Application for Life Insurance

The Baltimore Life Insurance Company

10075 Red Run Boulevard • Owings Mills, MD 21117-4871 • 800-628-5433 • www.baltlife.com

The Baltimore Life COMPANIES

The Proposed Insured(s) must sign all appropriate spaces marked by (X), initial all changes or corrections, and provide additional information in the Supplementary Report Section of this application. Please print all information except where signature is required.

Proposed Insured

1. Name of Proposed Insured (First, Middle, Last)

_____

2. Present Address

_____

City _____ State _____ Zip _____

Phone _____ Email _____

Previous Address *(If less than 2 years at present address)*

_____

3. Birthdate_____ Age _____ Gender: ☐ M ☐ F

State / Country of Birth _____

Marital Status: ☐ Single ☐ Mar ☐ Sep ☐ Div ☐ Widowed

SSN _____ Driver's Lic. No. _____

Previous Name(s) Used _____

4. Occupation _____

Employer _____ Phone _____

5. Beneficiary

Primary _____ Relationship _____

SSN/TIN _____ Phone _____

Street Address _____

City _____ State _____ Zip _____

Contingent _____ Relationship _____

SSN/TIN _____ Phone _____

Street Address _____

City _____ State _____ Zip _____

6. Smoking Status

Do you or have you ever smoked? ☐ Yes ☐ No

If Yes, Date stopped smoking _____

Do you use nicotine or tobacco in any other form? ☐ Yes ☐ No

If Yes, Explain _____

Additional Insure

1a. Name of Proposed Additional Insured

_____

Relationship _____

2a. Present Address

_____

City _____ State _____ Zip _____

Phone _____ Email _____

Previous Address *(If less than 2 years at present address)*

_____

3a. Birthdate_____ Age _____ Gender: ☐ M ☐ F

State / Country of Birth _____

Marital Status: ☐ Single ☐ Mar ☐ Sep ☐ Div ☐ Widowed

SSN _____ Driver's Lic No. _____

Previous Name(s) Used _____

4a. Occupation _____

Employer _____ Phone _____

5a. Beneficiary

Primary _____ Relationship _____

SSN/TIN _____ Phone _____

Street Address _____

City _____ State _____ Zip _____

Contingent _____ Relationship _____

SSN/TIN _____ Phone _____

Street Address _____

City _____ State _____ Zip _____

6a. Smoking Status

Do you or have you ever smoked? ☐ Yes ☐ No

If Yes, Date stopped smoking _____

Do you use nicotine or tobacco in any other form? ☐ Yes ☐ No

If Yes, Explain _____

7. Owner (If other than Proposed Insured)

Name _____

Birthdate_____ Relationship _____

Phone _____ SSN/TIN _____

Street Address _____

City _____ State _____ Zip _____

7a. Contingent Owner

Name _____

Birthdate_____ Relationship _____

Phone _____ SSN/TIN _____

Street Address _____

City _____ State _____ Zip _____

8. Children's Rider (Children over age 18 must sign the application. If last name differs from Proposed Insured's, explain in the Supplementary Report section.)

Full Name (First, Middle, Last)	Birthdate (Mo/Day/Yr)	Age	Gender M or F	Face Amount	Beneficiary & Relationship *(Is Proposed Insured unless specified here)*
				$	
				$	
				$	

9. Insurance Applied For

Insurance Plan: _____

Face Amount $ _____

Policy No. _____ Date _____

10. Additional Benefits

☐ Accidental Death
$ _____

☐ Additional Insured
☐ 15yr ☐ 20yr ☐ 30yr
$ _____

☐ Level Term
☐ Ren/Conv
☐ Nonren/Nonconv
Name _____
$ _____
Period/Yrs _____

☐ Premium Waiver

☐ Traditional Riders
Name _____
$ _____

☐ *UL Additional Benefits*
☐ Death Benefit Option
☐ Option 1 - Level
☐ Option 2 - Increasing
☐ Disability Benefit
☐ Option A
☐ Option B

☐ 10-Year Level Term
$ _____
☐ Convertible
☐ Reapplication

☐ Other ADBR
☐ Other _____
☐ Other _____

(All Benefits and Payment Options are not available on all plans.)

11. Amount Paid With Application **$** _____

Planned Modal Premium $ _____

Initial Lump Sum Payment $ _____

12. Premium

Duration: ☐ Life Pay
☐ Limited Pay *(Not UL)* Years _____
☐ Single Pay

Mode: ☐ EFT date_____ *For UL, draft date is policy date unless otherwise specified here:* _____
☐ Monthly Account Ordinary, if available
☐ Annual ☐ Semiannual ☐ Quarterly ☐ Monthly
☐ Single Premium
☐ Government Allotment ***(Submit bank forms)***
☐ Military Allotment ***(Submit Form 972)***
☐ Salary Savings **Case No.** _____
☐ Other _____

13a. Dividend Option, if available

☐ Cash ☐ Additions ☐ Accumulation
☐ Premium Reduction
☐ One Year Term Insurance, if available
☐ One Year Term & Paid-Up Additions, if available

b. Automatic Premium Loan: ☐ Yes ☐ No (Not available for term or interest-sensitive products)

14. Nonforfeiture Option, if available

☐ Extended Term Insurance ☐ Reduced Paid-Up

15. Special Requests / Billing Information

_____

_____

_____

16. Existing Insurance on All Persons Proposed for Coverage (Use Summary Report for additional space.)

Name of Insured	Company	Policy Number	Amount	Personal (✓)	Business (✓)	Year Issued	Accidental Death	Being Replaced or Changed
				☐	☐			
				☐	☐			
				☐	☐			
				☐	☐			

17. Replacements - Regarding any person proposed for coverage

Details to "Yes" Answers

a) Do you have existing life insurance or annuities, or have you lapsed or surrendered life insurance or annuities within the last six months? ☐ Yes ☐ No
If "Yes," policy status is: ☐ In force ☐ Terminated

b) Will this policy, if issued, replace or modify insurance or annuities in this or any other company? ☐ Yes ☐ No
(This includes the use of dividends or other policy values)
If "Yes," how affected: ☐ Exchange ☐ Modify ☐ Replace
Name of Company _____
Policy No. _____

c) Is any other application for insurance pending in this or any other company? ☐ Yes ☐ No

18. Understanding of Policy Replacement - Complete when replacement is occuring

This replacement is being made at the recommendation or request of: ☐ Policyowner ☐ Agent

Why is replacement occuring? _____

Can the existing policy(cies) be changed to accomplish the desired result? ☐ Yes ☐ No

If "No," explain Why: _____

Explain the source of premiums within the next twelve months, if applicable, payable on the new policy.

_____

Note to Our Customer: In most cases, the replacment of an existing life insurance policy, regardless of the issuing company, is not in your best interest. New policies contain contestable and suicide provisions which you should ask your agent to explain. In addition, there are expense charges associated with each new policy. You should ask your agent to explain both the benefits and the drawbacks of the replacement your are considering.

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.

I have read the above "Note to Our Customer."

Signature of Applicant _____ Date _____

Signature of Agent	Date	Signature of Manager	Date

19. Has Any Person Proposed for Insurance:

Details to "Yes" Answers

a) Ever applied for or received a pension, disability payment/ compensation, or benefit from any Armed Forces, insurance company, or other source due to illness or injury? ☐ Yes ☐ No

b) Had any application for life or health insurance declined, postponed, or modified in any way, or been refused issue, renewal, or reinstatement? ☐ Yes ☐ No

c) Within the past five years used marijuana, narcotics, hallucinogens, barbiturates, amphetamines, tranquilizers, except as prescribed by a physician, or been convicted for possession or sale of any of the above? ☐ Yes ☐ No

d) Within the last two years been refused a driver's license, had a license revoked or suspended, or had three or more moving violations or accidents? ☐ Yes ☐ No

e) Engaged within the last three years (or intend to engage) in flying as a student pilot, pilot, or crew member, or sky diving, scuba diving, hang gliding, boxing, or in racing any type of motor powered land vehicle or watercraft? ☐ Yes ☐ No

20. Medical Information

	Height		Weight Pounds	Weight Change in Past Year *(Give reason if more than 10 pounds)*	Name, Address, and Telephone No. of Personal Physician *(Give Date and Reason of last treatment or medication)*
	Feet	Inches			
Proposed Insured					
Additional Insured					
Child					
Child					
Child					

21. Have Any of the Proposed Insured(s) Ever Had Medical Treatment For:

a) Cysts, tumors, any kind of cancer, including melanoma? ☐ Yes ☐ No

b) Disease or disorder of heart or blood vessels, any shortness of breath, chest pains, palpitations, swelling of ankles, high blood pressure, rheumatic fever, heart murmur or other circulatory disorder? ☐ Yes ☐ No

c) Disease or disorder of brain or nervous system, paralysis or stroke, dizziness, weakness or numbness, headache, fainting spells, convulsion, epilepsy, hallucinations, mental disorder, Parkinson's disease, Alzheimer's disease or dementia? ☐ Yes ☐ No

d) Asthma, hay fever, chronic cough, bronchitis, emphysema, spitting blood, tuberculosis, or any other disorder of lungs or respiratory system? ☐ Yes ☐ No

e) Hernia, gallbladder disorder, ulcers, colitis, disease or disorder of stomach, intestines, or other digestive or swallowing complaints? ☐ Yes ☐ No

f) Diabetes, thyroid, or other endocrine disorder? ☐ Yes ☐ No

g) Anemia, Leukemia or other blood disorder? ☐ Yes ☐ No

h) Jaundice, disease or disorder of kidneys, liver, bladder; male or female reproductive organs; sugar, albumin, blood, or pus in urine? ☐ Yes ☐ No

i) Any form of arthritis; rheumatism; bone; joint; back disorder; lameness; loss of limb; or deformity? ☐ Yes ☐ No

j) Any defect of sight, speech, or hearing? ☐ Yes ☐ No

k) Disorder of nose or throat? ☐ Yes ☐ No

l) Alcoholism, narcotic addiction, or drug habituation? ☐ Yes ☐ No

22. Have Any of the Proposed Insured(s) Within The Past Five Years:

a) Had any disease, disorder, injury, or operation which has not been previously mentioned? ☐ Yes ☐ No

b) Consulted or been treated by a doctor or other practitioner? *(If consultation was for "checkup" or "physical exam" explain fully. Include symptoms and findings. If purpose of consultation was for employment physical, annual company physical, or the like, so state. Give full names and addresses of all physicians.)* ☐ Yes ☐ No

c) Been a patient or been under treatment or observation in any hospital, clinic, asylum, sanatorium, or any private or government facility performing similar services? ☐ Yes ☐ No

d) Had X-rays, electrocardiograms, or other medical tests or studies? ☐ Yes ☐ No

e) Been under the care of a physician, or taken treatment or medication for any reason? ☐ Yes ☐ No

23. Have Any of the Proposed Insured(s) Been Diagnosed by a Member of the Medical Profession For:

a) AIDS (Acquired Immune Deficiency Syndrome) or any other immunological disorder? ☐ Yes ☐ No

b) Enlargement of lymph nodes (glands), chronic diarrhea, unusual or persistent skin lesions or unexplained infections? ☐ Yes ☐ No

24. Give Complete Details of Any "Yes" Answers to Questions 21 through 23.

Use the Supplementary Report section or Form 1483 for additional space.

Ques. No.	Name of Person	Disease/Injury	Date	Full Names and addresses of physicians and hospitals

25. Family History of Proposed Insured: Diabetes, cancer, high blood pressure, or heart disease? ☐ Yes ☐ No

	Age if living	Age at death	Condition of health or cause and date of death
Father:			
Mother:			
Brother(s):			
Sister(s):			

26. Juvenile Insurance Only - List insurance in force on family members

Parents	Company (Full Name)	Face Amount	Plan	Accidental Death	Issue Date
		$			
		$			
Sister(s) / Brother(s)					
		$			
		$			

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

AGREEMENT: I have read or had read to me all of the questions and answers contained in this application. This application is complete and true to the best of my knowledge and belief.

WARNING: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

It is understood that the President, a Vice President, the Secretary, or the Actuary 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 first modal premium is paid in full to The Baltimore Life Insurance Company, and the application is approved and accepted by the Company (Automatic Bank Draft Authorization does not constitute payment).

AUTHORIZATION AND ACKNOWLEDGMENT: I 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, or the Medical Information Bureau, Inc., consumer reporting agency or employer having information available as to diagnosis, treatment and/or prognosis of me with respect to any physical or mental condition, including alcoholism and/or use of drugs, and any other nonmedical information about me to give to the Company any and all such information. I 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 my application or claim, or as may be otherwise lawfully required or as I may further authorize. I understand that I am granting permission to obtain an investigative consumer report, if required, and that I may request a copy of the investigative consumer report, if one is made. I understand that I 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. I acknowledge receipt of the Medical Information Bureau, Inc. Pre-Notice and the Fair Credit Reporting Act Notice.

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. If you are an individual, your Social Security number is your Taxpayer Identification Number.

Certification: I certify that ☐ **I am** ☐ **I am not** subject to a backup withholding order under Section 3406(a)(1)(c) of the Internal Revenue Code and I am a U.S. person (including a U.S. resident alien). I also certify that the Taxpayer Identification Number on this form is true, correct and complete.
The Internal Revenue Service does not require your consent to any provisions of this document other than the certification to avoid backup withholding.

I certify that I have read the health questions contained on this application and that my responses to these questions have been accurately recorded. I understand that no agent is authorized to advise me that any inaccurate answer is acceptable.

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

(X) _____
Signature of Proposed Insured (Unless under age 15)

(X) _____
Signature of Owner (If other than Proposed Insured)

(X) _____
Signature of Payor (If other than Proposed Insured)

(X) _____
Signature of Spouse, Payor, Additional Insured, or Parent /Legal Guardian (If Proposed Insured is under age 15)

_____
(Give official capacity if signed on behalf of a corporation, trust etc.)

(X) _____
Signature of Licensed Agent (Witness to all signatures)

Signature of each Child (If over age 18 for Children's Rider)

(X) _____

(X) _____

(X) _____

Agent's Statement All questions must be fully and accurately answered.

1. How well do you know the proposed insured? _____
   If relative, state relationship _____
2. Does the Proposed Insured(s) have any obvious physical impairments? ☐ Yes ☐ No
3. Do you have any knowledge of the Proposed Insured's personal habits, reputation, etc., which might influence the underwriting of this risk? ☐ Yes ☐ No
4. Are you requesting Preferred Class underwriting if available? *(Exam, blood profile and urine specimen required regardless of face amount)*
   Proposed Insured ☐ Yes ☐ No
   Additional Insured ☐ Yes ☐ No
5. Is a medical exam required? ☐ Yes ☐ No
6. Check which items below have been requested:
   ☐ Paramedical ☐ Exam by Medical Doctor
   ☐ EKG ☐ Urine Specimen
   ☐ X-Ray ☐ Blood chemical profile
   ☐ APS $ _____ fee

Exam date: _____ By: _____

at: _____

7. Did you see the Proposed Insured(s) when the application was written? ☐ Yes ☐ No Explain _____

_____

8. Best time to phone Proposed Insured: _____ ☐ AM ☐ PM
9. Is the Proposed Insured gainfully employed? ☐ Yes ☐ No
10. Financial Information of Proposed Insured

Gross Annual Income	Net Worth
☐ Less than $25,000	☐ Less than $50,000
☐ $25,000 - $50,000	☐ $50,000 - $100,000
☐ $50,000 - $100,000	☐ $100,000 - $250,000
☐ More than $100,000	☐ More than $250,000

Figures are based on: ☐ Proposed Insured(s) statement
☐ Agent's estimate

11. Is the insurance applied for to be used in connection with, or as part of, a pension plan? ☐ Yes ☐ No
12. Do you have knowledge or reason to believe that replacement of existing life insurance or annuities may be involved? ☐ Yes ☐ No
    If "Yes," complete applicable state replacement form(s) and answer these questions:
    a. Do you certify that only company approved advertising material was used and that a copy of all advertising used was provided to the applicant? ☐ Yes ☐ No
       If Yes, indicate form nos. _____
    b. Do you certify that this replacement is within the guidelines provided by The Baltimore Life Insurance Company? ☐ Yes ☐ No
13. Indicate the customer's needs that this product satisfies:
    ☐ Final Expenses ☐ Mortgage Protection
    ☐ Family Income ☐ Education Protection
    ☐ Estate Liquidity ☐ General Family Protection
    ☐ Debt Protection
    ☐ Other _____

    Was a Needs Analysis completed? ☐ Yes ☐ No

Supplementary Report - Avoid unnecessary underwriting delays by providing additional details pertinent to the risk.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Agent's Declaration

I certify that I have asked and have fully recorded the Proposed Insured's answers to all questions on this application. I believe this application to be correct and complete.

Agent's Signature _____ Date _____

Production Credit (Please print)

If more than one agent is to receive production credit for this case, please complete the information below:

Writing Agent _____ Code No. _____ Date _____

Agency Name _____ Agency Code _____

Writing Agent #2 _____ Code No. _____ % _____ of production credits

Manager's Signature _____

Automatic Bank Draft Authorization

As a convenience to me, I hereby request and authorize The Baltimore Life Insurance Company to withdraw from my account the amount of premium payable.

I agree that your treatment of each withdrawal and your rights thereunder shall be the same as if the withdrawal was personally taken by me. If any withdrawal is dishonored for any reason, I release The Baltimore Life Insurance Company from any liability resulting from the bank declining payment, even if the dishonor results in cancellation of my insurance or annuity policy.

I agree that this authorization shall remain in effect until written notice of its termination is provided by me to you or until terminated by The Baltimore Life Insurance Company.

_____

Name of Accountholder **(Print as it appears on bank records)**

Date_____

Policy/Contract No._____

Draft Date_____ ☐ New EFT ☐ Add to existing EFT

Bank Name _____

Bank Address _____

City,State,Zip _____

Routing No. _____

Type of Account ☐ Checking **(Attach Voided Check)**
☐ Savings **(Verify draft is allowed)**

Account No. _____

_____

Signature of Accountholder

_____

Signature of Joint Accountholder

Make sure all signatures, account numbers, and names are correct and legible.

- The Electronic Funds Transfer be made by The Baltimore Life Insurance Company each month on the date specified in the **"Premium"** section of this application.
- Your receipt for premium payments is your bank statement.
- The EFT Plan may be terminated:
  - —— if the bank declines payment;
  - —— if the account is closed for any reason;
  - —— by the Policyowner or Accountholder(s) by sending written notification to The Baltimore Life Insurance Company.

The Company will give written notice to you if your EFT plan is terminated. The notice will be mailed to the last known address of the Accountholder(s) who signed this Automatice Bank Draft Authorization request form.

Do not detach Automatic Bank Draft Authorization Form from application.

Conditional Receipt

Detach only after the appropriate premium payment has been received.

Received from_____

the sum of $_____ toward the premium for life insurance with The Baltimore Life Insurance Company, on the life of_____.
Name of Proposed Insured

No insurance will be effective unless all conditions of this receipt have been met. No agent or other representative of the Company is authorized to change any of these conditions.

The insurance provided by this receipt, subject to the provisions of the policy applied for, will become effective as of the date of the application or medical examination (if one is required), whichever is later, only if all of the following conditions are met:

- The amount paid as shown on the reverse side must be adequate to keep the policy in effect for at least one month.
- A fully completed application is received by the Company.
- All fully completed medical examinations, electrocardiograms, and X-rays required by the Company's published underwriting rules are received by the Company and satisfy the Company's underwriting guidelines.
- All other information necessary for the Company's customary investigation has been received.
- The Company is satisfied that any person for whom benefits are claimed during the period of this receipt is insurable by the Company for insurance exactly as applied for, according to the Company's rules and standards.

If all of these conditions are not met, insurance will take effect when the policy is issued, provided that all persons proposed for coverage are alive and continue to be insurable and whose health, smoking history, and occupation, as described in the application, are unchanged.

If one or more of the conditions have not been met, there shall be no liability on the part of the Company, except to return the premium.

Under no circumstances will the insurance provided by this receipt, **including any insurance in force or applied for with this Company,** or any benefit for accidental death, exceed $150,000 for each person proposed for coverage. Any coverage provided by this receipt will terminate when a policy is issued as a result of this application.

_____ _____

Signature of Proposed Insured Date

_____ _____

Signature of Agent Date

PLEASE MAKE CHECK PAYABLE TO:
THE BALTIMORE LIFE INSURANCE COMPANY

DO NOT MAKE CHECK PAYABLE TO THE AGENT OR LEAVE THE PAYEE BLANK.

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. Notice

Information regarding your insurability will be treated as confidential. The Baltimore Life Insurance Company or its reinsurers may, however, make a brief report thereon to the Medical Information Bureau, a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such company, the Bureau, upon request, will supply such company with the information in its file.

Upon receipt of a request from you, the Bureau will arrange disclosure to you of any information it may have in your file. If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the Bureau's information office is Post Office Box 105, Essex Station, Boston, Massachusetts, 02112; the telephone number is (617) 426-3660.

The Company or its reinsurers may also release information in its file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.