

Under penalties of perjury, I certify that the number shown on this form is my correct Taxpayer Identification Number (or that I am waiting for a number to be issued to me), and that I am not subject to backup withholding, either because I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or because the IRS has notified me that I am no longer subject to backup withholding. (If you do not give us your valid Social Security or Tax ID Number, the IRS may require us to withhold 31% of the interest payment made to you.)

I authorize any physician, medical practitioner, hospital, clinic, other health facility, consumer reporting agency, the Social Security Administration, the Medical Information Bureau, insurance or reinsurance company, or employer to release any and all medical and non-medical information in its possession about me to The Guardian Life Insurance Company of America or its legal representatives. Medical information means all information in the possession of or derived from providers of health care regarding the medical history, mental or physical condition, or treatment of me. I understand that Guardian will use the information obtained by this authorization to determine eligibility for insurance or eligibility for benefits under an existing plan. Guardian will not release any information obtained to any person or organization except to reinsurance companies, the Medical Information Bureau, or other persons or organizations performing business or legal services in connection with my application, claim, or as may be lawfully required or permitted, or as I may further authorize. I know that I may request and receive a copy of this authorization. I agree that a photocopy of this authorization shall be as valid as the original. I agree that this authorization shall be valid for the duration of my claim. I understand that I may request and receive a copy of the Medical Information Bureau report by writing to P.O. Box 105, Essex Station, Boston, MA 02112 or calling 866 692-6901 (TTY 866 346-3642).

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime. In New York the person shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation. In California, any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

"Please Note: Your Social Security number is required for IRS tax reporting purposes. Your Social Security number will not be used or disclosed to anyone for any other purpose and will not be retained in any record other than that pertaining to the claim."

✖ Signature of Claimant Date

EMPLOYER SECTION

1. Planholder/Employer's address	City	State	Zip	2. Telephone Number ( )
3. If branch or affiliate, name and relationship to parent company				

4. Employee's Name	5. Social Security No.	6. Job title at last time worked	7. Certificate No.	8. Insurance Class

9. Annual salary excluding bonus, overtime, and special compensation on the redetermination date of your plan $	10. Amount of Insurance: $	11. Date last worked full-time ____/____/____	12. Schedule at time last worked: ____ Hours per day ____ Days per week

13 Date of Employment ____/____/____	14. Date employee's insurance effective ____/____/____	15. Date employment terminated ____/____/____

16. Remarks

17. I certify that the employee named above has been a full-time, active employee for whom premiums have been paid and that the Premium Payment for the full amount of the Life Benefit will remain the same and will not decrease.

✖ Authorized Signature and Title Date

Guardian Asset Account

Guardian will mail you an information kit explaining the account along with personalized checks and a supplemental contract. Once payment is made to you via the Guardian Asset Account, you will have immediate access to the entire amount plus any interest accumulated. You may withdraw funds at any time by writing a check for any amount above $250 to the entire amount of proceeds. You have the ability to designate a beneficiary for the account where permitted by law. This account is not a bank checking account. The full amount of the proceeds and all interest earned are guaranteed by the full faith and credit of Guardian. Interest is compounded daily and credited monthly to your Account's balance.

This account is an accommodation that Guardian offers to beneficiaries. Guardian will pay the fees associated with maintaining the account. You will not be charged for checks and there is no limit to the number of checks you write, however, you will not be able to add additional funds to this account.

Unless the insured selected a payment option while the insured was living, you have the right to choose how payment of the death proceeds will be made to you. If the amount payable to you is more than $10,000.00, our usual method of payment is to open an account in your name at State Street Bank giving you complete control and immediate access to all of your funds. If the amount of proceeds is lower than above, a single check will be payable to you.

The Guardian Asset Account operates as a draft account administered by State Street Bank, Boston, Massachusetts. Under this payment method, Guardian will hold the proceeds within its General Account and pay you interest equal to the amount paid under the interest payment option of the Individual life insurance contract. The interest rate is set each year by the Company's Board of Directors and may change annually. For information on the current interest rate, please call 1-800-525-4542. You will receive monthly statements of your account indicating principal and accrued interest. Interest earned on your account may be taxable. It is recommended that you consult a tax adviser to determine your tax consequences.

You may choose another payment option or override the Guardian Asset Account by completing the section entitled, "Other manner of payment" on the front of this form. For example, you may request that a percentage of the death proceeds be paid to the Guardian Asset Account and the remainder be paid in a lump sum check.

For information contact Guardian at 1-800-525-4542.

GUARDIAN™

APS for Accelerated Benefit Rider

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The Physician is responsible for the completion of this form without expense to Guardian. To qualify for this benefit the insured's life expectancy must not exceed _____ months.

Patient Information: Plan Number: G-

Name of Patient: _____ Date of Birth: _____

Address: _____
Street City State Zip

History:

1. Name(s) and address(es) of physician(s) who have treated or are still treating the patient:

Physician Name Address: Street City State Zip

_____

_____

2. Hospital Name Address: Street City State Zip

_____

_____

3. When did patient's symptoms first appear or accident happen? _____

4. Is patient mentally competent? (Does the patient understand the nature of his or her actions and is the patient capable of handling his or her own affairs?) ❑ Yes ❑ No

Present Condition:

1. Subjective Symptoms: _____

2. Objective Findings: (Xrays, EKG, CAT Scans or other diagnostic tests) _____

_____

_____

3. Patient is Presently: ❑ ambulatory ❑ house-confined ❑ bed-confined ❑ hospital-confined ❑ in nursing home

4. If patient is presently in a nursing home or hospital, give the name and address of that institution:

_____

Diagnosis - Explain the Condition in Detail:

_____

_____

_____

Dates of Treatment: First Visit: _____ Last Visit: _____ Next Visit: _____

Frequency of Visits: ❑ Weekly ❑ Monthly ❑ Other: _____

Explain the Nature of the Treatment (Surgery, Chemotherapy, Radiation, etc.) and indicate medication prescribed (Dates and Dosages)

_____

_____

_____

(Complete reverse)

Prognosis: (How long do you expect the patient to live?) Additional Comments.

Remarks: (Include description if patient's life expectancy is based on current course of treatment)

Attending Physician's Name (Please Print)

Degree or Field of Speciality

Address: Street **City** **State** **Zip**

Telephone Number

Signature

Date