

SERFF Tracking Number: BALT-126232474 State: Arkansas
Filing Company: The Baltimore Life Insurance Company State Tracking Number: 42992
Company Tracking Number: 437-0709
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
Product Name: APPLICATION FOR POLICY CHANGE
Project Name/Number: APPLICATION FOR POLICY CHANGE/437-0709

Filing at a Glance

Company: The Baltimore Life Insurance Company

Product Name: APPLICATION FOR POLICY CHANGE SERFF Tr Num: BALT-126232474 State: Arkansas
CHANGE

TOI: L08 Life - Other

SERFF Status: Closed-Approved- State Tr Num: 42992
Closed

Sub-TOI: L08.000 Life - Other

Co Tr Num: 437-0709

State Status: Approved-Closed

Filing Type: Form

Reviewer(s): Linda Bird

Author: Lesia Williams

Disposition Date: 07/27/2009

Date Submitted: 07/17/2009

Disposition Status: Approved-
Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: APPLICATION FOR POLICY CHANGE

Status of Filing in Domicile: Pending

Project Number: 437-0709

Date Approved in Domicile:

Requested Filing Mode: Review & Approval

Domicile Status Comments:

Explanation for Combination/Other:

Market Type: Individual

Submission Type: New Submission

Group Market Size:

Overall Rate Impact:

Group Market Type:

Filing Status Changed: 07/27/2009

Explanation for Other Group Market Type:

State Status Changed: 07/27/2009

Deemer Date:

Created By: Lesia Williams

Submitted By: Lesia Williams

Corresponding Filing Tracking Number: 437-
0709

Filing Description:

Attached for your review and formal approval is the above captioned form. This is a new form that will supersede Form 437-0100(AR), which was approved by your department on March 9, 2000.

Form 437-0709(AR) will be used to make contractual as well as non-contractual policy changes. We certify that this submission meets the provisions of Regulations 19, as well as all of the applicable requirements of the department.

Company and Contact

SERFF Tracking Number: BALT-126232474 State: Arkansas
 Filing Company: The Baltimore Life Insurance Company State Tracking Number: 42992
 Company Tracking Number: 437-0709
 TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
 Product Name: APPLICATION FOR POLICY CHANGE
 Project Name/Number: APPLICATION FOR POLICY CHANGE/437-0709

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
 Group Code: 849
 Group Name:
 FEIN Number: 52-0236900
 State of Domicile: Maryland
 Company Type:
 State ID Number:

Filing Fees

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

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
The Baltimore Life Insurance Company	\$125.00	07/17/2009	29268956

SERFF Tracking Number: BALT-126232474 State: Arkansas
Filing Company: The Baltimore Life Insurance Company State Tracking Number: 42992
Company Tracking Number: 437-0709
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
Product Name: APPLICATION FOR POLICY CHANGE
Project Name/Number: APPLICATION FOR POLICY CHANGE/437-0709

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	07/27/2009	07/27/2009

SERFF Tracking Number: BALT-126232474 State: Arkansas
Filing Company: The Baltimore Life Insurance Company State Tracking Number: 42992
Company Tracking Number: 437-0709
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
Product Name: APPLICATION FOR POLICY CHANGE
Project Name/Number: APPLICATION FOR POLICY CHANGE/437-0709

Disposition

Disposition Date: 07/27/2009

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: BALT-126232474 State: Arkansas
 Filing Company: The Baltimore Life Insurance Company State Tracking Number: 42992
 Company Tracking Number: 437-0709
 TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
 Product Name: APPLICATION FOR POLICY CHANGE
 Project Name/Number: APPLICATION FOR POLICY CHANGE/437-0709

Form Schedule

Lead Form Number: 437-0709

Schedule Item Status	Form Number	Form Type Form Name	Action	Action Specific Data	Readability	Attachment
	437-0709(AR)	Application/ Enrollment Form	Initial	APPLICATION FOR POLICY CHANGE	56.000	437-0709-ar.pdf



APPLICATION FOR POLICY CHANGE

Policy Number _____ Name of Insured _____
 Address _____ City _____ State _____ Zip Code _____
 Home Phone _____ Work Phone _____ Cell Phone _____
 Date of Birth ___/___/___ Social Security # ___-___-___ Email Address _____
 Requested Date of Change ___/___/___

Submit policy for Section A & Section B Traditional Products and Change of Plans. Proof of age at issue must be submitted with application.

A. Plan Change

Change Plan of Insurance	from _____	to _____	New Policy # _____ (Home Office Use Only)
Face Amount:	from _____	to _____	Age at Issue: from ___ to ___
Other changes	_____ _____		

Note: If exercising a conversion option under term insurance or under a Family Plan Policy or rider, or exercising a Purchase Option under GIO or IOM; or adding additional insured on an interest sensitive product; show premium collected and select dividend option below.

___ Premium Collected with Application \$ _____	___ Revised Interest-Sensitive Premium \$ _____
Dividend Option: ___ Cash ___ Premium Reduction ___ Interest ___ Additions (One-Year term dividend option - refer to section C)	
___ Conversion Credits to pay premium ___ Conversion Credits used to purchase a SPAIR (minimum amount is \$100.00)	

B. For desired change insert below either A-ADD, C-CANCEL, or R-REDUCE

Traditional Products	Interest - Sensitive Products
___ Premium Waiver	___ Death Benefit Options
___ Accidental Death Benefit	___ Option 1 - Level ___ Option 2 - Increasing
___ Payor Death & Disability Waiver Rider	Additional Insured Rider \$ _____
___ Decreasing Term Rider \$ _____ for _____ years	___ Disability Benefit Rider ___ Option A ___ Option B
___ Children's Rider - Amount \$ _____* (Children must meet age requirement) ___ inclusion of child*	___ Accidental Death Benefit \$ _____
___ Level Term Rider \$ _____ for _____ years	___ Children's Rider - Amount \$ _____* (Children must meet age requirement) ___ inclusion of child*
___ Substandard or Extra Rating	___ Substandard or Extra Rating for _____ (person)
___ Additional Benefit Rider \$ _____	
___ Single Premium ___ Payable with base coverage	___ Term Rider \$ _____
___ Other _____	___ Other _____

*For items identified above, complete the information in the following chart.

Name	Social Security Number	Sex	Date of Birth Mo.Day.Yr	Height Ft. In	Weight Lbs..	Wt Change in Past Year (explain if over 10lbs)	Occupation
Primary Insured							
Other/Additional Insured							
Child							
Child							
Child							
Child							

If requesting a policy change which requires underwriting approval, please provide the name and address of the personal physician or the physician(s) most familiar with medical histories of the proposed insured(s).

Proposed Insured	Physician Name and Address

C. Smoking Status

Name	Do you or have you ever-smoked cigarettes?	If stopped, provide date	Do you or have you ever used nicotine or tobacco products in any other form?	If stopped, provide date
Primary Insured				
Spouse				
Other/Additional Insured				

D. Dividend Option Requiring Underwriting

<input type="checkbox"/> One-Year Term Dividend Option , Balance to:	<input type="checkbox"/> Additions	<input type="checkbox"/> Accumulations
<input type="checkbox"/> Use Dividend Accumulations to Purchase Paid-Up additions		

E. Replacement Information

- Do any proposed insureds (including children) have existing life or disability insurance or annuities, or have any policies been lapsed or surrendered within the last six months? Yes No
If "Yes", policy status is: In force Terminated
- Will this policy, if issued, replace or modify life or disability insurance or annuities in this or any other Company? (This includes the use of dividends or other policy values to pay premium of any new policy.) Yes No
Yes No
- Is any other application for life or disability insurance pending in this or any other company on any insured? Yes No
List all existing life insurance and annuities.

Name of Insured	Company	Policy Number	Amount\$	Type	Year Issued	Accidental Death	Replace or modify?
							<input type="checkbox"/> Yes <input type="checkbox"/> No
							<input type="checkbox"/> Yes <input type="checkbox"/> No
							<input type="checkbox"/> Yes <input type="checkbox"/> No
							<input type="checkbox"/> Yes <input type="checkbox"/> No

F. Medical Information

	YES	NO
1. Has any person proposed for insurance:		
a. Had any application for life or health insurance declined, postponed, or modified in any way, or been refused issue, renewal, or reinstatement?.....	<input type="checkbox"/>	<input type="checkbox"/>
b. Within the past five years used marijuana, narcotics, hallucinogenic, barbiturates, amphetamines tranquilizers, except as prescribe by a physician, or been convicted for possession or sale of any of the above?	<input type="checkbox"/>	<input type="checkbox"/>
c. With the last two years, been refused a driver's license, had a license revoked or suspended, or had there or more moving violations or accidents.....	<input type="checkbox"/>	<input type="checkbox"/>
2. Has any of the proposed insured(s) ever had medical treatment for:		
a. Disease or disorder of heart or blood vessels, any shortness or breath , chest pain, swelling of ankles, high blood pressure, rheumatic fever, anemia, or other blood or circulatory disorder?.....	<input type="checkbox"/>	<input type="checkbox"/>
b. Disease or disorder of brain or nervous system, paralysis, dizziness, fainting spells, convulsions, epilepsy, hallucinations, nervousness, mental disorder?.....	<input type="checkbox"/>	<input type="checkbox"/>
c. Asthma, hay fever, chronic cough, bronchitis, emphysema, spitting blood, tuberculosis, or any other disorder of the lungs or respiratory system?	<input type="checkbox"/>	<input type="checkbox"/>
d. Hernia, gallbladder disorder, ulcers disease or disorder of stomach, intestines, or other digestive complaints?.....	<input type="checkbox"/>	<input type="checkbox"/>
e. Diabetes, thyroid, or glandular disorder?.....	<input type="checkbox"/>	<input type="checkbox"/>
f. Jaundice, disease or disorder of kidneys, liver bladder, male or female reproductive organs, sugar, albumin blood or pus in urine?	<input type="checkbox"/>	<input type="checkbox"/>
g. Cysts, tumor, cancer, disease or disorder of skin or breast?.....	<input type="checkbox"/>	<input type="checkbox"/>
h. Any form of arthritis, rheumatism bone joint black disorder lameness, loss of limb or deformity?.....	<input type="checkbox"/>	<input type="checkbox"/>
i. Any defect of sight, speech, hearing, or discharging of ears?	<input type="checkbox"/>	<input type="checkbox"/>
j. Alcoholism, narcotic addictions or drug habituation?.....	<input type="checkbox"/>	<input type="checkbox"/>
3. Are any of the proposed insured(s) now under the care of a physician, or taking treatment or medication for any reason?	<input type="checkbox"/>	<input type="checkbox"/>
4. Other than above, has 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?.....	<input type="checkbox"/>	<input type="checkbox"/>
b. Consulted or been treated by a doctor or other practitioner? (If consultation was for a "check-up", explain fully. Include purpose, symptoms and findings. Give full names and addresses of all physicians.).....	<input type="checkbox"/>	<input type="checkbox"/>
5. Ever been a patient under treatment or observation in any hospital, clinic asylum, sanatorium, or any private or government facility performing similar services?	<input type="checkbox"/>	<input type="checkbox"/>
6. Ever had X-rats, electrocardiograms, or other medical test or studies?	<input type="checkbox"/>	<input type="checkbox"/>
7. Have you been diagnosed by or received treatment from a member of the medical profession for AIDS (Acquired Immune Deficiency Syndrome) or any other disorder of the immune system, including systemic Lupus, or have you tested positive for exposure to the HIV infection?	<input type="checkbox"/>	<input type="checkbox"/>

Details in Connection with questions, answered "Yes"

Question Number	Name of Person to Whom the Answer Applies	Date of History	Give full details for each question answered "Yes," including nature of illness or injury, number of attacks, duration, severity, treatment, results, name and address of doctors, hospital or clinic involved.

G. Authorization and Disclosures

It is agreed that all answers and statements in the application are complete and true to the best of my knowledge and belief.

I authorize any physician or other medical professional, any hospital or other medical care institution, prescription record service, Medical Information Bureau, any consumer reporting agency, any insurance company and any other organization to release certain information to The Baltimore Life Insurance Company, its reinsurer(s) and any consumer reporting agency acting on the Company's behalf. The information authorized for release is any record or other knowledge as to the health, medical treatment or advice, and other insurance coverage of myself and of any children who are to be insured.

I understand that if I provide any false or incomplete answers, and/or if the health of the Proposed Insured changes before the policy effective date and I don't notify The Baltimore Life Insurance Company (the Company) of such changes, then benefits may be denied or the policy may be rescinded. My policy will not take effect unless the first premium is paid in full and the application is approved by the Company. I understand that no agent is authorized to advise me that an inaccurate answer is acceptable.

When I sign the application, I understand, I am authorizing the MIB Group, Inc. ("MIB"), any medical or medically-related person or facility to provide health and/or treatment information about the proposed Insured to the Company. I understand that such information will be used to determine eligibility for insurance and/or benefits. Any information used will be subject to the Company's Notice of Privacy and Information Practices which is provided with my policy, or upon request. 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 have received the MIB pre-notification.

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 form 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.

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.

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

Signature of Proposed Insured Signature of Proposed Owner, if other than Proposed Insured

Spouse's Signature _____ Spouse's Social Security Number _____ Date _____
Signature and social security number of owner's spouse is required for all community property states, which include Arizona, California, Idaho, Louisiana, Nevada, New Mexico, Texas, Washington, and Wisconsin.

To Be Given To Applicant



Pre- Notification - 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: 50 Braintree Hill, Suite 400, Braintree, MA 02184-8734, (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.

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.

CONDITIONAL RECEIPT

YOUR REQUEST FOR AN INCREASE IN COVERAGE IS NOT APPROVED 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 policy change application;
- b) Premium payments made by check or 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 policy change application;
- d) The Proposed Insured is, on the date of the application for policy change and continuing until the request is approved, 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 or rider as applied for will cancel any insurance under this Receipt); and
- e) The policy change application request 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 policy change 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 policy change application. We may terminate coverage under this receipt by notice to you. Coverage under this Receipt terminates 60 days from the date of the policy change application. The suicide period starts anew for any increase in coverage and suicide, if committed while sane or insane, would result solely in a refund of premium. Any increase in coverage is subject to a two-year contestability period.

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 policy change 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.

RECEIVED FROM _____ POLICY NUMBER _____

AGENT _____ DATE _____

AGENCY _____

THIS RECEIPT SHOULD BE RETAINED BY THE POLICY OWNER UNTIL THE REQUESTED CHANGE HAS BEEN COMPLETED.

SERFF Tracking Number: BALT-126232474 State: Arkansas
Filing Company: The Baltimore Life Insurance Company State Tracking Number: 42992
Company Tracking Number: 437-0709
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
Product Name: APPLICATION FOR POLICY CHANGE
Project Name/Number: APPLICATION FOR POLICY CHANGE/437-0709

Supporting Document Schedules

	Item Status:	Status Date:
Satisfied - Item: Flesch Certification Comments: Attachment: ar-read.pdf		

	Item Status:	Status Date:
Bypassed - Item: Application Bypass Reason: N/A Comments:		

THE BALTIMORE LIFE INSURANCE COMPANY
10075 Red Run Boulevard • P.O. Box 1060 • Owings Mills, Maryland 21117-6050
(410) 581-6600

CERTIFICATION OF READABILITY

This is to certify that Form 437-0709(AR) meets the minimum reading ease score for the State of Arkansas on the Flesch reading ease test.

Score 56



Vice President

July 16, 2009

Date