Filing at a Glance

Company: The Baltimore Life Insurance Company

Product Name: TERM LIFE INSURANCE POLICY	SERFF Tr Num: BALT-126707058	State: Arkansas
TOI: L04I Individual Life - Term	SERFF Status: Closed-Approved-Closed	State Tr Num: 46142
Sub-TOI: L04I.213 Specified Age or Duration - Fixed/Indeterminate Premium - Single Life	Co Tr Num: 8167-0610	State Status: Approved-Closed
Filing Type: Form		Reviewer(s): Linda Bird
	Author: Lesia Williams	Disposition Date: 07/08/2010
	Date Submitted: 07/07/2010	Disposition Status: Approved-Closed
Implementation Date Requested: On Approval		Implementation Date:
State Filing Description:		

General Information

Project Name: TERM LIFE INSURANCE POLICY	Status of Filing in Domicile: Pending
Project Number: 8167-0610	Date Approved in Domicile:
Requested Filing Mode: Review & Approval	Domicile Status Comments: This form is being filed in Maryland, our domiciliary state via the Interstate Compact and is currently pending.
Explanation for Combination/Other:	Market Type: Individual
Submission Type: New Submission	Group Market Size:
Overall Rate Impact:	Group Market Type:
Filing Status Changed: 07/08/2010	Explanation for Other Group Market Type:
	State Status Changed: 07/08/2010
Deemer Date:	Created By: Lesia Williams
Submitted By: Lesia Williams	Corresponding Filing Tracking Number: 8167-0610

Filing Description:

Attached for your review and formal approval are the final versions of Form 8167-0610(AR) and Form 8168(AR). These are new forms and will not supersede any previously approved forms.

Form 8167-0610(AR) is a term life insurance policy renewable to age 100 with different premium payment options chosen at issue. Each premium payment option has scheduled basic premiums that are level for a specified number of years, i.e. 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.

Form 8168(AR) is an application. It is intended to be used electronically in conjunction with policy Form 8167-0610(AR).

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

Filing Contact Information

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

Filing Company Information

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

Filing Fees

Fee Required?	Yes
Fee Amount:	$250.00
Retaliatory?	Yes
Fee Explanation:	125/form
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
The Baltimore Life Insurance Company	$250.00	07/07/2010	37781712

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	07/08/2010	07/08/2010

Amendments

Schedule	Schedule Item Name	Created By	Created On	Date Submitted
Supporting Document	Flesch Certification	Lesia Williams	07/07/2010	07/07/2010

Disposition

Disposition Date: 07/08/2010

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*BALT-126707058*	*State:*	*Arkansas*
Filing Company:	*The Baltimore Life Insurance Company*	*State Tracking Number:*	*46142*
Company Tracking Number:	*8167-0610*		
TOI:	*L04I Individual Life - Term*	*Sub-TOI:*	*L04I.213 Specified Age or Duration - Fixed/Indeterminate Premium - Single Life*
Product Name:	*TERM LIFE INSURANCE POLICY*		
Project Name/Number:	*TERM LIFE INSURANCE POLICY/8167-0610*		

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document *(revised)*	Flesch Certification		Yes
Supporting Document	Flesch Certification	Replaced	Yes
Supporting Document	Application		Yes
Supporting Document	Life & Annuity - Acturial Memo		No
Supporting Document	Specimen Pages		Yes
Form	Term Life Insurance Policy		Yes
Form	Application for Life Insurance		Yes

Amendment Letter

Submitted Date: 07/07/2010

Comments:

The wrong Readability Certification was included in the initial submission. Attached is the correct Readability Certification. Our apologies for any inconvenience.

Changed Items:

Supporting Document Schedule Item Changes:

Satisfied -Name: Flesch Certification

Comment:

ar-read.pdf

Form Schedule

Lead Form Number: 8167-0610

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	8167-0610(AR)	Policy/Contract/Fraternal Certificate	Term Life Insurance Policy	Initial		50.600	8167-0610-ar.pdf
	8168(AR)	Application/Enrollment Form	Application for Life Insurance	Initial		50.000	8168-ar.pdf

THE BALTIMORE LIFE INSURANCE COMPANY

10075 Red Run Blvd. Owings Mills, Maryland 21117-4871
1-800-628-5433
www.baltlife.com

TERM LIFE INSURANCE POLICY

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 renewable annually to age 100.

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

<u>TAKE A 10 DAY FREE LOOK.</u> 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

Major Section **Page**

Policy Data Page 1
Defined Terms 2
Basic Policy Facts 3
Premium Payments 4
Death Benefit 5
Conversion Privilege 6
Other Important Terms 7
Riders/Endorsements
Copy of Application(s)

POLICY DATA PAGE

POLICY INFORMATION

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

POLICY NUMBER	[1234567]	FACE AMOUNT:	[$100,000]
POLICY DATE:	[08/01/2010]	EXPIRY DATE*	[07/31/2075]
		FINAL CONVERSION DATE	[07/31/2040]
INSURED:	[LORD BALTIMORE]	SEX / ISSUE AGE	[MALE / 35
OWNER:	[THE INSURED]		

POLICY DESCRIPTION	[30 YEAR TERM LIFE INSURANCE]
PREMIUM CLASS	STANDARD
UNDERWRITING CLASS	[NON TOBACCO]
ANNUAL PREMIUM	[$358.00]
LEVEL PREMIUM PERIOD	[30YEARS]**

TOTAL PREMIUM ON OTHER MODES IS AS FOLLOWS:

ANNUAL	SEMI-ANNUAL	MONTHLY
[$358.00]	[$179.00]	[$29.83]

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

* 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.

INSURED LORD BALTIMORE
POLICY NUMBER 1234567 $100,000.00 FACE AMOUNT

POLICY DATA PAGE

TABLE OF GUARANTEED MAXIMUM ANNUAL RENEWAL PREMIUMS

COVERAGE PERIOD BEGINNING AUGUST 1	AGE	BASE POLICY ANNUAL PREMIUM
[2040	65	$4,869.00
2041	66	5,334.00
2042	67	5,820.00
2043	68	6,333.00
2044	69	6,909.00
2045	70	7,581.00
2046	71	8,397.00
2047	72	9,351.00
2048	73	10,356.00
2049	74	11,436.00
2050	75	12,612.00
2051	76	13,938.00
2052	77	15,480.00
2053	78	17,271.00
2054	79	19,278.00
2055	80	21,516.00
2056	81	23,949.00
2057	82	26,536.00
2058	83	29,340.00
2059	84	32,469.00
2060	85	35,949.00
2061	86	39,777.00
2062	87	43,914.00
2063	88	48,312.00
2064	89	52,926.00
2065	90	57,522.00
2066	91	62,046.00
2067	92	66,786.00
2068	93	71,784.00
2069	94	77,049.00
2070	95	82,263.00
2071	96	87,354.00
2072	97	92,778.00
2073	98	98,562.00
2074	99	100,000.00]

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.

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

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.

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*. Unless *you* specify otherwise, the assignment will take effect as of the date *your* request was signed. *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, sex, age, premium class, and underwriting class of the *insured*.

After the Level Premium Period shown on the **POLICY DATA PAGE**, premiums may increase each year for this *policy*, but will never be more than the Guaranteed Maximum Annual Premium.

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 monthly. 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.

Any payment sent by US mail must be postmarked within the grace period. 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* in one lump sum. 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* may make payment of the proceeds into an interest bearing account owned by the *beneficiary*. When *we* pay the death benefit, this *policy* will end.

Death benefits will include interest from the date of death to the date of payment. Interest will accrue at a rate equal to the rate applicable to proceeds left on deposit with *us*. Additional interest will accrue at a rate of 10% annually beginning with the date that is 31 calendar days from the latest of:

- the date *we* receive due proof of death;
- the date *we* received sufficient information to determine *our* liability, the extent of the liability and the appropriate payee entitled to the death benefit; and
- the date that legal impediments to payment of the death benefit that depend on the action of parties other than *us* are resolved and sufficient evidence of the same is provided to *us*. Legal impediments to payment of the death benefit include, but are not limited to: (a) the establishment of guardianships and conservatorships; (b) the appointment and qualification of trustees, executors and administrators and (c) the submission of information required to satisfy state and federal reporting requirements.

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;
- the part of any premium paid for a period beyond the policy month of death;
- less any outstanding liens; and
- less one month's premium if death occurs during the grace period.

CONVERSION PRIVILEGE

If this *policy* was issued in a standard premium class *you* can convert this *policy* for 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 coverage will take effect when you pay the first premium for it. The premium for the new policy will be based on the sex and *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 the new policy is issued.

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 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. The suicide and contestability period in any new policy that is issued pursuant to the **CONVERSION PRIVILEGE** of this *policy* will be measured from the *policy date* of this *policy*, unless the new policy contains new benefits not contained in this *policy*. In this case, the suicide and contestability provisions of the new policy applicable to the new benefit will be measured from the *policy date* of the new policy.

9. Benefits, in addition to life insurance, may be added to the new policy, subject to requirements established by *us*.

10. Written consent of all irrevocable beneficiaries and/or assignees is required.

11. This *policy* is not eligible for conversion if there are any outstanding liens.

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 or Sex

If the *insured's age* or sex 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* or sex.

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, less any outstanding liens. This amount will be paid to the beneficiary in a single sum.

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.

Tax Status

This *policy* is intended to meet the requirements imposed by federal and state law on life insurance as of the *policy date*. *We* cannot accept responsibility for the tax treatment of this or any insurance policy. Please consult *your* tax advisor for individual assistance.

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

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 renewable annually to age 100.

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Application for Life Insurance

INSURED/OWNER

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

Mailing Street Address	City	State	ZIP Code

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

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

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

BENEFICIARY INFORMATION

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

HOME LOAN INFORMATION

Home Loan Amount	Home Loan Payment	Mortgage Lender	Loan Date

INSURANCE COVERAGE

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

ADDITIONAL BENEFITS INFORMATION

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

COMPLETE IF THE DISABILITY INCOME RIDER IS ELECTED:

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

REPLACEMENT INFORMATION

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

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

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

SECTION ONE

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

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

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

AUTHORIZATION AND ACKNOWLEDGMENT

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

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

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

SECTION TWO

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

SECTION THREE

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

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

Primary Physician's Name _____ Telephone _____

Address _____ City _____ State _____ ZIP Code _____

Details to Yes Answers

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

_____

_____

_____

_____

_____

_____

DECLARATIONS AND AUTHORIZATIONS

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

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

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

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

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

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

Certification: Under penalties of perjury, I certify that:

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

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

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

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

WARNING: Any person who knowingly 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.

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

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

SPECIMEN

(X) _____
Signature of Insured/Owner

PREMIUM AND BILLING INFORMATION

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

Payor Name	Relationship to Applicant	Social Security or Tax ID#

ELECTRONIC FUNDS TRANSFER (EFT) AUTHORIZATION

Statement of Authorization

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

SPECIMEN

_____ _____ _____

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

_____ _____

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

_____ **Type of Account:** ☐ Checking ☐ Savings

Account Number *(Attach voided check)* *(Verify draft is allowed)*

AGENT'S STATEMENT

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

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

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

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

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

Writing Agent Signature	Printed Name	Date	Writing Agent Code No.

If split commissions apply:

Writing Agent #2	Agent Number	Date	% Split (if applicable
Writing Agent #3	Agent Number	Date	% Split (if applicable)

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

NOTIFICATION AND DISCLOSURE

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.

FAIR CREDIT REPORTING ACT NOTICE

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

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

MEDICAL INFORMATION BUREAU, INC. PRE-NOTICE

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

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

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

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

CONDITIONAL RECEIPT

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

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

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

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

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

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

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

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

Supporting Document Schedules

Item Status: **Status Date:**

Satisfied - Item: Flesch Certification

Comments:

Attachment:

ar-read.pdf

Item Status: **Status Date:**

Satisfied - Item: Application

Comments:

The application is attached under the Form Schedule tab.

Item Status: **Status Date:**

Satisfied - Item: Specimen Pages

Comments:

Attached are specimen pages for the additional premium payment periods.

Attachments:

data page 15-8167-0610.pdf

data page 20-8167-0610 .pdf

THE BALTIMORE LIFE INSURANCE COMPANY
10075 Red Run Boulevard • P.O. Box 1060 • Owings Mills, Maryland 21117-5060
(410) 581-6600

CERTIFICATION OF READABILITY

This is to certify that Form 8167-0610(AR) and Form 8168(AR) when combined meet the minimum reading ease score for the state of Arkansas on the Flesch reading ease test.

Flesch Score = 50.1

Vice President _____ July 7, 2010
Date

POLICY INFORMATION

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

POLICY NUMBER	1234567	FACE AMOUNT:	$100,000
POLICY DATE:	08/01/2010	EXPIRY DATE*	07/31/2075
		FINAL CONVERSION DATE	07/31/2025
INSURED:	LORD BALTIMORE	SEX / ISSUE AGE	MALE / 35
OWNER:	THE INSURED		

POLICY DESCRIPTION	15 YEAR TERM LIFE INSURANCE
PREMIUM CLASS	STANDARD
UNDERWRITING CLASS	NON TOBACCO
ANNUAL PREMIUM	$260.00
LEVEL PREMIUM PERIOD	15 YEARS**

TOTAL PREMIUM ON OTHER MODES IS AS FOLLOWS:

ANNUAL	SEMI-ANNUAL	MONTHLY
$260.00	$130.00	$21.67

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

* 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.

POLICY DATA PAGE

TABLE OF GUARANTEED MAXIMUM ANNUAL RENEWAL PREMIUMS

COVERAGE PERIOD BEGINNING AUGUST 1	AGE	BASE POLICY ANNUAL PREMIUM
2025	50	$1,035.00
2026	51	1,131.00
2027	52	1,248.00
2028	53	1,383.00
2029	54	1,554.00
2030	55	1,746.00
2031	56	1,944.00
2032	57	2,136.00
2033	58	2,328.00
2034	59	2,553.00
2035	60	2,826.00
2036	61	3,159.00
2037	62	3,546.00
2038	63	3,969.00
2039	64	4,410.00
2040	65	4,869.00
2041	66	5,334.00
2042	67	5,820.00
2043	68	6,333.00
2044	69	6,909.00
2045	70	7,581.00
2046	71	8,397.00
2047	72	9,351.00
2048	73	10,356.00
2049	74	11,436.00
2050	75	12,612.00
2051	76	13,938.00
2052	77	15,480.00
2053	78	17,271.00
2054	79	19,278.00
2055	80	21,516.00
2056	81	23,949.00
2057	82	26,536.00
2058	83	29,340.00

INSURED LORD BALTIMORE
POLICY NUMBER1234567 $100,000.00 FACE AMOUNT

POLICY DATA PAGE

COVERAGE PERIOD BEGINNING AUGUST 1	AGE	BASE POLICY ANNUAL PREMIUM
2059	84	32,469.00
2060	85	35,949.00
2061	86	39,777.00
2062	87	43,914.00
2063	88	48,312.00
2064	89	52,926.00
2065	90	57,522.00
2066	91	62,046.00
2067	92	66,786.00
2068	93	71,784.00
2069	94	77,049.00
2070	95	82,263.00
2071	96	87,354.00
2072	97	92,778.00
2073	98	98,562.00
2074	99	100,000.00

POLICY DATA PAGE

POLICY INFORMATION

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

POLICY NUMBER	1234567	FACE AMOUNT:	$100,000
POLICY DATE:	08/01/2010	EXPIRY DATE*	07/31/2075
		FINAL CONVERSION DATE	07/31/2030
INSURED:	LORD BALTIMORE	SEX / ISSUE AGE	MALE / 35
OWNER:	THE INSURED		

POLICY DESCRIPTION	20 YEAR TERM LIFE INSURANCE
PREMIUM CLASS	STANDARD
UNDERWRITING CLASS	NON TOBACCO
ANNUAL PREMIUM	$285.00
LEVEL PREMIUM PERIOD	20 YEARS**

TOTAL PREMIUM ON OTHER MODES IS AS FOLLOWS:

ANNUAL	SEMI-ANNUAL	MONTHLY
$285.00	$142.50	$23.75

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

* 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.

INSURED LORD BALTIMORE
POLICY NUMBER 1234567 $100,000.00 FACE AMOUNT

POLICY DATA PAGE

TABLE OF GUARANTEED MAXIMUM ANNUAL RENEWAL PREMIUMS

COVERAGE PERIOD BEGINNING AUGUST 1	AGE	BASE POLICY ANNUAL PREMIUM
2030	55	$1,746.00
2031	56	1,944.00
2032	57	2,136.00
2033	58	2,328.00
2034	59	2,553.00
2035	60	2,826.00
2036	61	3,159.00
2037	62	3,546.00
2038	63	3,969.00
2039	64	4,410.00
2040	65	4,869.00
2041	66	5,334.00
2042	67	5,820.00
2043	68	6,333.00
2044	69	6,909.00
2045	70	7,581.00
2046	71	8,397.00
2047	72	9,351.00
2048	73	10,356.00
2049	74	11,436.00
2050	75	12,612.00
2051	76	13,938.00
2052	77	15,480.00
2053	78	17,271.00
2054	79	19,278.00
2055	80	21,516.00
2056	81	23,949.00
2057	82	26,536.00
2058	83	29,340.00
2059	84	32,469.00
2060	85	35,949.00
2061	86	39,777.00
2062	87	43,914.00
2063	88	48,312.00

INSURED LORD BALTIMORE
POLICY NUMBER 1234567 $100,000.00 FACE AMOUNT

POLICY DATA PAGE

COVERAGE PERIOD BEGINNING AUGUST 1	AGE	BASE POLICY ANNUAL PREMIUM
2064	89	52,926.00
2065	90	57,522.00
2066	91	62,046.00
2067	92	66,786.00
2068	93	71,784.00
2069	94	77,049.00
2070	95	82,263.00
2071	96	87,354.00
2072	97	92,778.00
2073	98	98,562.00
2074	99	100,000.00

Superseded Schedule Items

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Creation Date:	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
07/02/2010	Supporting Document	Flesch Certification	07/07/2010	ar-read.pdf (Superceded)

THE BALTIMORE LIFE INSURANCE COMPANY
10075 Red Run Boulevard • P.O. Box 1060 • Owings Mills, Maryland 21117-5060
(410) 581-6600

CERTIFICATION OF READABILITY

This is to certify that Form 8167-0610(AR) and Form 8168(AR) when combined meet the minimum reading ease score for the Interstate Compact Commission on the Flesch reading ease test.

Flesch Score = 50.1

Vice President _____ July 6, 2010
Date