



Simplified Application

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

All questions in this application are important. Please read and complete carefully.

All information below must be provided to avoid processing delays.

Plan 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 No. _____

Street Address _____

City, State, Zip _____

Home Telephone _____

Work Telephone _____

E-Mail Address _____

Occupation _____

Face Amount \$ _____ Premium \$ _____

Amount paid with application \$ _____

Premium Mode: Direct Bill Monthly Bank Draft

If Direct Bill: Annual Semi-Annual Quarterly

Dividends (if applicable): Not Applicable
 Benefit Increase Paid to Owner
 Premium Reduction (only on annual modes)
 Accumulations

Automatic Premium Loan: Yes No

Primary Beneficiary _____

Relationship _____

Social Security No. _____

Contingent Beneficiary _____

Relationship _____

Social Security No. _____

Payer of Policy if other than Proposed Insured

Relationship _____

Social Security No. _____

Street Address _____

City, State, Zip _____

Home Telephone _____

E-Mail _____

Owner if other than Proposed Insured

Relationship _____

Social Security No. _____

Street Address _____

City, State, Zip _____

Home Telephone _____

E-Mail _____

Note: Please read each question carefully and answer truthfully before signing this application.

Part 1

To the best of your knowledge and belief, have you, the Proposed Insured:

- 1. Ever been diagnosed with a terminal illness? Yes No
- 2. Ever 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? Yes No

Are you currently:

- 3. Bedridden at home, confined in a hospital, nursing home, hospice, assisted living or long-term care facility, or require the use of a wheelchair due to a chronic illness? Yes No
- 4. Using oxygen or recommended to use oxygen for any respiratory assistance? Yes No

Part 2

To the best of your knowledge and belief, have you, the Proposed Insured, within the last two years, had, been treated for (includes office visits or surgery), or are you taking medication or have you taken medication for any of the following:

- 1. Heart attack, congestive heart failure, irregular heartbeat, any condition leading to angioplasty or bypass surgery, or any other condition of the heart or arteries? Yes No
- 2. Uncontrolled high blood pressure, uncontrolled diabetes or blood sugars, diabetic coma, or insulin shock? Yes No
- 3. Internal cancer, melanoma, leukemia, sickle cell anemia, kidney disease, liver disease (including cirrhosis), or chronic lung disease including chronic obstructive pulmonary disease (COPD), or emphysema? Yes No
- 4. Alcoholism or drug abuse? Yes No
- 5. Stroke, any paralysis, Alzheimer's, Parkinson's, dementia, mental retardation or any other disease or disorder of the brain or nervous system 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? 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 or have you lapsed or surrendered life insurance or annuities within the last six months? Yes No
- 2. Will this policy, if issued, replace or modify life insurance or annuities in this or any other company? Yes No

If "Yes," how affected: Exchange Replace Modify

Name of Company _____ Policy Number _____



The Baltimore Life
COMPANIES

Please read and sign:

This application is complete and true to the best of my knowledge and belief. The Company is deemed to know only the facts contained in this application. Any policy issued with this application shall not go into force unless 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.

Authorization and Acknowledgement

I authorize any physician, medical practitioner, hospital, clinic, other medical or medically-related facility, insurance or reinsuring company, or the Medical Information Bureau, Inc. having information available as to diagnosis, treatment and/or prognosis of me with respect to any physical or mental condition, including alcoholism and/or use of drugs, and any other nonmedical information about me to give to the Company any and all such information. I 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 my application or claim, or as may be otherwise lawfully required or as I may further authorize. I understand that I may request a copy of this authorization and agree that a photographic copy of this authorization shall be as valid as the original. This authorization shall remain valid for a period of two years and six months from the date it is signed. I acknowledge receipt of the Applicant(s) Pre-Notice.

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. If you are an individual, your Social Security number is your Taxpayer Identification Number.

Certification: I certify that I am I am not subject to a backup withholding order under Section 3406(a)(1)(c) of the Internal Revenue Code and I am a U.S. person (including a U.S. resident alien). I also certify that the Taxpayer Identification Number on this form is true, correct and complete.

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

I certify that I have reviewed the health questions contained on this application and that my responses to these questions have been accurately recorded. I understand that no agent is authorized to advise me that any inaccurate answer is acceptable.

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

Signature of Proposed Insured

Signature of Proposed Owner, if other than Proposed Insured

Form 7430

D E T A C H A T P E R F O R A T I O N

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

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. Do you have knowledge or reason to believe that replacement of existing life insurance or annuities may be involved? Yes No
If yes, complete applicable state replacement form(s) and the Understanding Policy Replacement form, and answer questions 4 and 5 below.
- 4. Do you certify that only company approved advertising material was used and that a copy of all advertising used was provided to the applicant? Yes No
Indicate form numbers: _____
- 5. Do you certify that this replacement is within the guidelines provided by Baltimore Life? Yes No

Witness (Licensed Agent): 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.
Agency Name	Agency Code		
<i>If split commissions apply:</i>			
Writing Agent #2 (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 _____	Type of Account:
City, State, Zip _____	<input type="checkbox"/> Checking
Name of Accountholder _____	<input type="checkbox"/> Savings
Bank Routing Number _____	Date _____
(Must be 9 digits)	
Account Number _____	
Signature EXACTLY as it appears on bank records _____	Please attach a voided check.

Form 7430

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 Post Office Box 105, Essex Station, Boston, Massachusetts, 02112; the telephone number is (617) 426-3660.

The Company or its reinsurers may also release information in its file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

Form 7430