

**State:** Arkansas **Filing Company:** The Baltimore Life Insurance Company  
**TOI/Sub-TOI:** L08 Life - Other/L08.000 Life - Other  
**Product Name:** APPLICATION FOR LIFE INSURANCE  
**Project Name/Number:** APPLICATION FOR LIFE INSURANCE/8336-0113

## Filing at a Glance

Company: The Baltimore Life Insurance Company  
Product Name: APPLICATION FOR LIFE INSURANCE  
State: Arkansas  
TOI: L08 Life - Other  
Sub-TOI: L08.000 Life - Other  
Filing Type: Form  
Date Submitted: 01/11/2013  
SERFF Tr Num: BALT-128844341  
SERFF Status: Closed-Approved-Closed  
State Tr Num:  
State Status: Approved-Closed  
Co Tr Num: 8336-0113  
  
Implementation: On Approval  
Date Requested:  
Author(s): Lesia Braddy  
Reviewer(s): Linda Bird (primary)  
Disposition Date: 01/17/2013  
Disposition Status: Approved-Closed  
Implementation Date:  
  
State Filing Description:

**State:** Arkansas **Filing Company:** The Baltimore Life Insurance Company  
**TOI/Sub-TOI:** L08 Life - Other/L08.000 Life - Other  
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## General Information

Project Name: APPLICATION FOR LIFE INSURANCE	Status of Filing in Domicile: Pending
Project Number: 8336-0113	Date Approved in Domicile:
Requested Filing Mode: Review & Approval	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Individual
Submission Type: New Submission	Individual Market Type:
Overall Rate Impact:	Filing Status Changed: 01/17/2013
	State Status Changed: 01/17/2013
Deemer Date:	Created By: Lesia Braddy
Submitted By: Lesia Braddy	Corresponding Filing Tracking Number: 8336

### Filing Description:

Attached for your review are copies of application form 8336-0113(AR) and endorsement form E499.

Form 8336-0113(AR) is a new form which will supersede Form 8336(AR) approved on 01/13/2011, under SERFF tracking #BALT-126945060. The application was redesigned and now offers the applicant the option of electing automatic premium loan. A redline copy is also attached which identifies the additional revisions.

Form E499 is a new form designed to add an automatic premium loan provision to policy Form 8335 that was approved on 01/13/2011, under SERFF tracking # BALT-126945060.

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 Braddy, Director Policy Forms Compliance	lesia.williams@baltlife.com
10075 Red Run Boulevard	800-628-5433 [Phone] 7586 [Ext]
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: 4723	Company Type:
Owings Mills, MD 21117	Group Name:	State ID Number:
(443) 681-7586 ext. [Phone]	FEIN Number: 52-0236900	

## Filing Fees

Fee Required?	Yes
Fee Amount:	\$250.00
Retaliatory?	Yes
Fee Explanation:	
Per Company:	No

**State:** Arkansas **Filing Company:** The Baltimore Life Insurance Company  
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**Product Name:** APPLICATION FOR LIFE INSURANCE  
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Company	Amount	Date Processed	Transaction #
The Baltimore Life Insurance Company	\$250.00	01/11/2013	66468784

State: Arkansas Filing Company: The Baltimore Life Insurance Company  
TOI/Sub-TOI: L08 Life - Other/L08.000 Life - Other  
Product Name: APPLICATION FOR LIFE INSURANCE  
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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	01/17/2013	01/17/2013

SERFF Tracking #:

BALT-128844341

State Tracking #:

Company Tracking #:

8336-0113

State:

Arkansas

Filing Company:

The Baltimore Life Insurance Company

TOI/Sub-TOI:

L08 Life - Other/L08.000 Life - Other

Product Name:

APPLICATION FOR LIFE INSURANCE

Project Name/Number:

APPLICATION FOR LIFE INSURANCE/8336-0113

## Disposition

Disposition Date: 01/17/2013

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		Yes
Supporting Document	Redline Copy		Yes
Form	Endorsement		Yes
Form	Application for Life Insurance		Yes

SERFF Tracking #:

BAL-128844341

State Tracking #:

Company Tracking #:

8336-0113

State:

Arkansas

Filing Company:

The Baltimore Life Insurance Company

TOI/Sub-TOI:

L08 Life - Other/L08.000 Life - Other

Product Name:

APPLICATION FOR LIFE INSURANCE

Project Name/Number:

APPLICATION FOR LIFE INSURANCE/8336-0113

## Form Schedule

Lead Form Number: 8336-0113

Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data		Readability Score	Attachments
1		Endorsement	Form E499	POLA	Initial			54.200	E499.pdf
2		Application for Life Insurance	Form 8336-0113(AR)	AEF	Revised	Previous Filing Number:	BALT-126945060	53.200	8336-0113-ar.pdf
						Replaced Form Number:	8336(AR)		

### Form Type Legend:

<b>ADV</b>	Advertising	<b>AEF</b>	Application/Enrollment Form
<b>CER</b>	Certificate	<b>CERA</b>	Certificate Amendment, Insert Page, Endorsement or Rider
<b>DDP</b>	Data/Declaration Pages	<b>FND</b>	Funding Agreement (Annuity, Individual and Group)
<b>MTX</b>	Matrix	<b>NOC</b>	Notice of Coverage
<b>OTH</b>	Other	<b>OUT</b>	Outline of Coverage
<b>PJK</b>	Policy Jacket	<b>POL</b>	Policy/Contract/Fraternal Certificate
<b>POLA</b>	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	<b>SCH</b>	Schedule Pages

**The Baltimore Life Insurance Company**  
**10075 Red Run Boulevard**  
**Owings Mills, MD 21117**

**Endorsement**

This endorsement is made a part of the policy to which it is attached and adds to the policy as follows:

**Automatic Premium Loan**

You may request this option in the application. You may also request this option in writing in which case it must be recorded at our Home Office before the end of the grace period for an unpaid premium. Unless you request this option, it will not be in force.

If this option is requested and:

- a premium remains unpaid on the last day of the grace period; and
- the net cash value of this policy exceeds the unpaid premium,

we will automatically loan the amount needed to pay the premium (see **CASH VALUE BENEFITS FOR YOU**).

If the net cash value is less than the amount needed to pay the premium, and the premium is payable annually, semiannually, or quarterly, the next smaller modal premium will be paid by automatic premium loan. If the net cash value is less than a monthly premium, no automatic premium loan will be made and the policy will end unless continued under a cash value benefit

You may notify us in writing at any time if you do not wish coverage continued in this manner.

  
\_\_\_\_\_  
President

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

**Application for Life Insurance**

**PROPOSED INSURED**

Last Name		First Name			MI
Street Address		City		State	Zip Code
Telephone	Day	Evening		Email Address	
Social Security Number		Age	Sex	Date of Birth	State or Country of Birth
Occupation		Regular Hours per Week		Tobacco or Nicotine User in Past Year: <input type="checkbox"/> Yes <input type="checkbox"/> No	

**OWNER (If other than Insured)**

Name		Relationship		Social Security Number	
Street Address		City		State	Zip Code
Telephone		Email Address			

**PAYOR INFORMATION (If other than Insured)**

Name		Relationship
Employer		Case #

**BENEFICIARY INFORMATION**

Primary	Relationship	Social Security Number
Primary	Relationship	Social Security Number
Contingent	Relationship	Social Security Number
Contingent	Relationship	Social Security Number

**LIFE PLAN APPLIED FOR**

Insurance Plan (*check one*)       10-Pay Whole Life       20-Pay Whole Life       Whole Life

Policy	Face Amount	Money Purchase Per: _____
Waiver of Premium	_____	_____
Accidental Death Benefit Rider	_____	_____
Level Term Rider	_____	_____
Automatic Premium Loan	<input type="checkbox"/> Yes <input type="checkbox"/> No	<u>\$0.00</u>

*Selecting this option means a loan may be made against the policy cash value to pay premiums that has not otherwise been paid.*

Other _____	_____	_____
<b>Total</b>	_____	_____

**Issue Age Disclosure:** Due to administrative processing time associated with issuing the policy that you have applied, it is possible the proposed insured's age at the time of application may change before the policy is issued, depending upon their date of birth. This age adjustment may result in a slight change in the policy face amount or premium for your policy when it is issued. By signing this application you are authorizing The Baltimore Life Insurance Company to amend this application to reflect the proposed insured's current age of as of the policy issue date if necessary.

## MEDICAL HISTORY

1. Height \_\_\_\_\_ ft./in.      Weight \_\_\_\_\_ lbs      Weight gained or lost in the past year \_\_\_\_\_ lbs  
Please provide reason if weight change is more than 10 lbs \_\_\_\_\_
2. Are you actively at work 30 hours per week .....  Yes    No  
If not, please provide details \_\_\_\_\_
3. Have you been hospitalized or disabled in the past six months? .....  Yes    No
4. Have you been diagnosed by a member of the medical profession or tested positive for AIDS (Acquired Immune Deficiency Syndrome) or any other disorder of the immune system, including Systemic Lupus (SLE)? .....  Yes    No
5. Have you ever been diagnosed by or treated by a licensed member of the medical profession for:
  - a. Leukemia, lymphoma, melanoma, cancer (other than basal cell skin cancer)? .....  Yes    No
  - b. Disorder of eyes, ears, nose, throat or skin? .....  Yes    No
  - c. Dizziness, convulsions, headaches, or nervous disorders? .....  Yes    No
  - d. Disorder of heart, blood vessels or lungs; chest pain? .....  Yes    No
  - e. High blood pressure, heart murmur, attack or surgery? .....  Yes    No
  - f. Disorder of stomach, intestines, liver or gall bladder, including any form of hepatitis? .....  Yes    No
  - g. Sugar, protein, blood or pus in urine? .....  Yes    No
  - h. Disorder of kidney, bladder, or genitourinary organs? .....  Yes    No
  - i. Diabetes, thyroid disorder, tumor, cancer or hernia? .....  Yes    No
  - j. Neuritis, sciatica, rheumatism, arthritis or gout? .....  Yes    No
  - k. Disorder of muscles, bones, spine, back or joints? .....  Yes    No
  - l. Alcoholism, drug abuse; mental retardation, Alzheimer's or dementia, or a mental, or physical disorder not listed? .....  Yes    No
  - m. Do you currently have any medical testing pending or procedures that have not yet been completed, other than routine lab work? .....  Yes    No
6. Other than above, have you within the past five years had a checkup, consultation, illness, injury, or surgery? .....  Yes    No
7. In the past five years, have you been convicted of driving under the influence of alcohol or drugs, driving while impaired by alcohol or drugs, or more than four moving violations. ....  Yes    No

**Details for questions 3 thru 5 answered "yes."**

Question Number	Disease or injury	Date	Details	Names and Addresses of Physicians and Hospitals

## 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? .....  Yes    No  
*(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?
			\$		<input type="checkbox"/> Yes <input type="checkbox"/> No
			\$		<input type="checkbox"/> Yes <input type="checkbox"/> No
			\$		<input type="checkbox"/> Yes <input type="checkbox"/> No

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## AUTHORIZATION AND ACKNOWLEDGMENT

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**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 a Conditional Receipt, it is agreed that no policy will take effect unless:

1. A policy is delivered to and accepted by the owner while the insured 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.)

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 MIB, 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 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, MIB, 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.

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.

**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.

**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. 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.

\_\_\_\_\_  
Signed at (City, State)

\_\_\_\_\_  
Signature of Insured

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Owner (If Other Than Insured)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Payor (If other than Insured)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Licensed Agent

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**AGENT'S STATEMENT**

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- 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 and you are unaware of any additional information that might affect the Company's underwriting decision.**

\_\_\_\_\_  
Writing Agent Signature                      Printed Name                      Date                      Writing Agent Code No.

*If split commissions apply:*

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

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

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## **INFORMATION DISCLOSURES NOTICES**

*This notice must be detached and left with the Proposed Insured*

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### **Fair Credit Reporting Act Notice**

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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.

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### **MIB Inc. Notice**

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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 MIB, Inc., a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB, Inc., member company for life or health insurance coverage, or a claim for benefits is submitted to such company, MIB, Inc., upon request, will supply such company with the information in its file.

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

The Baltimore Life Insurance 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.

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

SERFF Tracking #:

BALT-128844341

State Tracking #:

Company Tracking #:

8336-0113

State:

Arkansas

Filing Company:

The Baltimore Life Insurance Company

TOI/Sub-TOI:

L08 Life - Other/L08.000 Life - Other

Product Name:

APPLICATION FOR LIFE INSURANCE

Project Name/Number:

APPLICATION FOR LIFE INSURANCE/8336-0113

## Supporting Document Schedules

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

		Item Status:	Status Date:
Satisfied - Item:	Application		
Comments:	See Form Schedule Tab		

		Item Status:	Status Date:
Satisfied - Item:	Redline Copy		
Comments:			
Attachment(s):			
8336-0113-ar-redline.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 the following forms meet the minimum reading ease score for the state of Arkansas on the Flesch reading ease test.

8336-0113(AR) = 52.3  
E499=54.2

Vice President



January 11 2013

Date

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

**Application for Life Insurance**

**PROPOSED INSURED**

Last Name		First Name			MI
Street Address		City		State	Zip Code
Telephone	Day	Evening		Email Address	
Social Security Number		Age	Sex	Date of Birth	State or Country of Birth
Occupation		Regular Hours per Week		Tobacco or Nicotine User in Past Year: <input type="checkbox"/> Yes <input type="checkbox"/> No	

**OWNER (If other than Insured)**

Name		Relationship		Social Security Number	
Street Address		City		State	Zip Code
Telephone		Email Address			

**PAYOR INFORMATION (If other than Insured)**

Name		Relationship
Employer		Case #

**BENEFICIARY INFORMATION**

<u>Primary</u>	<u>Relationship</u>	<u>Social Security Number</u>
<u>Primary</u>	<u>Relationship</u>	<u>Social Security Number</u>
<u>Contingent</u>	<u>Relationship</u>	<u>Social Security Number</u>
<u>Contingent</u>	<u>Relationship</u>	<u>Social Security Number</u>

**LIFE PLAN APPLIED FOR**

Insurance Plan (check one)       10-Pay Whole Life       20-Pay Whole Life       Whole Life

	Face Amount	Money Purchase Per: _____
Policy	_____	_____
Waiver of Premium	_____	_____
Accidental Death Benefit Rider	_____	_____
Level Term Rider	_____	_____
<u>Automatic Premium Loan</u>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<u>\$0.00</u>
Other _____	_____	_____
<b>Total</b>	_____	_____

*Selecting this option means a loan may be made against the policy cash value to pay premiums that has not otherwise been paid.*

**Issue Age Disclosure:** Due to administrative processing time associated with issuing the policy that you have applied, it is possible the proposed insured's age at the time of application may change before the policy is issued, depending upon their date of birth. This age adjustment may result in a slight change in the policy face amount or premium for your policy when it is issued. By signing this application you are authorizing The Baltimore Life Insurance Company to amend this application to reflect the proposed insured's current age of as of the policy issue date if necessary.

## MEDICAL HISTORY

1. Height \_\_\_\_\_ ft./in.      Weight \_\_\_\_\_ lbs      Weight gained or lost in the past year \_\_\_\_\_ lbs  
Please provide reason if weight change is more than 10 lbs \_\_\_\_\_
2. Are you actively at work 30 hours per week .....  Yes    No  
If not, please provide details \_\_\_\_\_
3. Have you been hospitalized or disabled in the past six months? .....  Yes    No
4. Have you been diagnosed by a member of the medical profession or tested positive for AIDS (Acquired Immune Deficiency Syndrome) or any other disorder of the immune system, including Systemic Lupus (SLE)? .....  Yes    No
5. Have you ever been diagnosed by or treated by a licensed member of the medical profession for:
  - a. Leukemia, lymphoma, melanoma, cancer (other than basal cell skin cancer)? .....  Yes    No
  - b. Disorder of eyes, ears, nose, throat or skin? .....  Yes    No
  - c. Dizziness, convulsions, headaches, or nervous disorders? .....  Yes    No
  - d. Disorder of heart, blood vessels or lungs; chest pain? .....  Yes    No
  - e. High blood pressure, heart murmur, attack or surgery? .....  Yes    No
  - f. Disorder of stomach, intestines, liver or gall bladder, including any form of hepatitis? .....  Yes    No
  - g. Sugar, protein, blood or pus in urine? .....  Yes    No
  - h. Disorder of kidney, bladder, or genitourinary organs? .....  Yes    No
  - i. Diabetes, thyroid disorder, tumor, cancer or hernia? .....  Yes    No
  - j. Neuritis, sciatica, rheumatism, arthritis or gout? .....  Yes    No
  - k. Disorder of muscles, bones, spine, back or joints? .....  Yes    No
  - l. Alcoholism, drug abuse; mental retardation, Alzheimer's or dementia, or a mental, or physical disorder not listed? .....  Yes    No
  - m. Do you currently have any medical testing pending or procedures that have not yet been completed, other than routine lab work? .....  Yes    No
6. Other than above, have you within the past five years had a checkup, consultation, illness, injury, or surgery? .....  Yes    No
7. In the past five years, have you been convicted of driving under the influence of alcohol or drugs, driving while impaired by alcohol or drugs, or more than four moving violations. ....  Yes    No

**Details for questions 3 thru 5 answered "yes."**

Question Number	Disease or injury	Date	Details	Names and Addresses of Physicians and Hospitals

## 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?
			\$		<input type="checkbox"/> Yes <input type="checkbox"/> No
			\$		<input type="checkbox"/> Yes <input type="checkbox"/> No
			\$		<input type="checkbox"/> Yes <input type="checkbox"/> No

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## AUTHORIZATION AND ACKNOWLEDGMENT

---

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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 a Conditional Receipt, it is agreed that no policy will take effect unless:

1. A policy is delivered to and accepted by the owner while the insured 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.)

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 MIB, 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 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, MIB, 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.

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.

**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.

**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. 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.

\_\_\_\_\_  
Signed at (City, State)

\_\_\_\_\_  
Signature of Insured

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Owner (If Other Than Insured)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Payor (If other than Insured)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Licensed Agent

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**AGENT'S STATEMENT**

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- 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 and you are unaware of any additional information that might affect the Company's underwriting decision.**

\_\_\_\_\_  
Writing Agent Signature                      Printed Name                      Date                      Writing Agent Code No.

*If split commissions apply:*

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

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

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## **INFORMATION DISCLOSURES NOTICES**

*This notice must be detached and left with the Proposed Insured*

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### **Fair Credit Reporting Act Notice**

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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.

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### **MIB Inc. Notice**

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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 MIB, Inc., a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB, Inc., member company for life or health insurance coverage, or a claim for benefits is submitted to such company, MIB, Inc., upon request, will supply such company with the information in its file.

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

The Baltimore Life Insurance 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.

### **The Baltimore Life Insurance Company**

**10075 Red Run Boulevard • Owings Mills, MD 21117-4871 • 800.628.5433 • www.baltlife.com**