

SERFF Tracking Number: BALT-125839708 State: Arkansas
 Filing Company: The Baltimore Life Insurance Company State Tracking Number: 40572
 Company Tracking Number: 8167
 TOI: L04I Individual Life - Term Sub-TOI: L04I.213 Specified Age or Duration - Fixed/Indeterminate Premium - Single Life
 Product Name: TERM LIFE INSURANCE POLICY RENEWABLE TO AGE 100
 Project Name/Number: TERM LIFE INSURANCE POLICY RENEWABLE TO AGE 100/8167

Filing at a Glance

Company: The Baltimore Life Insurance Company

Product Name: TERM LIFE INSURANCE POLICY RENEWABLE TO AGE 100 SERFF Tr Num: BALT-125839708 State: ArkansasLH

TOI: L04I Individual Life - Term SERFF Status: Closed State Tr Num: 40572
 Sub-TOI: L04I.213 Specified Age or Duration - Fixed/Indeterminate Premium - Single Life Co Tr Num: 8167 State Status: Approved-Closed
 Filing Type: Form Co Status: Reviewer(s): Linda Bird
 Author: Lesia Williams Disposition Date: 10/22/2008
 Date Submitted: 10/15/2008 Disposition Status: Approved

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: TERM LIFE INSURANCE POLICY RENEWABLE TO AGE 100 Status of Filing in Domicile: Pending

Project Number: 8167

Date Approved in Domicile:

Requested Filing Mode: Review & Approval

Domicile Status Comments: This form is being submitted concurrently in our domiciliary state.

Explanation for Combination/Other:

Market Type: Individual

Submission Type: New Submission

Group Market Size:

Overall Rate Impact:

Group Market Type:

Filing Status Changed: 10/22/2008

State Status Changed: 10/22/2008

Deemer Date:

Corresponding Filing Tracking Number: 8167

Filing Description:

Form 8167(AR) is a term life insurance policy renewable to age 100 with different premium options at issue. Each premium option has scheduled basic premiums that are level for a specified number of years, i.e. 10, 15, 20 or 30 years.

After the specified number of years, premiums may increase, but never higher than the maximum guaranteed premiums. This policy will not be illustrated.

SERFF Tracking Number: BALT-125839708 State: Arkansas
 Filing Company: The Baltimore Life Insurance Company State Tracking Number: 40572
 Company Tracking Number: 8167
 TOI: L04I Individual Life - Term Sub-TOI: L04I.213 Specified Age or Duration -
 Fixed/Indeterminate Premium - Single Life
 Product Name: TERM LIFE INSURANCE POLICY RENEWABLE TO AGE 100
 Project Name/Number: TERM LIFE INSURANCE POLICY RENEWABLE TO AGE 100/8167

The application intended for use with this form is Form 7637(AR), which was approved by your Department on April 1, 2003

Company and Contact

Filing Contact Information

Lesia Williams, Director Policy Forms Compliance
 10075 Red Run Boulevard Owings Mills, MD 21117-4871
 lesia.williams@baltlife.com
 (800) 628-5433 [Phone]
 (410) 581-6605[FAX]

Filing Company Information

The Baltimore Life Insurance Company
 10075 Red Run Boulevard Owings Mills, MD 21117
 (410) 581-6600 ext. 3050[Phone]
 CoCode: 61212 State of Domicile: Maryland
 Group Code: 849 Company Type:
 Group Name: State ID Number:
 FEIN Number: 52-0236900

Filing Fees

Fee Required? Yes
 Fee Amount: \$125.00
 Retaliatory? No
 Fee Explanation:
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
The Baltimore Life Insurance Company	\$125.00	10/15/2008	23195061

SERFF Tracking Number: BALT-125839708 State: Arkansas
Filing Company: The Baltimore Life Insurance Company State Tracking Number: 40572
Company Tracking Number: 8167
TOI: L041 Individual Life - Term Sub-TOI: L041.213 Specified Age or Duration -
Fixed/Indeterminate Premium - Single Life
Product Name: TERM LIFE INSURANCE POLICY RENEWABLE TO AGE 100
Project Name/Number: TERM LIFE INSURANCE POLICY RENEWABLE TO AGE 100/8167

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved	Linda Bird	10/22/2008	10/22/2008

SERFF Tracking Number: *BALT-125839708* *State:* *Arkansas*
Filing Company: *The Baltimore Life Insurance Company* *State Tracking Number:* *40572*
Company Tracking Number: *8167*
TOI: *L04I Individual Life - Term* *Sub-TOI:* *L04I.213 Specified Age or Duration -*
Fixed/Indeterminate Premium - Single Life

Product Name: *TERM LIFE INSURANCE POLICY RENEWABLE TO AGE 100*
Project Name/Number: *TERM LIFE INSURANCE POLICY RENEWABLE TO AGE 100/8167*

Disposition

Disposition Date: 10/22/2008

Implementation Date:

Status: Approved

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: BALT-125839708 State: Arkansas
 Filing Company: The Baltimore Life Insurance Company State Tracking Number: 40572
 Company Tracking Number: 8167
 TOI: L041 Individual Life - Term Sub-TOI: L041.213 Specified Age or Duration -
 Fixed/Indeterminate Premium - Single Life
 Product Name: TERM LIFE INSURANCE POLICY RENEWABLE TO AGE 100
 Project Name/Number: TERM LIFE INSURANCE POLICY RENEWABLE TO AGE 100/8167

Form Schedule

Lead Form Number: 8167

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	8167(AR)	Policy/Contract/Fraternal Certificate	TERM LIFE INSURANCE POLICY RENEWABLE TO AGE 100	Initial		55	8167-ar.pdf



THE BALTIMORE LIFE INSURANCE COMPANY

10075 Red Run Bvd. Owings Mills, Maryland 21117-4871

1-800-628-5433

www.baltlife.com

TERM LIFE INSURANCE POLICY RENEWABLE TO AGE 100

This is a term life insurance policy to age 100. This *policy* insures the life of the *insured*. It also gives important benefits to *you*. Insurance is payable at the *insured's* death while this *policy* is in effect. Premiums are payable during the life of the *insured* until the *expiry date*. This *policy* terminates on the *expiry date*. This *policy* is nonparticipating and is not eligible to share in dividends. This *policy* may be converted to another policy in accordance with the conversion privilege.

This *policy* is a legal contract between *you* and *us*. **PLEASE READ IT CAREFULLY.**

TAKE A 10 DAY FREE LOOK. YOU CAN RETURN THIS POLICY TO THE AGENT WHO SOLD IT TO YOU OR TO OUR HOME OFFICE WITHIN 10 DAYS AFTER YOU RECEIVE IT. IF YOU DO, WE WILL REFUND ANY PREMIUM PAID. THE POLICY WILL THEN BE TREATED AS IF IT WERE NEVER ISSUED.

IF THIS POLICY REPLACES ANOTHER LIFE INSURANCE POLICY, YOU CAN RETURN IT TO THE AGENT WHO SOLD IT TO YOU OR TO OUR HOME OFFICE WITHIN 30 DAYS AFTER YOU RECEIVE IT. IF YOU DO, WE'LL REFUND ANY PREMIUM PAID. THE POLICY WILL THEN BE TREATED AS IF IT WERE NEVER ISSUED.


President

SPECIMEN


Secretary

Policy Guide

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POLICY DATA PAGE

THIS PAGE SHOWS SPECIFIC INFORMATION ABOUT THIS POLICY AND IS REFERRED TO THROUGHOUT THE POLICY.

POLICY NUMBER	1234567	FACE AMOUNT:	\$100,000
POLICY DATE:	AUGUST 1, 2008	EXPIRY DATE*	8/01/2073
		FINAL CONVERSION DATE	8/01/2043
INSURED:	LORD BALTIMORE	ISSUE AGE	35
OWNER:	THE INSURED		

POLICY DESCRIPTION	30 YEAR TERM LIFE INSURANCE RENEWABLE TO AGE 100
PREMIUM CLASS	STANDARD
UNDERWRITING CLASS	NON TOBACCO
ANNUAL PREMIUM	\$321.00
PREMIUM GUARANTEE PERIOD	30 YEARS**
ANNUAL INTEREST RATE FOR PAYMENT PLANS 2 AND 3	2%
ANNUAL INTEREST RATE FOR PAYMENT PLANS 4 AND 5	3%

TOTAL PREMIUM ON OTHER MODES IS AS FOLLOWS:

<u>ANNUAL</u>	<u>SEMI-ANNUAL</u>	<u>MONTHLY BANK DRAFT***</u>	<u>MONTHLY DIRECT BILL****</u>
\$321.00	\$170.13	\$28.09	\$32.10

* THE PREMIUMS FOR A BENEFIT ARE PAYABLE UNTIL THE EXPIRY DATE SHOWN, BUT NOT BEYOND THE END OF THE POLICY MONTH IN WHICH THE INSURED'S DEATH OCCURS.

** AFTER THE NUMBER OF POLICY YEARS SHOWN, THE ANNUAL PREMIUM FOR THIS COVERAGE MAY CHANGE. HOWEVER, FOR ANY GIVEN POLICY YEAR, THE ANNUAL PREMIUM WILL NEVER EXCEED THE GUARANTEED MAXIMUM AMOUNT SPECIFIED IN THE TABLE OF GUARANTEED MAXIMUM ANNUAL RENEWAL PREMIUMS.

*** MONTHLY BANK DRAFT – A RATE AVAILABLE IF WE ARE AUTHORIZED BY YOU TO RECEIVE PREMIUM PAYMENTS DIRECTLY FROM YOUR BANK ACCOUNT.

**** WE MAY SWITCH YOUR POLICY TO THIS MODE IF A MONTHLY BANK DRAFT PREMIUM PAYMENT IS NOT HONORED BY YOUR BANK. YOU MAY NOT ELECT TO PAY PREMIUMS ON THE MONTHLY DIRECT BILL MODE.

TABLE OF GUARANTEED MAXIMUM ANNUAL RENEWAL PREMIUMS

<u>COVERAGE PERIOD BEGINNING AUGUST 1</u>	<u>AGE</u>	<u>BASE POLICY ANNUAL PREMIUM</u>
2038	65	\$4,296.00
2039	66	\$4,689.00
2040	67	\$5,109.00
2041	68	\$5,556.00
2042	69	\$6,057.00
2043	70	\$6,630.00
2044	71	\$7,317.00
2045	72	\$8,100.00
2046	73	\$8,931.00
2047	74	\$9,828.00
2048	75	\$10,809.00
2049	76	\$11,898.00
2050	77	\$13,143.00
2051	78	\$14,553.00
2052	79	\$16,116.00
2053	80	\$17,904.00
2054	81	\$19,920.00
2055	82	\$22,038.00
2056	83	\$24,303.00
2057	84	\$26,802.00
2058	85	\$29,457.00
2059	86	\$32,421.00
2060	87	\$35,775.00
2061	88	\$39,291.00
2062	89	\$42,834.00
2063	90	\$45,816.00
2064	91	\$48,579.00
2065	92	\$52,173.00
2066	93	\$56,625.00
2067	94	\$61,971.00
2068	95	\$67,746.00
2069	96	\$73,509.00
2070	97	\$77,784.00
2071	98	\$80,643.00
2072	99	\$85,281.00

DEFINED TERMS

Before explaining *your* benefits, it is important to understand some of the terms that will be used throughout this *policy*. All defined terms are in *italics*.

Age means actual *age* on the *insured's* last birthday.

Attained Age means *insured's* *age* on the most recent *policy anniversary*.

Beneficiary is the person designated to receive the death benefit under this *policy*.

Expiry Date is the date this policy ends.

Grace Period is the period of time the *insured* will continue to be insured after a premium due has not been paid.

Home Office means The Baltimore Life Insurance Company, 10075 Red Run Boulevard, Owings Mills, MD 21117-4871.

Insured means the person whose life is covered under this *policy*.

Irrevocable Beneficiary is a *beneficiary* designation that cannot be changed without the consent of the person named as the *irrevocable beneficiary*.

Issue Age is the *age* of the *insured* on the *policy date*.

Owner means the person who has contractual rights under this *policy*.

Policy means the entire agreement between *you* and *us*. The *policy* includes the attached copy of the application and any attached riders, amendments, and endorsements.

Policy Anniversary occurs each year on the anniversary of the *policy date*.

Policy Date is the date this *policy* goes into effect. *Policy anniversaries* are measured from the *policy date*.

Policy Month means each successive one month period starting with the *policy date*.

Policy Year means each successive one year period starting with the *policy date*.

You and *Yours* means the *owner* of the *policy*.

We, *Our* or *Us* means The Baltimore Life Insurance Company.

BASIC POLICY FACTS

This section gives important information about *your policy*.

How To Change the Terms of This Policy

In order for changes to this *policy* to be effective, any agreements *we* make with *you* must be signed by *our* President, a Vice President or the Corporate Secretary. No other person, including an insurance agent, can:

- change any of this *policy's* terms;
- extend the time for paying premiums; or
- make any agreement that will bind *us*.

The Owner

If the *insured* is 18 years of *age* or older, he or she will be the *owner* of this *policy* unless the application names a different *owner*. If the *insured* is younger than 18 years of *age*, the *owner* will be as named in the application.

If the *owner* is not the *insured*, a contingent *owner* may be named. During the *insured's* life, unless otherwise provided, *you* as the *owner* have all the rights in this *policy*. If *you* die before the *insured*, the contingent *owner* will be the new *owner*. If there is no contingent *owner*, *your* estate becomes the new *owner*.

How to Change the Ownership of this Policy

You may change the *owner* while the *insured* is alive. A request to change the *owner* must be in writing on a form satisfactory to *us* and recorded at *our Home Office*. Keep *your policy* in a safe place, since *we* may require the *policy* to process the requested change. Once *we* record the change, it will take effect as of the date *your* request was signed. Until *we* have recorded *your* change in *our Home Office*, *we* will not be responsible for the validity of the change nor for any payment made or other action taken by *us*. *We* will send *you* written confirmation when the change is recorded. A change in *owner* may subject *you* to income and/or gift tax; please consult *your* tax advisor prior to requesting such a change.

The Beneficiary

We will pay the death benefit to the primary *beneficiary* if living at the *insured's* death. If the primary *beneficiary* has died, the death benefit will be paid to any contingent *beneficiary*. If there is no surviving *beneficiary*, *we* may pay the estate of the *insured*. If there is no estate established at the time of claim, *we* will pay whomever *we* deem to be equitably entitled, in accordance with state law and/or regulation.

You may name more than one person as primary *beneficiary* or contingent *beneficiary*. In that case, *we* will assume the death benefit is to be paid in equal shares to the surviving primary *beneficiaries* unless otherwise directed. If there are no surviving primary *beneficiaries*, *we* will pay in equal shares to the surviving contingent *beneficiaries*. *You* can specify other than equal shares.

If the *beneficiary* dies simultaneously with or within fifteen days after the death of the *insured*, we will pay the death benefit as if the *beneficiary* died before the *insured*. However, we will not be responsible for any payment we make before we are notified of the *beneficiary's* death.

How to Change the Beneficiary

You may change a *beneficiary* while the *insured* is alive. Such a request must be in writing, on a form satisfactory to us and recorded at our *Home Office*. We may require your *policy* to process the requested change. Once we record the change, it will take effect as of the date your request was signed. Until we have recorded your change in our *Home Office*, we will not be responsible for the validity of the change nor for any payment made or other action taken by us. We will send you written confirmation when the change is recorded.

You cannot change the *beneficiary*, or remove the irrevocable nature of the designation, without the consent of all *irrevocable beneficiaries*. You may name one or more *irrevocable beneficiaries*.

How to Assign the Policy

You may assign this *policy* using a form acceptable to us. An assignment does not change the ownership. You will need the written consent of all *irrevocable beneficiaries*. We will not be responsible for the validity of the assignment or any payment we make before we receive notice of the assignment at our *Home Office*.

PREMIUM PAYMENTS

The first premium is due on the *policy date*. After that, a premium is due on the first day of the period it covers.

Premium Amount

The premium amount shown on the **POLICY DATA PAGE** is based on the face amount, age, premium class, and underwriting class of the *insured*.

Where to Pay Premiums

All premiums after the first are payable at our *Home Office*. Premiums can also be paid to an authorized agent who will give you a signed receipt upon request.

When to Pay Premiums

The **POLICY DATA PAGE** shows the period and mode of premium payments. Premiums can be paid annually, semiannually, or by monthly bank draft. Premium modes other than annual will result in a higher overall total premium. On any premium due date, you can request a change in the payment mode.

Grace Period

If any premium after the first is not paid when due, this *policy* will continue in effect for 31 days. This is called the grace period. If the *insured* dies during the grace period, the unpaid premium will be deducted from the death benefit and treated as paid.

If the premium remains unpaid at the end of the grace period, this *policy* will end.

How to Reinstate This Policy

If any premium remains unpaid after the end of the grace period, *you* may request reinstatement of this *policy*. *You* must do this within five years from the due date of the first unpaid premium.

You will have to provide evidence satisfactory to *us* that the *insured's* insurability has not changed since this *policy* was issued. *You* will also have to pay all unpaid premiums plus interest at 6% per year, compounded annually.

The *policy* will be contestable for two years from the effective date of reinstatement. (See **CONTESTING THIS POLICY**.)

DEATH BENEFIT

We will pay the death benefit to the *beneficiary*. The death benefit is payable as provided in this *policy* from *our Home Office* when *we* receive due proof that the *insured* has died while this *policy* is in effect. *We* will pay interest on the death benefit if required in accordance with the laws of the state in which this *policy* was issued. When *we* pay the death benefit, this *policy* will end.

Determining the Death Benefit

The death benefit will include:

- the face amount provided by this *policy*, as shown on the **POLICY DATA PAGE**;
- any insurance provided by riders; and
- the part of any premium paid for a period beyond the policy month of death.

Paying The Death Benefit

The death benefit can be paid in cash or under one of our payment plans. Before the *insured* dies, *you* can choose how the death benefit is to be paid. After the *insured* dies, the *beneficiary* can choose the manner of payment unless prior to that death *you* tell *us* otherwise in writing. For details see **PAYMENT PLANS**.

CONVERSION PRIVILEGE

If this *policy* was issued in a standard premium class *you* can convert this *policy* to a new permanent life insurance policy on the life of the *insured*. The conversion may be made anytime prior to the Final Conversion Date shown on the **POLICY DATA PAGE**, while this *policy* remains in effect. If this *policy* was issued in a premium class other than standard then the *policy* is not eligible for conversion. Any riders attached to this *policy* are not eligible for conversion. Conversion of the *policy* is subject to the following:

1. A written application for the new policy must be completed and submitted to *our Home Office* any time prior to the Final Conversion Date.

2. The face amount of the new policy must be at least as great as the minimum face amount for the new policy's plan of insurance at the time of the conversion, but it may not exceed the face amount of this *policy* at the time of the conversion.
3. The new policy will take effect when you pay the first premium for it. The premium for the new policy will be based on the *age* of the *insured* on the *policy date* of the new policy.
4. This *policy* will end when insurance under the new policy begins. The premium class, underwriting class, and any restrictions applicable to this *policy* will apply to the new policy. No evidence of insurability is required for the new policy.
5. The *policy date* of the new policy will be the date to which premiums for this *policy* have been paid.
6. The new policy can be any permanent life insurance plan offered by *us* for this purpose on the date of the conversion, with the same risk class as this *policy*. At least one plan of life insurance will be available for the conversion. If the risk classification is not available on the new policy, the risk classification will be the one *we* determine to be the most comparable.
7. The new policy will be issued at the *insured's attained age* on his/her last birthday as of the *policy date* of the new policy.
8. Benefits, in addition to life insurance, may be added to the new policy, subject to requirements established by *us*.
9. Written consent of all irrevocable beneficiaries and/or assignees is required.

PAYMENT PLANS

While the *insured* is alive, *you* can choose how the policy proceeds will be paid by selecting a payment plan. If no plan is chosen before the *insured's* death, the *beneficiary* can choose a plan. The *beneficiary* must do this within six months after the *insured's* death and before any proceeds have been paid. If no payment plan is chosen, proceeds will be payable in a single sum. Proceeds will be payable to the recipient under the chosen plan.

We will also pay the proceeds in a single sum if:

- the proceeds are less than \$5,000;
- the recipient is not a natural person (for example, a corporation is not a natural person);
- *you* change the *beneficiary* after *you* choose a payment plan; or
- the *policy* is assigned.

We may make payments of proceeds into an interest bearing account owned by the *beneficiary*. However, *you* may opt out of this arrangement, by written request.

Each payment under a plan must be at least \$20. When a plan goes into effect, this *policy* must be returned to *us*. We will then issue a plan agreement for the chosen plan. Payments under a plan cannot be assigned.

Payment Plan 1 - Deposit With Interest

Proceeds are left on deposit and earn interest at an annual rate declared by *us*, but never less than 1% per year. The right to withdraw money under this plan will be shown in the new agreement.

Payment Plan 2 - Payments for a Definite Period

Proceeds will be paid in equal installments for a chosen number of years, up to 30. Installments may be paid annually, semiannually, quarterly, or monthly. The balance of any remaining value may be withdrawn at any time. The table below shows the amount of monthly payments.

Payments for a Definite Period Table

(Monthly payment for each \$1,000 of proceeds. Payments begin one month after proceeds are applied under this payment plan.)

Period in Years	Payment	Period in Years	Payment
1	\$84.23	16	\$6.08
2	42.53	17	5.78
3	28.63	18	5.51
4	21.69	19	5.27
5	17.52	20	5.05
6	14.74	21	4.85
7	12.76	22	4.68
8	11.27	23	4.51
9	10.12	24	4.37
10	9.19	25	4.23
11	8.44	26	4.10
12	7.81	27	3.99
13	7.28	28	3.88
14	6.82	29	3.78
15	6.43	30	3.69

Payment amount for frequencies other than monthly will be provided on request.

Payment Plan 3 - Payments of a Definite Amount

Proceeds of a chosen amount will be paid annually, semiannually, quarterly, or monthly. Payments in each year must equal at least 5% of the proceeds. Payments will continue until the principal and interest are fully paid. The balance of any remaining value may be withdrawn at any time.

Payment Plan 4 - Income for Life

Proceeds will be paid in equal monthly installments for as long as the recipient lives. However, payments will never be made for a period less than the guaranteed number of years chosen. This guaranteed period can be 10 or 20 years. Payments will be made according to the table below.

Income for Life Table

(Monthly payment for each \$1,000 of proceeds. Age shown is the recipient's age when proceeds are applied under this payment plan. Payments begin one month after proceeds are applied under this payment plan.)

<i>Age of Recipient</i>	Male Guaranteed Period		Female Guaranteed Period	
	10 Years	20 Years	10 Years	20 Years
15 and under	\$2.91	\$2.91	\$2.85	\$2.85
16	2.93	2.92	2.86	2.86
17	2.94	2.94	2.87	2.87
18	2.96	2.95	2.89	2.89
19	2.98	2.97	2.90	2.90
20	2.99	2.99	2.92	2.91
21	3.01	3.00	2.93	2.93
22	3.03	3.02	2.95	2.94
23	3.05	3.04	2.97	2.96
24	3.07	3.06	2.98	2.98
25	3.09	3.08	3.00	3.00
26	3.11	3.10	3.02	3.01
27	3.13	3.12	3.04	3.03
28	3.16	3.15	3.06	3.05
29	3.18	3.17	3.08	3.07
30	3.21	3.20	3.10	3.09
31	3.23	3.22	3.12	3.12
32	3.26	3.25	3.15	3.14
33	3.29	3.28	3.17	3.16
34	3.32	3.31	3.20	3.19
35	3.35	3.34	3.23	3.22
36	3.39	3.37	3.25	3.24
37	3.42	3.40	3.28	3.27
38	3.46	3.44	3.32	3.30
39	3.50	3.47	3.35	3.33
40	3.54	3.51	3.38	3.37
41	3.58	3.55	3.42	3.40

<i>Age of Recipient</i>	Male		Female	
	Guaranteed Period		Guaranteed Period	
	10 Years	20 Years	10 Years	20 Years
42	3.63	3.59	3.46	3.43
43	3.67	3.63	3.49	3.47
44	3.72	3.67	3.54	3.51
45	3.77	3.72	3.58	3.55
46	3.83	3.76	3.62	3.59
47	3.88	3.81	3.67	3.63
48	3.94	3.86	3.72	3.68
49	4.00	3.91	3.77	3.72
50	4.06	3.96	3.83	3.77
51	4.13	4.02	3.88	3.82
52	4.20	4.07	3.94	3.88
53	4.27	4.13	4.01	3.93
54	4.35	4.19	4.07	3.99
55	4.43	4.25	4.14	4.05
56	4.51	4.31	4.22	4.11
57	4.60	4.38	4.30	4.17
58	4.70	4.44	4.38	4.23
59	4.80	4.51	4.46	4.30
60	4.90	4.57	4.56	4.37
61	5.01	4.64	4.65	4.44
62	5.13	4.71	4.75	4.51
63	5.25	4.77	4.86	4.58
64	5.38	4.84	4.98	4.66
65	5.51	4.90	5.10	4.73
66	5.65	4.96	5.22	4.80
67	5.79	5.02	5.36	4.87
68	5.94	5.08	5.50	4.94
69	6.10	5.13	5.65	5.01
70	6.26	5.18	5.81	5.07
71	6.42	5.23	5.97	5.13
72	6.59	5.27	6.14	5.19
73	6.76	5.31	6.32	5.24
74	6.94	5.34	6.51	5.28
75	7.11	5.38	6.70	5.33
76	7.29	5.40	6.90	5.36
77	7.47	5.43	7.10	5.39
78	7.64	5.45	7.30	5.42
79	7.82	5.46	7.50	5.44
80 and over	7.99	5.48	7.70	5.46

Payment Plan 5 - Joint Life and Survivor Annuity Payments

Proceeds will be paid jointly in equal monthly installments for as long as both designated recipients are alive. If either dies, monthly payments to the survivor will continue for life at $\frac{2}{3}$ of the original amount. Original payment amounts are shown in the Table below.

Joint Life and Survivor Annuity Payments Table

(Monthly payment for each \$1,000 of proceeds. Ages shown are the ages of the recipients when proceeds are applied under this payment plan. Payments begin one month after proceeds are applied under this payment plan.)

Male Age	Female Age						
	50	55	60	65	70	75	80
50	3.81	3.96	4.13	4.32	4.52	4.75	4.99
55	3.95	4.13	4.33	4.55	4.80	5.07	5.35
60	4.10	4.31	4.55	4.82	5.12	5.45	5.80
65	4.27	4.51	4.79	5.12	5.49	5.92	6.36
70	4.45	4.72	5.05	5.44	5.91	6.45	7.04
75	4.64	4.94	5.31	5.78	6.35	7.04	7.81
80	4.82	5.15	5.58	6.11	6.79	7.64	8.65

Payment amounts for ages not shown in the table will be provided on request.

Additional Payment Plan Facts

Another payment plan acceptable to *us* can be arranged.

If all persons receiving proceeds under a payment plan die, *we* will make a single sum payment of any amount still due. For Plan 1, the single sum payment will be proceeds left on deposit with *us*. For Plans 2, 3, and 4, the single sum payment will be the discounted value of any guaranteed unpaid installments. For Plan 5, the single sum payment is zero. *You* may name a person to receive the single sum payment. The recipient can name someone if *you* did not. If no one has been named, *we* will pay the estate of the recipient.

Annual interest rates for payment plans 2, 3, 4 and 5 are shown on the **POLICY DATA PAGE**. Additional interest may be allowed under Plans 1, 2, and 3 at rates declared by *us* from time to time. Payments under Plans 4 and 5 are based on the Annuity 2000 Mortality Table.

We will require satisfactory evidence of the age and survival of any recipient under Plans 4 and 5.

Amounts held by *us* under all payment plans will be free from claims of creditors to the extent allowed by law.

We can delay payment for up to six months after we receive a request for money which is payable under any of these plans.

OTHER IMPORTANT TERMS

This Policy Is a Contract

This *policy* is a contract. In entering into this contract, we relied on the accuracy of the statements made in the application. In the absence of fraud, these statements are considered representations and not warranties. We can contest this *policy* and use statements made in the application in defense of a claim if the application contains a material misstatement and a copy of it was attached to this *policy* when issued.

Contesting This Policy

We will not contest this *policy* after it has been in effect during the insured's lifetime for two years from the *policy date*, except: (a) for nonpayment of premium; and (b) with respect to any additional benefit providing coverage for disability or accidental death.

A new period of contestability begins if the *policy* is reinstated. We will not contest this *policy* based on statements made in the reinstatement application after this *policy* has been in effect during the *insured's* lifetime for two years from the reinstatement date. However, we can contest any additional benefit that provides coverage for disability or accidental death.

Mistake in Age

If the *insured's age* shown in the application is misstated, *policy* benefits will be based on the face amount that the premium paid would have bought at the true *age*.

Suicide

If the *insured* commits suicide, while sane or insane, within two years after the *policy date*, the death benefit payable under this *policy* will be limited to the sum of all premiums paid. This amount will be paid to the beneficiary in a single sum.

When the laws of the state in which this *policy* is delivered require less than this two year period, the period will be as stated in such laws.

Nonparticipating

This *policy* is nonparticipating and is not eligible to share in dividends.

Conformity with State Law

This *policy* will be governed under the laws of the state where the *policy* is issued, which is defined as the state in which the application was signed.

Written Notices

Send any required written notice to *our Home Office* at:

**The Baltimore Life Insurance Company
10075 Red Run Boulevard
Owings Mills, Maryland 21117-4871**

Please include the *policy* number.

If we at The Baltimore Life Insurance Company fail to provide you with reasonable and adequate service, you should feel free to contact:

Arkansas Insurance Department
Consumer Services Division
1200 West Third Street
Little Rock, Arkansas 72201
1-800-852-5494



TERM LIFE INSURANCE POLICY RENEWABLE TO AGE 100

This is a term life insurance policy to age 100. This *policy* insures the life of the *insured*. It also gives important benefits to *you*. Insurance is payable at the *insured's* death while this *policy* is in effect. Premiums are payable during the life of the *insured* until the *expiry date*. This *policy* terminates on the *expiry date*. This *policy* is nonparticipating and is not eligible to share in dividends. This *policy* may be converted to another policy in accordance with the conversion privilege.

The Baltimore Life Insurance Company
10075 Red Run Boulevard
Owings Mills, Maryland 21117-4871
1-800-628-5433
A Stock Company
www.baltlife.com

SERFF Tracking Number: *BALT-125839708* *State:* *Arkansas*
Filing Company: *The Baltimore Life Insurance Company* *State Tracking Number:* *40572*
Company Tracking Number: *8167*
TOI: *L041 Individual Life - Term* *Sub-TOI:* *L041.213 Specified Age or Duration -*
Fixed/Indeterminate Premium - Single Life

Product Name: *TERM LIFE INSURANCE POLICY RENEWABLE TO AGE 100*
Project Name/Number: *TERM LIFE INSURANCE POLICY RENEWABLE TO AGE 100/8167*

Rate Information

Rate data does NOT apply to filing.

SERFF Tracking Number: BALT-125839708 State: Arkansas
Filing Company: The Baltimore Life Insurance Company State Tracking Number: 40572
Company Tracking Number: 8167
TOI: L041 Individual Life - Term Sub-TOI: L041.213 Specified Age or Duration -
Fixed/Indeterminate Premium - Single Life
Product Name: TERM LIFE INSURANCE POLICY RENEWABLE TO AGE 100
Project Name/Number: TERM LIFE INSURANCE POLICY RENEWABLE TO AGE 100/8167

Supporting Document Schedules

Review Status:

Satisfied -Name: Certification/Notice 10/01/2008

Comments:

We certify that this submission meets the provisions of Regulations 19, as well as all of the applicable requirements of the department.

Review Status:

Satisfied -Name: Application 10/01/2008

Comments:

The application intended for use with this form is Form 7637(AR), which was approved by your Department on April 1, 2003.

Attachment:

7637-AR.pdf



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 Insured

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 _____

a. 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 _____
 - 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

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

- | | |
|--|--|
| <p>a) Cysts, tumors, any kind of cancer, including melanoma? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>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? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>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? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>d) Asthma, hay fever, chronic cough, bronchitis, emphysema, spitting blood, tuberculosis, or any other disorder of lungs or respiratory system? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> | <p>e) Hernia, gallbladder disorder, ulcers, colitis, disease or disorder of stomach, intestines, or other digestive or swallowing complaints? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>f) Diabetes, thyroid, or other endocrine disorder? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>g) Anemia, Leukemia or other blood disorder? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>h) Jaundice, disease or disorder of kidneys, liver, bladder; male or female reproductive organs; sugar, albumin, blood, or pus in urine? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>i) Any form of arthritis; rheumatism; bone; joint; back disorder; lameness; loss of limb; or deformity? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>j) Any defect of sight, speech, or hearing? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>k) Disorder of nose or throat? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>l) Alcoholism, narcotic addiction, or drug habituation? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> |
|--|--|

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

- | | |
|--|--|
| <p>a) Had any disease, disorder, injury, or operation which has not been previously mentioned? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>b) Consulted or been treated by a doctor or other practitioner? <i>(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.)</i> <input type="checkbox"/> Yes <input type="checkbox"/> No</p> | <p>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? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>d) Had X-rays, electrocardiograms, or other medical tests or studies? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>e) Been under the care of a physician, or taken treatment or medication for any reason? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> |
|--|--|

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

- a) AIDS (Acquired Immune Deficiency Syndrome), ARC (AIDS Related Complex)* 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
- * AIDS Related Complex (ARC) is a condition with signs and symptoms which may include generalized lymphadenopathy (swollen lymph nodes), loss of appetite, weight loss, fever, infections of the tongue, palate, cheeks or lips, skin rashes, unexplained infections, dementia, depression or other psychoneurotic disorders with no known cause.

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

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 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 _____

\$50,000 - \$100,000 \$100,000 - \$250,000
 More than \$100,000 More than \$250,000

2. Does the Proposed Insured(s) have any obvious physical impairments? Yes No

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

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

11. Is the insurance applied for to be used in connection with, or as part of, a pension plan? 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

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:

5. Is a medical exam required? Yes No

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. _____

6. Check which items below have been requested:
 Paramedical Exam by Medical Doctor
 EKG Urine Specimen
 X-Ray Blood chemical profile
 APS \$ _____ fee

b. Do you certify that this replacement is within the guidelines provided by The Baltimore Life Insurance Company? Yes No

Exam date: _____ By: _____
at: _____

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 _____

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

Was a Needs Analysis completed? Yes No

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

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 Automatic 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.