GUARDIAN℠

Life Customer Service Office
3900 Burgess Place
Bethlehem, PA 18017

Disability Customer Service Office
700 South Street
Pittsfield, MA 01201

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

Alcohol And Drug Usage Supplement

This Supplement is attached to and made part of the policy.

Name of the Proposed Insured: _____ Date of Birth: _____

1. Alcohol Usage History **Yes** **No**

a. Do you presently use alcoholic beverages? ..... ☐ ☐
If yes, please provide details of type of beverages, quantity and frequency.

_____

b. Have you ever consulted a physician or received treatment because of your alcohol use? ..... ☐ ☐
If yes, please provide details including dates, length of treatment, name and addresses of physician, hospital or treatment facility.

_____

c. Are you now or have you ever been a member of AA? ..... ☐ ☐
If yes, date of membership and how often you attend meetings.

_____

d. Have you been cited or arrested for driving under the influence of alcohol? ..... ☐ ☐
If yes, please provide details and driver's license number.

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2. Drug Usage History

a. Are you presently or have you in the past used any of the following drugs:

i. Opiates (Codeine, Heroin, Methadone, etc.)? ..... ☐ ☐
ii. Barbiturates (Amytal, Phenobarbital, Tuinal, etc.)? ..... ☐ ☐
iii. Non-barbiturates (Placidyl, Doriden, Parest, etc.)? ..... ☐ ☐
iv. Amphetamines (Benzedrine, Dexedrine, Preludin, etc.)? ..... ☐ ☐
v. Anticholinergics (Belladonna), Bromides or Cocaine? ..... ☐ ☐
vi. Hallucinogens (LSD-25, Peyote, Psilocin, etc.)? ..... ☐ ☐
vii. Cannabis (Marijuana, Hashish, THC-Delta 9)? ..... ☐ ☐
viii. Tranquilizers (Librium, Valium)? ..... ☐ ☐
ix. Others? ..... ☐ ☐

If yes, give details:

Type	How Often Used?	Dosage or Amount Used?	Dates Used From	To

	Yes	No
b. Have you ever been medically treated because of drug usage?	☐	☐

If yes, please provide dates of treatment and name of physician or treatment facility consulted.

_____

Any person who knowingly, and with intent to defraud any insurance company or other person, files an application of insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and may also be subject to civil penalties.

I declare that my statements and answers are correctly recorded, complete and true to the best of my knowledge and belief. I am aware that these statements and answers will become part of my application to the Company.

_____ _____

Date Signed Signature of Proposed Insured

_____

Witness

Information Practices: Please refer to the Notice of Insurance Information Practices provided to you at the time you applied for this insurance. This information will be treated as information subject to our Insurance Information Practices.