The Baltimore Life Insurance Company
10075 Red Run Boulevard | Owings Mills, MD 21117-4871
(800) 628-5433 | (410) 581-6600 | baltlife.com

APPLICATION FOR INDIVIDUAL LIFE INSURANCE

PROPOSED INSURED INFORMATION

First Name	Middle Name /Initial	Last Name	Suffix

Street Address

City | State | ZIP

Country of Birth	State of Birth	Are the Proposed Insured and the proposed Policy Owner U.S. citizens or permanent legal residents of the United States? ☐ Yes ☐ No

Date of Birth (MM/DD/YYYY)	Age	Height	Weight	Social Security No. or TIN	Gender
/ /		ft. in.	lbs.	– –	☐ F ☐ M

Marital Status	State Identification or Driver's License Number

Area Code and Telephone Number
( ) –

Is this a mobile phone?
☐ Yes ☐ No

Email Address	Occupation

FOR JUVENILE INSURANCE POLICY ONLY: Parent or Legal Guardian please complete the following information if the Proposed Insured is under age 15 *(State variations may apply):*

Parent/Guardian

Name	
Street Address	
City, State ZIP	
Date of Birth	/ /
Social Security No.	– –
Email	

Mod 1

COMPLETE ONLY IF APPLYING FOR CHILDREN'S INSURANCE BENEFIT RIDER(S)

Please complete for any child age 0-14

Health questions must be completed for each child applying for a rider.

First Name		Middle Name/Initial		Last Name	Suffix
Date of Birth (MM/DD/YYYY) / /	Age	Height ft. in.	Weight lbs.	Gender ☐ F ☐ M	Social Security Number or TIN – –

Is this proposed insured child a U.S. citizen or permanent legal resident of the United States? ☐ Yes ☐ No

First Name		Middle Name/Initial		Last Name	Suffix
Date of Birth (MM/DD/YYYY) / /	Age	Height ft. in.	Weight lbs.	Gender ☐ F ☐ M	Social Security Number or TIN – –

Is this proposed insured child a U.S. citizen or permanent legal resident of the United States? ☐ Yes ☐ No

First Name		Middle Name/Initial		Last Name	Suffix
Date of Birth (MM/DD/YYYY) / /	Age	Height ft. in.	Weight lbs.	Gender ☐ F ☐ M	Social Security Number or TIN – –

Is this proposed insured child a U.S. citizen or permanent legal resident of the United States? ☐ Yes ☐ No

First Name		Middle Name/Initial		Last Name	Suffix
Date of Birth (MM/DD/YYYY) / /	Age	Height ft. in.	Weight lbs.	Gender ☐ F ☐ M	Social Security Number or TIN – –

Is this proposed insured child a U.S. citizen or permanent legal resident of the United States? ☐ Yes ☐ No

First Name		Middle Name/Initial		Last Name	Suffix
Date of Birth (MM/DD/YYYY) / /	Age	Height ft. in.	Weight lbs.	Gender ☐ F ☐ M	Social Security Number or TIN – –

Is this proposed insured child a U.S. citizen or permanent legal resident of the United States? ☐ Yes ☐ No

First Name		Middle Name/Initial		Last Name	Suffix
Date of Birth (MM/DD/YYYY) / /	Age	Height ft. in.	Weight lbs.	Gender ☐ F ☐ M	Social Security Number or TIN – –

Is this proposed insured child a U.S. citizen or permanent legal resident of the United States? ☐ Yes ☐ No

First Name		Middle Name/Initial		Last Name	Suffix
Date of Birth (MM/DD/YYYY) / /	Age	Height ft. in.	Weight lbs.	Gender ☐ F ☐ M	Social Security Number or TIN – –

Is this proposed insured child a U.S. citizen or permanent legal resident of the United States? ☐ Yes ☐ No

First Name		Middle Name/Initial		Last Name	Suffix
Date of Birth (MM/DD/YYYY) / /	Age	Height ft. in.	Weight lbs.	Gender ☐ F ☐ M	Social Security Number or TIN – –

Is this proposed insured child a U.S. citizen or permanent legal resident of the United States? ☐ Yes ☐ No

NOTICE: *The beneficiary for the child rider is the Insured unless changed by the Owner. If additional space is needed, attach an application amendment form.*

Mod 2

PROPOSED INSURED AUTHORIZATION

Authorization: I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, pharmacy or pharmacy benefit manager, insurance company, MIB, Inc, (MIB) or other organization, institution or person, that has any paper or electronic records possesses prescription history, or knowledge of me or my child(ren)'s health, to give to The Baltimore Life Insurance Company, or its reinsurers, any such information for the purpose of evaluating me or my child(ren)'s application for insurance. **This medical or health information may include information related to diagnosis, testing or treatment for mental illness, HIV, AIDS, sexually transmitted diseases, alcohol or drug use.** Health information obtained will be kept confidential and not be redisclosed other than as permitted by law, **in which case it may not be protected under federal privacy rules.**

I authorize the Baltimore Life Insurance Company, or its reinsurers, to make a brief report of me or my child(ren)'s personal health information to MIB. A photographic copy of this authorization shall be as valid as the original.

This authorization shall be valid for two years or a different time frame as required by applicable laws in the state where the policy is delivered or issued for delivery from this date and may be revoked by sending written notice to The Baltimore Life Insurance Company.

_____ _____

Signature of Proposed Insured or Parent/Legal Guardian Date

(If Proposed Insured is under age 15. State variations may apply)

List the name(s) of each minor child(ren) to which this Authorization applies:

First Name *Middle Name/Initial* *Last* *Suffix*

_____

_____

_____

_____

_____

_____

_____

_____

Mod 3

HEALTH QUESTIONS FOR PROPOSED INSURED
ISSUE AGES 50-80
INSURANCE COVERAGE UP THROUGH $150,000

1. Proposed Insured: Have you used any nicotine or tobacco-based products in the last 12 months? ☐ Yes ☐ No
2. Do you have a primary care physician? ☐ Yes ☐ No

If "yes", provide the contact information for the proposed insured's primary care physician (* denotes required fields):

a. Physician Name*:_____

b. Physician Address:_____

Address City* State* ZIP Code

c. Date of last visit:_____

Month/Year (MM/YYYY)

Part A

1. Within the past 12 months have you:		
a. Required constant human assistance or supervision with any of the following normal activities of daily living: dressing, eating, bathing, toileting, transferring from bed to chair, walking or maintaining continence?	☐ Yes	☐ No
b. Been hospitalized, for 5 or more consecutive days, confined to a bed or nursing facility, received hospice care or been advised to receive hospice care?	☐ Yes	☐ No
c. Been treated for cancer or recurrence of cancer (excluding Basal cell or Squamous cell skin cancer)?	☐ Yes	☐ No
d. Plead guilty to or been convicted of a felony or misdemeanor or do you have such charge currently pending against you?	☐ Yes	☐ No
2. Have you ever:		
a. Had, or been medically advised to have, an organ transplant, or been diagnosed by a member of the medical profession as having a terminal medical condition that is expected to result in death within the next 12 months?	☐ Yes	☐ No
b. Been medically diagnosed, treated, or taken medication for chronic kidney disease (including dialysis), kidney or liver failure, cirrhosis, congestive heart failure, cardiomyopathy, organic brain syndrome, Alzheimer's, dementia, Lou Gehrig's disease (ALS), schizophrenia, or mental incapacity?	☐ Yes	☐ No
c. Been medically treated or diagnosed by a medical professional as having Acquired Immune Deficiency Syndrome (AIDS), AIDS related complex (ARC), or any immune deficiency related disorder or tested positive for the Human Immunodeficiency Virus (HIV)?	☐ Yes	☐ No
d. Had more than one occurrence or any metastasis of any cancer in your lifetime (excluding Basal or Squamous cell skin cancer), or had an amputation caused by cancer?	☐ Yes	☐ No
e. Been treated or hospitalized for insulin shock, diabetic coma, amputation due to diabetes, or have you taken insulin injections or by other methods prior to age 40 or diagnosed with diabetes prior to age 25?	☐ Yes	☐ No
3. Within the past 12 months have you been medically diagnosed, advised to have treatment for, hospitalized for, or started taking medications for stroke, transient ischemic attack (TIA or mini-stroke), or Hepatitis C?	☐ Yes	☐ No
4. Within the past 24 months have you been medically diagnosed, treated for, advised to have treatment for, hospitalized for, or taken medication for:		
a. Chronic obstructive pulmonary disease (COPD) or lung disease, emphysema, chronic bronchitis, or required oxygen to assist in breathing?	☐ Yes	☐ No
b. Angina, heart attack, heart or vascular surgery (including coronary artery bypass, initial pacemaker placement, defibrillator, heart valve replacement, abdominal aortic aneurysm, but excluding angioplasty, stent placement or varicose vein stripping) or any procedure to improve circulation to the heart or brain?	☐ Yes	☐ No
c. Neuromuscular or brain disease (including cerebral palsy, muscular dystrophy, multiple sclerosis, cystic fibrosis), systemic lupus (SLE) or paralysis of two or more extremities?	☐ Yes	☐ No
d. Attempted suicide, alcohol abuse or drug abuse?	☐ Yes	☐ No
5. Within the past 24 months, have you been convicted of operating a vehicle while intoxicated or impaired?	☐ Yes	☐ No

Part B

1. Within the past 36 months have you been medically diagnosed, hospitalized for, treated for, or taken medication for:
   a. Lymphoma, melanoma, leukemia, any internal cancer, Hodgkin's disease, Parkinson's disease, stroke, transient ischemic attack (TIA or mini-stroke), or liver disease? ☐ Yes ☐ No
   b. Angina, heart disease, heart attack, heart or vascular surgery, angioplasty, cardiac or vascular stent placement or graft, pacemaker replacement, defibrillator, or any procedure to improve circulation to the heart or brain? ☐ Yes ☐ No
   c. Chronic obstructive pulmonary disease (COPD) or lung disease, emphysema, chronic bronchitis, or required oxygen to assist in breathing? ☐ Yes ☐ No
   d. Diabetic complications (including neuropathy, retinopathy, uncontrolled blood sugar)? ☐ Yes ☐ No
   e. Insulin Dependent diabetes accompanied by heart disease or peripheral arterial disease (PAD)? ☐ Yes ☐ No
2. Within the past 24 months have you been confined three or more times to a hospital, nursing facility, convalescent care facility or mental facility? ☐ Yes ☐ No

Part C Additional information may be required for some questions.

1. Are you taking any prescription medication for any impairment listed above? ☐ Yes ☐ No
2. Have you been medically diagnosed with or treated for uncontrolled high blood pressure? ☐ Yes ☐ No

2a. If yes, are you taking all prescribed medication(s) for uncontrolled high blood pressure as directed by your physician? ☐ Yes ☐ No

3. In the last 2 years, has a member of the medical profession recommended diagnostic testing that has not yet been complete, or completed diagnostic testing for which a diagnosis or results are not yet known? ☐ Yes ☐ No

Part D **If you are over age 60 and applying for $75,001 and above, please complete the following.**
Additional underwriting is required.

1. Are you currently taking any medication (opiate) for chronic pain syndrome or any other pain control? ☐ Yes ☐ No
2. Have you ever been medically treated for any condition listed in Parts A, B, or C above? ☐ Yes ☐ No
   If "Yes", please describe:

Mod 4 – **OPTION C**

QUESTIONS FOR RIDERS

Please complete if you are applying for the riders listed below.

If you are applying for the Accidental Death Benefit Rider, Waiver of Premium Rider, or the Non-Occupational Disability Income Benefit Rider, please complete the following:

1.	Within the past 24 months, have you engaged in, or do you plan to engage in any aviation activity other than as a fare paying passenger?	☐ Yes ☐ No
2.	Within the past 24 months, have you engaged in, or do you plan to engage in any form of:	
	a. SCUBA diving to depths of greater than 130 feet, commercially, or without a dive partner?	☐ Yes ☐ No
	b. Hang gliding to heights greater than 50 feet?	☐ Yes ☐ No
	c. Parachuting (other than as tandem recreational jump)?	☐ Yes ☐ No
	d. Mountain, rock, or ice climbing (other than on a man-made wall)?	☐ Yes ☐ No
	e. Organized motor racing with average attained speeds of over 125 m.p.h.?	☐ Yes ☐ No

For the Non-Occupational Disability Income Benefit Rider, please also complete the following:

1.	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
2.	What is your current monthly gross income from occupation**?**	$
3.	What is the amount of monthly disability insurance currently in force**?**	$
4.	Is your average work week *less than* 30 hours?	☐ Yes ☐ No
5.	Are you engaged in any of the following occupations: law enforcement officer, fire fighter, underground miner, or active in the military, National Guard, or Reserve?	☐ Yes ☐ No
6.	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

Mod 4 – **RIDERS**

PRODUCT SELECTION FOR NEW INSURANCE

Please select **only one** product.

Note: *Rider availability is based on the product selected, the policy face amount, and state availability.*

☐ **Whole Life Policy With Dividends**	☐ **Whole Life Policy Without Dividends** (Issue ages 50 – 80)	☐ **Term Life Policy**	☐ **Flexible Premium Adjustable Life Policy**
Face Amount $	Face Amount $	Face Amount $	Face Amount $
Select One ☐ Life Pay ☐ Limited Pay Years _____		_____ Years Initial Payment Period	
Nonforfeiture Option ☐ Extended Term ☐ Reduced Paid Up	Nonforfeiture Option ☐ Extended Term – *Standard only* ☐ Reduced Paid Up		
Automatic Premium Loan: ☐ Yes ☐ No	Automatic Premium Loan: ☐ Yes ☐ No		
Accelerated Death Benefit Rider - **To decline, check here** ☐ ☐ Accidental Death Benefit Rider Amount _____ ☐ Children's Insurance Benefit Rider ☐ Guaranteed Insurability Option Rider Amount _____ ☐ Non-Occ Disability Income Monthly Benefit Amount $_____ ☐ Single Premium Additional Insurance Rider ☐ Waiver of Premium Rider ☐ Other_____ Select ONE Dividend Option**:** ☐ Accumulation ☐ Cash ☐ Paid-Up Additions ☐ Premium Reduction	☐ Accidental Death Benefit Rider – *Standard only* ☐ Other_____	Accelerated Death Benefit Rider - **To decline, check here** ☐ ☐ Accidental Death Benefit Rider Amount _____ ☐ Children's Insurance Benefit Rider ☐ Non-Occ Disability Income Monthly Benefit Amount $_____ ☐ Waiver of Premium Rider ☐ Other_____	Accelerated Death Benefit Rider - **To decline, check here** ☐ ☐ Accidental Death Benefit Rider Amount _____ ☐ Children's Insurance Benefit Rider ☐ Non-Occ Disability Income Monthly Benefit Amount $_____ ☐ Waiver of Premium Rider ☐ Other_____

Complete for Children's Insurance Benefit Rider as identified in Mod 2:

Child's Name	*Face Amount*
	$
	$
	$
	$
	$
	$
	$
	$

Mod 5

PREMIUM AND BILLING INFORMATION

Premium Methods *(All methods may not be available for all products)*

☐ Electronic Funds Transfer (EFT):
☐ Monthly ☐ Semiannual ☐ Annual

☐ Direct Bill *(Initial premium must be check or credit card)*:
☐ Quarterly ☐ Semiannual ☐ Annual

Initial Premium paid with the application $ _____

☐ Planned Premium $ _____
☐ Draft Premium Immediately
☐ Future Draft Date Request:
☐ Draft Day (1-28) _____
☐ Social Security Benefit Draft:
☐ 1st of month ☐ 3rd of month ☐ 2nd Wednesday
☐ 3rd Wednesday ☐ 4th Wednesday
☐ Pay by Check
☐ Charge to Credit Card *(Must complete Baltimore Life Form)*
☐ Init. Lump Sum Prem. ☐ 1035 $_____ ☐ Non-1035 $_____
☐ SPAIR Premium (Dividend WL Only)
☐ 1035 $_____ ☐ Non-1035 $_____

Mod 6

OWNER INFORMATION

POLICY OWNER *(If Other than Proposed Insured)*

First Name | Middle Name/Initial | Last Name | Suffix

Street Address

City | State | ZIP

Date of Birth (MM/DD/YYYY) / / | Social Security No. or TIN – – | Marital Status

Area Code and Telephone Number ( ) - | Is this a mobile phone? ☐ Yes ☐ No

Email Address | Relationship to Proposed Insured

CONTINGENT OWNER *(This option is only available when the Proposed Insured is not the Owner.)*

First Name | Middle Name/Initial | Last Name | Suffix

Street Address

City | State | ZIP

Date of Birth (MM/DD/YYYY) / / | Social Security No. or TIN – – | Marital Status

Area Code and Telephone Number ( ) - | Is this a mobile phone? ☐ Yes ☐ No

Email Address | Relationship to Proposed Insured

Mod 7

OPTIONAL SECONDARY ADDRESSEE

For notification of a past due premium payment and/or possible lapse in coverage, do you want to designate a secondary addressee? ☐ Yes ☐ No

First Name | Middle Name/Initial | Last Name | Suffix

Street Address

City | State | ZIP

Relationship to Proposed Insured

Mod 8

PRIMARY BENEFICIARY INFORMATION

Notice: *Unless otherwise directed, the insurance proceeds will be divided equally among all persons who are named as Primary Beneficiary and who survive the insured. If no Primary Beneficiary survives, proceeds will be divided equally among all persons who are named as a Contingent Beneficiary and who survive the insured. If additional space is needed, attach an application amendment form.*

Total benefits must equal 100%

First Name	Middle Name/Initial	Last Name	Suffix
Street Address	City	State	ZIP
Date of Birth (MM/DD/YYYY) / /	Social Security No. or TIN – –	Area Code and Telephone Number ( ) –	
Email Address	Relationship to Proposed Insured	Benefit %	

First Name	Middle Name/Initial	Last Name	Suffix
Street Address	City	State	ZIP
Date of Birth (MM/DD/YYYY) / /	Social Security No. or TIN – –	Area Code and Telephone Number ( ) –	
Email Address	Relationship to Proposed Insured	Benefit %	

CONTINGENT BENEFICIARY *(If any)*

First Name	Middle Name/Initial	Last Name	Suffix
Street Address	City	State	ZIP
Date of Birth (MM/DD/YYYY) / /	Social Security No. or TIN – –	Area Code and Telephone Number ( ) –	
Email Address	Relationship to Proposed Insured	Benefit %	

First Name	Middle Name/Initial	Last Name	Suffix
Street Address	City	State	ZIP
Date of Birth (MM/DD/YYYY) / /	Social Security No. or TIN – –	Area Code and Telephone Number ( ) –	
Email Address	Relationship to Proposed Insured	Benefit %	

First Name	Middle Name/Initial	Last Name	Suffix
Street Address	City	State	ZIP
Date of Birth (MM/DD/YYYY) / /	Social Security No. or TIN – –	Area Code and Telephone Number ( ) –	
Email Address	Relationship to Proposed Insured	Benefit %	

First Name	Middle Name/Initial	Last Name	Suffix
Street Address	City	State	ZIP
Date of Birth (MM/DD/YYYY) / /	Social Security No. or TIN – –	Area Code and Telephone Number ( ) –	
Email Address	Relationship to Proposed Insured	Benefit %	

Mod 9

EXISTING INSURANCE REPLACEMENT QUESTIONS

1. Does the Proposed Insured have existing life insurance or annuities currently in force or pending with this company or any other company? ☐ Yes ☐ No
2. Has the Proposed Insured had any policies lapse or surrender within the last six (6) months? ☐ Yes ☐ No
3. Will this policy, if issued, replace or modify life insurance or annuities in force with this or any other company? ☐ Yes ☐ No

If any question is answered "Yes", provide the following information.
(Exclude property, casualty or liability, and employer-paid group life insurance).

Company Name	Policy Number	Name of Insured or Annuitant	Amount (incl. ADB)	Year Issued	Replacing? (Yes or No)

Mod 10

PREMIUM PAYOR INFORMATION

Please check if Premium Payor is the Owner or Insured: ☐ Owner ☐ Insured

If Premium Payor is other than Owner or Insured, please complete the information below:

Full Name: *First* *Middle* *Last* *Suffix*

Street Address City State ZIP

Email Address | Relationship to Proposed Insured

Mod 11

AUTHORIZATION, ACKNOWLEDGMENT AND CERTIFICATION

DECLARATION: I understand that statements and answers in the application are the basis for any policy issued and that no information about them will be considered to have been given to the Baltimore Life Insurance Company ("the Company") unless stated in the application. 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 do not notify 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 while each Proposed Insured is alive and this application is approved by the Company and the policy is delivered to and accepted by the Owner. Only the Company's President, Vice President, or Secretary may: (a) make or change any contract of insurance; (b) make a binding promise about insurance; or (c) change or waive any term of an amendment(s) or supplement(s). Paying my insurance premium more frequently than annually may result in higher yearly out-of-pocket cost or different cash values. This application will expire after 60 days if not received by the Company. I understand that no agent is authorized to advise me that an inaccurate answer is acceptable. I understand that the Company can contest any benefits that provide accidental death benefit coverage or disability coverage. I have read the application and all statements and answers, and they are true and complete to the best of my knowledge and belief.

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

NOTICE: State insurance law may prohibit the owner of a life insurance policy from entering into any agreement to sell, transfer or assign a life insurance policy **before** the date the policy was issued, or within a period specified by state law after the date the policy was issued. Please consult with legal advisors if you have any questions about these matters.

Tax Notice: Under Federal Tax law, the company is required to ask you to certify your correct Taxpayer Identification Number (TIN) and to include it in any reports of taxable income it makes to the IRS. If you are an individual, your Social Security Number is your Taxpayer Identification Number.

Certification: 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 because: a) I am exempt from backup withholding, or b) I have not been notified by the Internal Revenue Service (IRS) 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 U.S. citizen or other U.S. person (defined in the Instructions to the Form W-9); and 4) I am exempt from the Foreign Account Tax Compliance Act (FATCA) reporting.

☐ **Check this box if the IRS has notified you that you are subject to backup withholding.**

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 statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

This Application was signed at _____ and _____ _____day of _____, _____
CITY STATE DAY MONTH YEAR

_____ _____
Signature of Proposed Insured Signature of Owner *(If other than Proposed Insured)*
(Unless under age 15. State variations may apply)

_____
Signature of Parent/Legal Guardian of Proposed Minor Child/Children

Mod 12