The Baltimore Life Insurance Company
10075 Red Run Boulevard • Owings Mills, MD 21117-4871
410.581.6600 • 800.628.5433 • www.baltlife.com

Application for Life Insurance

INSURED/OWNER

Insured/Owner (First, M.I., Last, Suffix)	Social Security or Tax ID	Date of Birth	Place of Birth

Mailing Street Address	City	State	ZIP Code

Gender	Marital Status	Driver's License Number	Occupation	E-mail

Telephone number where you would like to be reached: _____ Best Time To Call:_____

Within the past 12 months, have you used any form of tobacco or nicotine product, including cigarettes, cigars, pipes, chewing tobacco, snuff, marijuana, or tobacco use cessation aids? ☐ Yes ☐ No

BENEFICIARY INFORMATION

Primary Beneficiary Name (First, M.I., Last, Suffix)	Relationship	Social Security or Tax ID

Contingent Beneficiary Name (First, M.I., Last, Suffix)	Relationship

HOME LOAN INFORMATION

Home Loan Amount	Home Loan Payment	Mortgage Lender	Loan Date

INSURANCE COVERAGE

Plan	Face Amount	Term Period: ☐ 15 ☐ 20 ☐ 30 ☐ Other _____

ADDITIONAL BENEFITS INFORMATION

☐ Waiver of Premium
☐ Disability Income
☐ Other_____

☑ Accelerated Death Benefit included (if available) unless you check **"No"** here ☐
☐ Return of Premium

COMPLETE IF THE DISABILITY INCOME RIDER IS ELECTED:

1. Current monthly gross income from occupation: ..... $ _____
2. Amount of monthly disability insurance currently in force: ..... $ _____
3. Monthly income being applied for: ..... $ _____
4. Is your average work week 30 hours or more? ..... ☐ Yes ☐ No
5. Does your employer provide worker's compensation or any other form of on-the-job disability coverage for work-related sicknesses or injuries? ..... ☐ Yes ☐ No
6. Are you engaged in any of the following occupations: postal, city, county, state, or federal employee, railroad, law enforcement, fire fighter, underground miner, or active in the military, National Guard or Reserve? ..... ☐ Yes ☐ No
7. Have you within the past 12 months, received disability benefits of any kind or been disabled for more than 30 days, other than for pregnancy, or have you applied to receive, or are you eligible to receive disability payment compensation or a benefit from any source as a result of illness or injury? ..... ☐ Yes ☐ No
8. Do you need supervision and/or assistance of any kind with bathing, bowel or bladder function, dressing, eating, using the toilet or transferring? ..... ☐ Yes ☐ No

REPLACEMENT INFORMATION

1) Do you have existing life insurance or annuities currently in force or pending with this or any other company? ☐ Yes ☐ No
2) Will this policy, if issued, replace or modify any existing life insurance or annuities in this or any other company? *(This includes the use of dividends or other policy values.)* ☐ Yes ☐ No

If you answered "Yes" to either question, please provide the following information

Company Name	Policy Number	Insured/Annuitant	Amount (incl. ADB)	Year Issued	Replace or Modify?
			$		☐ Yes ☐ No
			$		☐ Yes ☐ No
			$		☐ Yes ☐ No

SECTION ONE

If the answer to any of the questions in this section is "Yes", you will not qualify for coverage:

Height _____ft./in. Weight _____lbs..... Weight gained or lost in the past year _____lbs.

1. Do you currently require the use of a wheelchair? ☐ Yes ☐ No
2. Have you been told by a medical professional you have a terminal illness or 12 months or less to live, or been advised to seek or use hospice services? ☐ Yes ☐ No
3. Have you been convicted more than once of driving under the influence of alcohol or drugs? ☐ Yes ☐ No
4. Have you ever tested positive for HIV, the human immunodeficiency virus, or have you ever been diagnosed by a medical professional as having acquired immunodeficiency syndrome or AIDS, or AIDS Related Complex? ☐ Yes ☐ No
5. Have you had more than one occurrence of cancer, lymphoma, or melanoma other than basal or squamous cell skin cancer? ☐ Yes ☐ No
6. Have you ever been treated by a medical professional or been diagnosed as having any of the following: ALS or Lou Gehrig's disease, Huntington's disease, multiple sclerosis, muscular dystrophy, myocardial infarction or heart attack, cardiomyopathy or weakened or poorly functioning heart muscle, systemic lupus erythematosus, scleroderma, cystic fibrosis, sickle cell anemia, chronic renal failure or advised to undergo dialysis, hepatitis C, cirrhosis or other chronic liver disease, schizophrenia, psychosis, dementia, Alzheimer's, bi-polar disorder, mental retardation, down syndrome, or Parkinson's disease? ☐ Yes ☐ No
7. Have you ever had or been advised to have an organ transplant, coronary or heart surgery, angioplasty or stent placement, pacemaker or defibrillator implantation, heart valve repair or replacement, or amputation due to disease? ☐ Yes ☐ No
8. In the past 10 years, have you received or been advised to seek treatment for alcoholism or drug addiction? ☐ Yes ☐ No
9. In the past 5 years, have you been confined to a nursing facility, had carotid artery surgery, had gastric bypass or lap band surgery, used or been advised to use supplemental oxygen or insulin? ☐ Yes ☐ No
10. In the past 5 years, have you used substances such as cocaine, heroin, amphetamines, barbiturates or hallucinogens? ☐ Yes ☐ No
11. In the past 5 years, have you been convicted of a felony or been on parole or probation? ☐ Yes ☐ No

AUTHORIZATION AND ACKNOWLEDGMENT

You authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical or medically-related facility or health care provider, insurance or reinsuring company, prescription record service, or the Medical Information Bureau, Inc., motor vehicle report, consumer reporting agency or employer having information available as to diagnosis, treatment, prescriptions and/or prognosis of you with respect to any physical or mental condition, including alcoholism and/or use of drugs, and any other non-medical information about you to give to The Baltimore Life Insurance Company (also known as The Company) any and all such information. You understand the information obtained by use of this authorization will be used by The Company to determine eligibility for insurance and/or benefits. Any information obtained will not be released by The Company to any person or organization except to reinsuring companies, the Medical Information Bureau, Inc., or other persons or organizations performing business or legal services in connection with your application or claim, or as may be otherwise lawfully required or as you may further authorize. You acknowledge receipt of the Notification and Disclosure form. You also acknowledge that the agent has provided you with the HIPAA authorization release, replacement form (if required), the accelerated death benefit disclosure form (if applicable) and any state required forms. You understand that you may request a copy of this authorization and agree that a photographic copy of this authorization shall be as valid as the original. This authorization shall remain valid for a period of two years and six months from the date it is signed.

Signature of Insured/Owner	**Date/City and State**

The following questions determine eligibility for coverage. A "Yes" response is not an automatic disqualification.

SECTION TWO

1. Within the past 2 years, have you engaged in or, do you plan to engage in any aviation activity other than as a fare-paying passenger on commercial airlines? ☐ Yes ☐ No
2. Within the past 2 years, have you engaged in or, in the next 2 years do you plan to engage in any form of scuba diving, hang-gliding, cave exploration, parachuting, mountain, rock or ice climbing, bungee jumping, mixed martial arts, organized motor racing, street luge or cliff diving? ☐ Yes ☐ No
3. Within the past 5 years, have you been convicted of driving under the influence of alcohol or drugs or have you had more than three motor vehicle moving violations? ☐ Yes ☐ No
4. Within the past 5 years, have you had an application for life, health, or disability insurance declined, postponed, rated, or denied reinstatement? ☐ Yes ☐ No

SECTION THREE

For purposes of this section of questions, the terms "treated" and "diagnosed" mean that any of the following have occurred within the past 10 years; you have been treated or you have been diagnosed by a medical professional, as having, or you have received follow-up care, including observation and monitoring.

5. Within the past 10 years, have you been treated for or diagnosed as having any heart disorder, including, abdominal aortic aneurysm, angina (chest pain), congestive heart failure, abnormal heart rhythm, arrhythmia, heart murmur, any blockage or narrowing of the arteries, stroke, transient ischemic attack, TIA or mini-stroke? ☐ Yes ☐ No
6. Within the past 10 years, have you been treated for or diagnosed as having diabetes, anemia, blood or platelet disorders, liver disease including hepatitis, kidney disease, other than kidney stones, Crohn's disease, ulcerative colitis, or pancreatitis? ☐ Yes ☐ No
7. Within the past 10 years, have you been treated for or diagnosed as having cancer, leukemia, lymphoma, or melanoma? ☐ Yes ☐ No
8. Within the past 10 years, have you been treated for or diagnosed as having memory loss, seizures, cerebral palsy, any other disease or disorder of the brain or nervous system, or neuro-muscular disorders, including paralysis? ☐ Yes ☐ No
9. Within the past 10 years, have you been treated for or diagnosed as having sleep apnea, asthma, rheumatoid arthritis, chronic obstructive pulmonary disease or COPD or other respiratory disorder? ☐ Yes ☐ No
10. Within the past 10 years, have you been treated for or diagnosed as having any disease or disorder of the breast or prostate, including an elevated PSA or prostate screening test? ☐ Yes ☐ No
11. Within the past 10 years, have you been treated for or diagnosed as having hypertension, high blood pressure or elevated cholesterol? ☐ Yes ☐ No
12. Within the past 10 years, have you been treated for or diagnosed as having depression, eating disorders or any other psychological or emotional disorders requiring hospitalization or treatment by a psychiatrist? ☐ Yes ☐ No
13. Do you currently have any medical testing pending or procedures that have not yet been completed, other than routine lab work? ☐ Yes ☐ No
14. Other than as already disclosed above, are you currently taking any medication or receiving medical or mental health treatment of any kind? ☐ Yes ☐ No

Primary Physician's Name _____ Telephone _____

Address _____ City _____ State _____ ZIP Code _____

Details to Yes Answers

Include name, address and telephone number of treating physician, diagnosis, date of diagnosis, prescribed medications and location of medical records.

_____

_____

_____

_____

_____

_____

DECLARATIONS AND AUTHORIZATIONS

It is understood that The Baltimore Life Insurance Company (The Company) has the right to require a medical examination. If so, this application is not complete until the medical examination has been performed.

It is understood that the President, a Vice President, or the Secretary must sign all agreements made by The Company. No other person, including an insurance agent or broker, can change the terms of any policy or make any promise or agreement binding on The Company.

Except as may be provided by the Conditional Receipt bearing the same date and form number as this application, it is agreed that no policy will take effect unless:

1. A policy is delivered to and accepted by the owner while each person proposed for coverage is alive and continues to be insurable, and whose condition of health and occupation, as described in this application, are unchanged from the date of the application.
2. The required premium is paid in full to The Baltimore Life Insurance Company, and the application is approved and accepted by The Company. (Electronic Funds Transfer Authorization does not constitute payment.)

ACCELERATED DEATH BENEFIT TAX DISCLOSURE: The receipt of a benefit under the Accelerated Death Benefit Rider may be taxable. Before claiming a benefit under this Rider, assistance should be sought from a personal tax advisor.

IMPORTANT TAX NOTICE FOR POLICYOWNER: Under federal Tax law, The Company is required to ask you to certify your correct Taxpayer Identification Number (TIN), and to include it in any reports of taxable income it makes to the IRS.

Certification: Under penalties of perjury, I certify that:

1) the number shown on this application is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and

2) I am not subject to backup withholding under provisions of section 3406(a)(1)(c) of the Internal Revenue Code because a) I am exempt from backup withholding, or b) I have not been notified that I am subject to backup withholding as a result of a failure to report all interest or dividends, or c) the IRS has notified me that I am no longer subject to backup withholding, and

3) I am a US person (including a US resident alien). The Internal Revenue Service does not require your consent to any provisions to this document other than the certification to avoid backup withholding.

If you are replacing an existing policy and you are not satisfied with the new policy for any reason, you have the right to return your policy to us within 30 days after you receive it and receive a refund of all premiums paid.

WARNING: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

You have had read to you all of the questions and answers contained in this application. You certify the loan date stated on this application is accurate. This application is complete and true to the best of your knowledge and belief. You understand that no agent is authorized to advise you that any inaccurate answer is acceptable.

Application made at_____ this _____ day of _____, _____
(City, State) (Day) (Month) (Year)

(X) _____
Signature of Insured/Owner

PREMIUM AND BILLING INFORMATION

Planned Premium: $_____ Amount Paid with Application: $_____ ☐ EFT initial premium – Draft Immediately ☐ EFT initial premium – Draft at Issue	Premium Mode:	☐ Monthly Electronic Funds Transfer (EFT) Future draft date _____*(Any date except 29th, 30th, 31st.)* ☐ Annual Electronic Funds Transfer (EFT) ☐ Semi-Annual Electronic Funds Transfer (EFT)

Payor Name	Relationship to Applicant	Social Security or Tax ID#

ELECTRONIC FUNDS TRANSFER (EFT) AUTHORIZATION

Statement of Authorization

As a duly authorized check signer on the financial institution account identified below, you hereby authorize The Baltimore Life Insurance Company, also known as The Company, to initiate recurring electronic funds transfer, also known as EFT, withdrawal transactions as indicated in this application. You hereby authorize your financial institution to transfer the premium amount indicated in this application. Adjusting entries to correct errors is also authorized. You agreed that these debits and any adjustments will be made electronically. If any EFT withdrawal is dishonored for any reason, you release The Company from any and all resulting liabilities even if the dishonor results in cancellation of the applicant's insurance policy. This authorization is to remain in full force and effect until written notification of its termination is given to The Company.

Payor (Print Name) _____ Payor Signature EXACTLY as it appears on bank record _____ Signature Date _____

Bank Name _____ Bank Routing Number *(Must be 9 Digits)* _____

Account Number _____ **Type of Account:** ☐ Checking *(Attach voided check)* ☐ Savings *(Verify draft is allowed)*

AGENT'S STATEMENT

1) Based on your knowledge, does the proposed insured have existing life insurance or annuities? ☐ Yes ☐ No

2) Do you have knowledge or reason to believe that replacement of existing life insurance or annuities may be involved? ☐ Yes ☐ No

3) If replacement is occurring, do you certify that this replacement is within the guidelines provided by Baltimore Life? ☐ Not Applicable ☐ Yes ☐ No

4) Would you like the policy mailed to the policyowner? ☐ Yes ☐ No

You certify that only advertising previously approved by Baltimore Life Insurance Company was used in conjunction with this sale, and that copies of all sales materials used in this sale have been left with the applicant. Any electronically presented sales materials will be provided in printed form to the applicant no later than at the time of policy delivery. You also certify that you have read or provided the applicant with the Notification and Disclosure Form, HIPAA authorization release, replacement form (if required), accelerated death benefit disclosure form (if applicable), conditional receipt and any other required state disclosures. You hereby certify that you have truly and accurately recorded on this application the information supplied by the insured(s) and you are unaware of any additional information that might affect the Company's underwriting decision.

Writing Agent Signature _____ Printed Name _____ Date _____ Writing Agent Code No. _____

If split commissions apply:

Writing Agent #2 _____ Agent Number _____ Date _____ % Split (if applicable _____

Writing Agent #3 _____ Agent Number _____ Date _____ % Split (if applicable) _____

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NOTIFICATION AND DISCLOSURE

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FAIR CREDIT REPORTING ACT NOTICE

As part of our evaluation of your application for insurance, an investigative consumer report may be prepared, whereby information is obtained through personal interviews with agencies, friends, neighbors or others with whom you are acquainted or who may have information about you. This report, among other things, may include information as to your character, general reputation, personal characteristics, health, and mode of living, except as may be related directly or indirectly to your sexual orientation.

Upon your written request, and within a reasonable period of time, you have the right to receive additional detailed information about the nature and scope of the investigation and to receive a copy of the report at your expense.

MEDICAL INFORMATION BUREAU, INC. PRE-NOTICE

Information regarding your insurability will be treated as confidential. Baltimore Life Insurance Company or its reinsurers may, however, make a brief report thereon to the MIB, Inc., formerly known as Medical Information Bureau, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information about you in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at 866-692-6901 (TTY 866 346-3642). If you question the accuracy of the information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.

Baltimore Life Insurance Company, or its reinsurers, may also release information from its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.

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CONDITIONAL RECEIPT

(This receipt is not valid unless the full initial premium has been deposited at the time of application)

YOU DO NOT HAVE INSURANCE PRIOR TO RECEIPT OF THE POLICY UNLESS THE FOLLOWING CONDITIONS ARE MET:

a) We receive the correct premium payment for the mode selected and the amount of insurance applied for on the application;
b) Premium payments made by check or bank draft are honored when first presented for payment;
c) All required medical examinations or tests required by the Company's underwriting rules and standards are completed within 60 days from the date of the application;
d) The Proposed Insured is, on the date of application and continuing until the policy is delivered, an insurable risk under the Company's rules, as applied for **(i.e., any changes to the plan, benefits, premium, class and amount of the policy as applied for will cancel any insurance under this Receipt)**; and
e) The application is approved by The Company.

IF YOU DO NOT MEET THE ABOVE CONDITIONS, THE COMPANY'S ONLY LIABILITY WILL BE TO REFUND THE PREMIUM PAYMENT.

Subject to satisfactory completion of all of the above conditions, the effective date of coverage provided by receipt will be the later of: (1) the date of the application; (2) the date of the last of any medical examinations, tests, or medical record receipt required under the Company's underwriting rules and practices; or (3) the date, if any, requested in the application. Once coverage under this receipt becomes effective, the maximum death benefit (including all riders and benefits, if any), will be the **lesser** of: a) the total death benefit payable under the policy(ies), including any Accidental Death Benefit, on all pending applications with The Company or b) $150,000. We may terminate coverage under this receipt by notice to you. Coverage under this Receipt terminates 60 days from the date of the application. Suicide, whether sane or insane, will solely result in a refund of premium.

No broker, agent or medical examiner is authorized to accept risks or pass on insurability, make or alter any contract, waive a complete answer to any question in the application, waive any conditions under this receipt or waive any of the Company's rights or requirements or otherwise bind The Company in any way by any promise or statement.

ALL CHECKS MUST BE MADE PAYABLE TO THE BALTIMORE LIFE INSURANCE COMPANY.

Received $ _____ from _____
for an application on _____Dated _____.