Simplified Application

The Baltimore Life Insurance Company
10075 Red Run Boulevard, Owings Mills, Maryland 21117-4871
(800) 628-5433 • www.baltlife.com

Product Applied For _____

☐ Limited Pay – Number of Years _____

PROPOSED INSURED *(First, Initial, Last Name)*

_____

State of Birth _____

Country of Birth _____

Date of Birth _____ Present Age _____

Sex _____ Height _____ Weight _____

Social Security Number _____

Street Address _____

_____

City, State ZIP _____

Home Telephone _____

Work Telephone _____

E-mail Address _____

Occupation _____

PAYER OF POLICY *if other than Proposed Insured*

_____

Relationship _____

Street Address _____

_____

City, State ZIP _____

Home Telephone _____

OWNER *if other than Proposed Insured*

_____

Relationship _____

Social Security Number _____

Street Address _____

_____

City, State ZIP _____

Home Telephone _____

FACE AMOUNT $ _____

Premium $ _____

Premium Mode ☐ Monthly Bank Draft

If Direct Bill: ☐ Annual ☐ Semi-Annual ☐ Quarterly
(Initial premium must be check or credit card)

Initial Premium paid with application $ _____

☐ Draft Premium Immediately

☐ Charge to Credit Card *(Complete Form 5122)*

☐ Payment by Check

☐ Future Draft Date Request

Draft Date _____

Automatic Premium Loan: ☐ Yes ☐ No

☐ Rider(s)

_____

PRIMARY BENEFICIARY

_____

Relationship _____

CONTINGENT BENEFICIARY

_____

Relationship _____

Form 7430-0508

Part 1

1. Have you been medically diagnosed as having Alzheimer's, or any other form of dementia, or have you been told that you have a life expectancy of 12 months or less? ☐ Yes ☐ No

2. Have you been diagnosed by or received treatment from a member of the medical profession for AIDS (Acquired Immune Deficiency Syndrome) or any other disorder of the immune system, including systemic Lupus, or have you tested positive for exposure to the HIV infection? ☐ Yes ☐ No

3. Have you ever been medically advised to have any organ transplant, are you receiving kidney dialysis, or have you been diagnosed with hepatitis C? ☐ Yes ☐ No

4. Are you currently bedridden, confined to a wheelchair due to chronic illness, in a hospital, living in a nursing home, hospice, assisted living facility, or long-term care facility, or using oxygen or has a doctor recommended that you use oxygen? ☐ Yes ☐ No

(If the answer to any question in Part 1 is "Yes" then the Proposed Insured is not eligible for any coverage.)

Part 2

In the past two (2) years, have you been told or have you had a medical diagnosis, received treatment, had symptom(s) or been hospitalized for any of the following:

1. Heart attack, congestive heart failure, irregular heartbeat, circulatory disorder, aneurysm, or any other disease or condition of the heart or arteries, have you undergone angioplasty or bypass surgery, or have you used a pacemaker? ☐ Yes ☐ No

2. Uncontrolled high blood pressure, uncontrolled diabetes or blood sugars, diabetic coma, or any diabetes requiring the use of insulin? ☐ Yes ☐ No

3. Internal cancer, melanoma, leukemia, sickle cell anemia, kidney disease, liver disease, cirrhosis, chronic lung disease, chronic obstructive pulmonary disease (COPD), or emphysema? ☐ Yes ☐ No

4. Alcoholism or drug abuse? ☐ Yes ☐ No

5. Stroke, any paralysis, Parkinson's, mental retardation, psychosis, suicide attempt, disease or disorder of the brain, or any condition affecting or relating to circulation to the brain? ☐ Yes ☐ No

Part 3

1. Within the last two years, have you had an application for life or health insurance declined, postponed, modified, or refused for any reason, or have you been convicted of a felony or incarcerated? ☐ Yes ☐ No

2. Have you used tobacco products in any form in the last 12 months? ☐ Yes ☐ No

Comments:

REPLACEMENTS:

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 life insurance or annuities in this or any other company? ☐ Yes ☐ No

If either question is answered "Yes," provide the following information:

Policy #	Company Name	Replacing Yes or No

PLEASE READ AND SIGN:

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

When I sign the application, I understand, I am authorizing the MIB Group, Inc. ("MIB"), any medical or medically-related person or facility to provide health and/or treatment information about the proposed Insured to the Company. I understand that such information will be used to determine eligibility for insurance and/or benefits. Any information used will be subject to the Company's Notice of Privacy and Information Practices which is provided with my policy, or upon request. I understand that I may request a copy of this authorization and agree that a photographic copy of this authorization shall be as valid as the original. This authorization shall remain valid for a period of two years and six months from the date it is signed.

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 civil fines and criminal penalties.

APPLICANT(S) PRE-NOTICE

Information regarding your insurability will be treated as confidential. The Company or its reinsurers may, however, make a brief report thereon to the Medical Information Bureau, a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such company, the Bureau, upon request, will supply such company with the information in its file. Upon receipt of a request from you, the Bureau will arrange disclosure to you of any information it may have in your file. If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the Bureau's information office is 50 Braintree Hill, Suite 400, Braintree, MA 02184-8734; the telephone number is (866) 692-6901. The Company or its reinsurers may also release information in its file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

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

_____ Signature of Proposed Insured

_____ Signature of Proposed Owner, if other than Proposed Insured

AGENT'S STATEMENT

1. Have you, the writing agent, personally seen the Proposed Insured? ☐ Yes ☐ No
2. Are you aware of any additional information that may affect our underwriting decision? ☐ Yes ☐ No
3. Based on your knowledge, does the Proposed Insured have existing life insurance or annuities? ☐ Yes ☐ No
4. Do you have knowledge or reason to believe that replacement of existing life insurance or annuities may be involved? ☐ Yes ☐ No
5. If replacement is occurring, do you certify that this replacement is within the guidelines provided by Baltimore Life? ☐ Not Applicable ☐ Yes ☐ No
6. Would you like the policy mailed to the policyowner? ☐ Yes ☐ No

Witness (Licensed Agent): I certify that only advertising previously approved by The 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.

I hereby certify that I have truly and accurately recorded on this application the information supplied by the applicant.

Writing Agent Signature	Printed Name	Date	Writing Agent Code No.

If split commissions apply:

Writing Agent #2 (Printed Name)	Date	Writing Agent Code	% of Commission to be paid
Writing Agent #3 (Printed Name)	Date	Writing Agent Code	% of Commission to be paid

MONTHLY AUTOMATIC CHECK AUTHORIZATION

As a convenience to me, I hereby request and authorize you to issue and charge to my account checks drawn on my account by and payable to the order of The Baltimore Life Insurance Company. I agree that your treatment of each check and your rights thereunder shall be the same as if the check was personally signed by me. If any check is dishonored for any reason, I release you from any liability resulting from the dishonor of the check, even if the dishonor results in cancellation of my insurance or annuity policy. Lastly, I agree that this authorization shall remain in effect until written notice of its termination is provided by me to you or until terminated by the Company.

Name _____ Signature _____

Bank Name _____

City, State, ZIP _____

Name of Accountholder _____

Bank Routing Number _____ Account Number _____
(Must be 9 digits)

Signature EXACTLY as it appears on bank records _____

Form 7430-0508

CONDITIONAL RECEIPT

Received from _____ The sum of $_____

This receipt is given and accepted with the understanding that the insurance applied for shall go into force when the application is completed, the first premium is paid in full, and the application is approved by the Company while the Proposed Insured's condition of health is unchanged from the date of the application.

Proposed Insured _____ Date _____

Agent _____

THE PREMIUM CHECK MUST BE MADE PAYABLE TO THE BALTIMORE LIFE INSURANCE COMPANY. DO NOT MAKE THE CHECK PAYABLE TO THE AGENT OR LEAVE THE PAYEE BLANK.

Form 7430-0508

Tax Notice and Certification

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); (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. person (including a U.S. Resident Alien).

Section 6109 of the Internal Revenue Code requires you to provide your correct tax identification number (TIN) to persons who must file information returns with the IRS to report interest, dividends and certain other income. We may also disclose this information to other countries under a tax treaty to federal and state agencies to enforce federal non-tax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

The IRS does not require your consent to any provisions of this document other than the certification required to avoid backup withholding.

Printed Name	Social Security Number (TIN)
Signature	Licensed Agent Signature (Witness)

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