The Baltimore Life Insurance Company

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

Application for Single Premium Life Insurance

1. Proposed Insured and Beneficiary Information

Last Name	First Name	MI

Social Security Number	Age	Sex	Date of Birth	State or Country of Birth	Height	Weight

Telephone: Day Evening	Email Address

Street Address	City	State	ZIP Code

Drivers License Number	Drivers License State

Primary Beneficiary	Social Security Number	Relationship

Contingent Beneficiary	Social Security Number	Relationship

2. Owner *(if other than Proposed Insured)*

Last Name	First Name	MI	Relationship

Date of Birth	Tax ID# or Social Security#	Email Address

Street Address	City	State	ZIP Code

3. Insurance Product Applied For

Product _____ Face Amount $ _____ Premium Amount $ _____

4. Medical Questions

Part A

1. Do you have any impairment, whether physical or mental, for which you need or receive assistance or supervision in performing normal activities of daily living such as bathing, toileting, eating, dressing, taking medications, or moving without any type of physical assistance? ..... ☐ Yes ☐ No
2. Have you ever:
   a. 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
   b. Had, or been medically advised to have, an organ transplant, or been diagnosed as having a terminal medical condition that is expected to result in death within the next 12 months or are you currently hospitalized, confined to a bed or nursing facility, or receiving hospice care?..... ☐ Yes ☐ No
   c. Been medically diagnosed, treated, or taken medication for chronic kidney disease (including dialysis), kidney or liver failure, congestive heart failure, cardiomyopathy, organic brain syndrome, Alzheimer's, dementia, Lou Gehrig's disease (ALS), schizophrenia, bipolar disorder, or mental incapacity? ..... ☐ Yes ☐ No

d. 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

e. Had more than one occurrence or any metastasis of any cancer in your lifetime (excluding Basal or Squamous cell skin cancer), or are you currently being treated for cancer or recurrence of cancer or had an amputation caused by cancer? ☐ Yes ☐ No

3. Within the past 24 months have you:
   a. Been declined or postponed for life or health insurance? ☐ Yes ☐ No
   b. Been convicted of a felony or are you currently on probation or parole? ☐ Yes ☐ No
   c. Been convicted of operating a vehicle while intoxicated or impaired? ☐ Yes ☐ No
4. Within the past 24 months have you been medically diagnosed, treated for or taken medication for:
   a. Internal cancer, leukemia, lymphoma, melanoma, Hodgkin's disease, Parkinson's disease, stroke, transient ischemic attack (TIA), cirrhosis, liver disease, attempted suicide, alcohol abuse or drug abuse? ☐ Yes ☐ No
   b. Chronic obstructive pulmonary or lung disease (COPD), emphysema, chronic bronchitis, or required oxygen to assist in breathing? ☐ Yes ☐ No
5. Within the past 24 months have you been diagnosed as having, been treated for, advised to have treatment for or hospitalized for:
   a. Angina, heart disease, heart attack, uncontrolled high blood pressure, heart or vascular surgery (including heart transplant, coronary artery bypass, pacemaker or replacement pacemaker, heart valve replacement, abdominal aortic aneurysm, but excluding angioplasty or stent placement) or any procedure to improve circulation to the heart or brain? ☐ Yes ☐ No
   b. 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

Part B

1. Within the past 48 months have you been medically diagnosed, hospitalized for, treated for or taken medication for lymphoma, melanoma, leukemia, any internal cancer, Hodgkin's disease, Parkinson's disease, stroke, transient ischemic attack (TIA), cirrhosis, or liver disease? ☐ Yes ☐ No
2. Within the past 36 months have you been medically diagnosed, hospitalized for, treated for or taken medications for:
   a. Angioplasty, cardiac or vascular stent placement, angina, heart attack, heart or vascular surgery or any procedure to improve circulation to heart or brain? ☐ Yes ☐ No
   b. Chronic obstructive pulmonary or lung disease (COPD), emphysema, chronic bronchitis, or required oxygen to assist in breathing? ☐ Yes ☐ No
   c. Diabetic complications (including neuropathy, retinopathy, uncontrolled blood sugar)? ☐ Yes ☐ No
3. 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

1. Are you taking medication for any impairment listed above? ☐ Yes ☐ No
2. Have you used any nicotine or tobacco based products in the past 12 months? ☐ Yes ☐ No
3. Have you applied for life insurance with any other insurance companies in the last two years? ☐ Yes ☐ No

Please provide details of all "Yes" answers from Section 4 in the area below. *(Use Additional Comments section if more space is needed.)*

Question #	Explanation	Dates/Duration	Name of Medical Professional

5. Replacement Information

1. Does the proposed insured have any existing life insurance or annuities? ☐ Yes ☐ No
   If "Yes", policy status is: _____
2. Has the proposed insured had any policies lapsed or surrendered within the last six months? ☐ Yes ☐ No
3. 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.)
4. Is any other application for annuity or life insurance pending in this or any other company on the proposed insured? ☐ Yes ☐ No

Existing or Pending Insurance:

Name of Insured	Company	Policy Number	Amount $	Year Issued	Replace or modify?
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No

5. Why is this replacement occurring? _____

6. Additional Ownership Questions

1. Has any party to the application, such as the applicant, proposed insured, owner, if other than the applicant, or any beneficiary, entered or made plans to enter into any agreement or contract to sell or assign the ownership of, or a beneficial interest in the applied for policy? ☐ Yes ☐ No

2. Has any person promised or agreed to give or has given to any party to the application, or has any party to the application received or will receive from any person, any inducement, fee or compensation as an incentive to purchase the policy? ☐ Yes ☐ No

Please provide agreement details of all "Yes" answers in the Additional Comments section.

7. Additional Comments

_____

_____

_____

_____

_____

_____

_____

_____

_____

8. 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.

AGREEMENT: I am not currently taking and I am not under the influence of any medications or drugs that would affect my ability to fully understand and to fully and accurately complete this application. I have read or had read to me all of the questions and answers contained in this application. This application is complete and true to the best of my knowledge and belief.

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.

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.

AUTHORIZATION AND ACKNOWLEDGMENT: I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, pharmacy benefit manager, medical or medically-related facility or health care provider, insurance or reinsuring company, or MIB, Inc., consumer reporting agency or employer having information available as to diagnosis, treatment, prescriptions 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, MIB, 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. I understand I have the right to receive in writing the reason for an adverse underwriting decision. This authorization shall remain valid for a period of two years and six months following the date of my signature below, regardless of my condition and whether living or deceased, and a copy of this authorization is as valid as the original. I acknowledge receipt of MIB, Inc.'s Pre-Notice and the Fair Credit Reporting Act 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.

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 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.

I certify that I have read the medical 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.

If replacement is occurring, please read the following notice: In many cases, the replacement of an existing life insurance policy, regardless of the issuing company, is not in your best interest. New policies contain contestable and suicide provisions which you should ask your agent to explain. In addition, there are expense charges associated with each new policy. You should ask your agent to explain both the benefits and the drawbacks of the replacement you are considering.

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.

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

(X) _____ (X) _____
Signature of Proposed Insured Signature of Owner (If other than Proposed Insured)

(X) _____ _____
Signature of Licensed Agent (Witness to all signatures) *(Give official capacity if signed on behalf of a corporation, trust etc.)*

9. Agent Certification

I certify that I have asked the person proposed for coverage all of the questions contained in this application and have accurately recorded on this application the information supplied by the persons proposed for coverage.

a. Did you verify the identity of the applicant by viewing their driver's license or other government issued form of identification? ..... ☐ Yes ☐ No

b. Do you have knowledge or reason to believe that replacement of existing life insurance or annuity policies may be involved? ..... ☐ Yes ☐ No

c. If replacement is occurring, do you certify that this replacement complies with Baltimore Life's replacement guidelines? ..... ☐ Yes ☐ No ☐ Not Applicable

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 certify that the above statements and responses are true and accurate.

_____ (X)_____

Print Agent's Name | Agent Number | Agent Signature | Date

Split Credit

If more than one agent is to receive split credit for this case, please complete the information below. Please Print.

Split Agent 2 _____ Agent No. _____ %_____ of split credits

Split Agent 3 _____ Agent No. _____ %_____ of split credits

Agent Comments

_____

_____

_____

_____

_____

_____

10. Conditional Receipt

(This receipt must not be detached unless the full initial premium is received at the time of application)

NO INSURANCE WILL BECOME EFFECTIVE PRIOR TO POLICY DELIVERY AND ACCEPTANCE UNLESS THE FOLLOWING CONDITIONS REQUIRED BY THIS RECEIPT ARE MET:

a. The full initial premium is paid according to the method of premium payment selected in the application for the amount of insurance applied for;
b. Any check given or draft authorized for premium payment is honored when first presented for payment;
c. All medical examinations, tests, X-rays and electrocardiograms 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, limits and standards as to plan, benefits, class, and amount for the policy applied for;
e. The application is approved by the Company; and
f. There is no material misrepresentation in the application or medical information furnished to the Company.

IF ANY OF THE ABOVE CONDITIONS ARE NOT MET, 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 or tests 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 and all other supplemental benefits provided by this receipt 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. Either the Company or the proposed insured or owner, as applicable, may terminate coverage under this receipt by notice to the other. In no event will coverage under this receipt be in force after 60 days from the date of the application. If the Company declines to issue a policy or issues a policy other than as applied for which is not accepted, the premium payment will be refunded. There will be no liability on account of this receipt if any premium check or draft is not honored upon presentation for payment. If there is material misrepresentation in the application (or in any medical information furnished to the Company), the Company's only liability will be limited to refunding the premium payment. If the proposed insured commits suicide, whether sane or insane, the Company's only liability will be limited to refunding the premium payment. 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 PREMIUM CHECKS MUST BE MADE PAYABLE TO THE BALTIMORE LIFE INSURANCE COMPANY. DO NOT MAKE THE CHECK PAYABLE TO THE AGENT OR LEAVE THE PAYEE BLANK.

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

_____ _____

Signature of Proposed Insured Signature of Proposed Owner (If other than Proposed Insured)

_____

Signature of Agent

Tear here and leave notices below with Applicant

11. 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.

12. MIB, Inc. Notice

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, Suite 400, Braintree, Massachusetts, 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.

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IMPORTANT NOTICE:
REPLACEMENT OF LIFE INSURANCE OR ANNUITIES

This document must be signed by the applicant and the producer, if there is one, and a copy left with the applicant.

You are contemplating the purchase of a life insurance policy or annuity contract. In some cases this purchase may involve discontinuing or changing an existing policy or contract. If so, a replacement is occurring. Financed purchases are also considered replacements.

A replacement occurs when a new policy or contract is purchased and, in connection with the sale, you discontinue making premium payments on the existing policy or contract, or an existing policy or contract is surrendered, forfeited, assigned to the replacing insurer, or otherwise terminated or used in a financed purchase.

A financed purchase occurs when the purchase of a new life insurance policy involves the use of funds obtained by the withdrawal or surrender of or by borrowing some or all of the policy values, including accumulated dividends, of an existing policy, to pay all or part of any premium or payment due on the new policy. A financed purchase is a replacement.

You should carefully consider whether a replacement is in your best interest. You will pay acquisition costs and there may be surrender costs deducted from your policy or contract. You may be able to make changes to your existing policy or contract to meet your insurance needs at less cost. A financed purchase will reduce the value of your existing policy and may reduce the amount paid upon the death of the insured.

We want you to understand the effects of replacements before you make your purchase decision and ask that you answer the following questions and consider the questions on the back of this form.

1. Are you considering discontinuing making premium payments, surrendering, forfeiting, assigning to the insurer, or otherwise terminating your existing policy or contract? ☐ YES ☐ NO
2. Are you considering using funds from your existing policies or contracts to pay premiums due on the new policy or contract? ☐ YES ☐ NO

If you answered "yes" to either of the above questions, list each existing policy or contract you are contemplating replacing (include the name of the insurer, the insured or annuitant, and the policy or contract number if available) and whether each policy or contract will be replaced or used as a source of financing:

INSURER NAME	CONTRACT OR POLICY #	INSURED OR ANNUITANT	REPLACED (R) OR FINANCING (F)
1.			
2.			
3.			

Make sure you know the facts. Contact your existing company or its agent for information about the old policy or contract. If you request one, an in-force illustration, policy summary or available disclosure documents must be sent to you by the existing insurer. Ask for and retain all sales material used by the agent in the sales presentation. Be sure that you are making an informed decision.

The existing policy or contract is being replaced because:

_____

I certify that the responses herein are, to the best of my knowledge, accurate:

You have the right to return the policy within 30 days of its delivery and receive an unconditional full refund of all premiums.

_____
Applicant's Signature

_____ _____
Applicant's Printed Name Date

_____
Producer's Signature

_____ _____
Producer's Printed Name Date

I do not want this notice read aloud to me. _____ (Applicants must initial only if they do not want the notice read aloud.)

A copy of this form must be provided tot he applicant and a second copy must be provided to the Home Office along with the application.

A replacement may not be in your best interest, or your decision could be a good one. You should make a careful comparison of the costs and benefits of your existing policy or contract and the proposed policy or contract. One way to do this is to ask the company or agent that sold you your existing policy or contract to provide you with information concerning your existing policy or contract. This may include an illustration of how your existing policy or contract is working now and how it would perform in the future based on certain assumptions. Illustrations should not, however, be used as a sole basis to compare policies or contracts. You should discuss the following with your agent to determine whether replacement or financing your purchase makes sense:

PREMIUMS:
Are they affordable?
Could they change?
You're older—are premiums higher for the proposed new policy?
How long will you have to pay premiums on the new policy? On the old policy?

POLICY VALUES:
New policies usually take longer to build cash values and to pay dividends.
Acquisition costs for the old policy may have been paid; you will incur costs for the new one.
What surrender charges do the policies have?
What expense and sales charges will you pay on the new policy?
Does the new policy provide more insurance coverage?

INSURABILITY:
If your health has changed since you bought your old policy, the new one could cost you more, or you could be turned down.
You may need a medical exam for a new policy.
Claims on most new policies for up to the first two years can be denied based on inaccurate statements.
Suicide limitations may begin anew on the new coverage.

IF YOU ARE KEEPING THE OLD POLICY AS WELL AS THE NEW POLICY:
How are premiums for both policies being paid?
How will the premiums on your existing policy be affected?
Will a loan be deducted from death benefits?
What values from the old policy are being used to pay premiums?

IF YOU ARE SURRENDERING AN ANNUITY OR INTEREST SENSITIVE LIFE PRODUCT:
Will you pay surrender charges on your old contract?
What are the interest rate guarantees for the new contract?
Have you compared the contract charges or other policy expenses?

OTHER ISSUES TO CONSIDER FOR ALL TRANSACTIONS:
What are the tax consequences of buying the new policy?
Is this a tax-free exchange? (See your tax advisor.)
Is there a benefit from favorable "grandfathered" treatment of the old policy under the federal tax code?
Will the existing insurer be willing to modify the old policy?
How does the quality and financial stability of the new company compare with your existing company?

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Modified Endowment Contract Information

I understand that as defined in the Internal Revenue Code Section 7702A, the life insurance policy for which I have applied, or which has been issued, is a Modified Endowment Contract.

The Federal Government created a class of life insurance policies known as Modified Endowment Contracts under the Technical and Miscellaneous Revenue Act of 1988 (TAMRA). These are life insurance policies under which the gross premiums paid at any time during the first seven years - or during the seven years after a material change - exceed the sum of the annual net level premiums under the seven-pay test defined in the law.

Death benefits on life insurance policies are not subject to income tax, but in some cases may be subject to estate taxes.

When a policy becomes a Modified Endowment Contract, there is a change in the tax treatment of any distribution made during the life of the policy. The kinds of distributions that may be subject to income tax include dividends paid in cash or withdrawn, any loan, interest on the loan, partial withdrawals, policy surrender, or any assignment or pledge.

When a taxable distribution is made, only the amount of the distribution that represents any gain in the contract is included in your taxable income.

Taxable distributions are subject to a two-part tax — ***income tax*** on the amount of the gain and an ***additional 10%*** penalty unless the taxpayer is disabled, over the age of 59½ or the benefit is paid as a life annuity.

Before making any decision concerning the tax status of your policy, you should consult your tax advisor.

_____	_____
Name of Applicant and/or Policyholder (Print)	Policy Number
_____	_____
Signature of Applicant and/or Policyholder	Date
_____	_____
Name of Agent (Print)	Agent Number
_____	_____
Signature of Agent	Date

A copy of this form must be provided to the applicant and a copy must be submitted to the home office with the application.

Form 3994-0309

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When a policy becomes a Modified Endowment Contract, there is a change in the tax treatment of any distribution made during the life of the policy. The kinds of distributions that may be subject to income tax include dividends paid in cash or withdrawn, any loan, interest on the loan, partial withdrawals, policy surrender, or any assignment or pledge.

When a taxable distribution is made, only the amount of the distribution that represents any gain in the contract is included in your taxable income.

Taxable distributions are subject to a two-part tax — ***income tax*** on the amount of the gain and an ***additional 10%*** penalty unless the taxpayer is disabled, over the age of 59½ or the benefit is paid as a life annuity.

Before making any decision concerning the tax status of your policy, you should consult your tax advisor.

_____	_____
Name of Applicant and/or Policyholder (Print)	Policy Number
_____	_____
Signature of Applicant and/or Policyholder	Date
_____	_____
Name of Agent (Print)	Agent Number
_____	_____
Signature of Agent	Date

A copy of this form must be provided to the applicant and a copy must be submitted to the home office with the application.

Form 3994-0309

The Baltimore Life COMPANIES

Acknowledgment

Secure Solutions®
Single Premium Whole Life

Source of Funds

Due to anti-money laundering regulations, it is the policy of Baltimore Life to take reasonable steps to identify the source of funds used to purchase our products. Please identify where the funds are coming from by checking the appropriate box below. ***If you have been in possession of the funds for thirty (30) days or less, please specify how money was obtained.**

☐ Money Market/CD ☐ Loan ☐ Reverse Mortgage ☐ IRA/Qualified Funds ☐ Existing Fixed Annuity

☐ Existing Variable Annuity ☐ Existing life insurance cash value (Section 1035 Exchange)

☐ Income/Checking/Savings ☐ Inheritance ☐ Sale of Property ☐ Other (*please specify*) _____

***Explanation (if applicable)**_____

I acknowledge that:

- I am applying for a **Single Premium Whole Life Insurance Policy.**
- I understand that, once my premium is paid into the policy, I will have limited access to my cash value. I do not expect to need these funds for my current or future living expenses.
- I have other sources of income to provide for my daily living needs and enough additional saving for emergency cash needs.
- I believe that a Single Premium Whole Life Insurance Policy is appropriate based on my financial situation and goals

_____ _____
Applicant's Signature Date

I acknowledge that:

- Based on the information disclosed to me by the applicant, my recommendation of a Single Premium Whole Life Insurance Policy is reasonably suited to fulfill the applicant's needs.
- I have recorded the applicant's needs analysis information, which formed the basis for my recommendation, and I will make this information available to Baltimore Life in the event it is needed.

_____ _____
Agent's Signature Date

A copy of this form must be submitted with the application.

The Baltimore Life COMPANIES

Acknowledgment

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Agent's Signature Date

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

Authorization for Release of Health-Related Information

This authorization complies with the HIPAA Privacy Rule

_____ _____/_____/_____
Printed Name of Proposed Insured Date of Birth

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy benefit manager, pharmacy, medical facility, or other health care provider that has provided payment treatment or services to me or on my behalf within the past 10 years ("My Providers") to disclose my entire medical record and any other protected health information concerning me to The Baltimore Life Insurance Company and its agents, employees, and representatives. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct any physician, health care professional, hospital, clinic, medical facility, or other health care provider to release and disclose my entire medical record without restriction.

This protected health information is to be disclosed under this Authorization so that The Baltimore Life Insurance Company may:

1) Underwrite my application for coverage, make eligibility, risk rating, policy issuance and enrollment determinations;
2) Obtain reinsurance;
3) Administer claims and determine or fulfill responsibility for coverage and provision of benefits;
4) Administer coverage; and
5) Conduct other legally permissible activities that relate to any coverage I have or have applied for with The Company.

This authorization shall remain in force for 30 months following the date of my signature below, and a copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by sending a written request for revocation to **The Baltimore Life Insurance Company at 10075 Red Run Boulevard, Owings Mills, MD 21117-4871, Attention: Privacy Official.**

I understand that a revocation is not effective to the extent that any of My Providers has relied on this Authorization or to the extent that The Baltimore Life Insurance Company has a legal right to contest a claim under an insurance policy or to contest the policy itself; any information that is disclosed pursuant to this authorization may be redisclosed and no longer covered by federal rules governing privacy and confidentiality of health information; My Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this authorization; and further, if I refuse to sign this authorization to release my complete medical record, The Baltimore Life Insurance Company may not be able to process my application, or if coverage has been issued may not be able to make any benefit payments.

I acknowledge that I have received a copy of this authorization.

_____ _____
Signature of Proposed Insured or Personal Representative Date

_____
Personal Representative's Authority or Relationship to Proposed Insured

_____ _____
Signature of Licensed Agent (Witness) Printed Name of Licensed Agent

Please provide one copy to the Home Office and one copy to the Applicant

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

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Personal Representative's Authority or Relationship to Proposed Insured

_____ _____
Signature of Licensed Agent (Witness) Printed Name of Licensed Agent

Please provide one copy to the Home Office and one copy to the Applicant

The Baltimore Life Companies

The Baltimore Life Insurance Company
10075 Red Run Boulevard • Owings Mills, Maryland 21117-4871

EXCHANGE AGREEMENT

Complete a separate form for each existing insurer. This form must be dated the same date as the application for the new insurance to qualify as a tax-free exchange. If an assignment is now in effect on any existing policy listed below, the person to whom it is assigned must also sign this form. **ALL POLICIES LISTED BELOW MUST BE ATTACHED.**

Name of Insured _____

Insured's Social Security No. _____ / _____ / _____
I CERTIFY THAT THE TIN ON THIS FORM IS TRUE, CORRECT, AND COMPLETE.

Name of Owner _____
If different from Insured

Owner's Social Security No._____ / _____ / _____
I CERTIFY THAT THE TIN ON THIS FORM IS TRUE, CORRECT, AND COMPLETE.

Existing Insurer_____

Address_____

City/State/Zip _____

Telephone No._____

FOR HOME OFFICE USE ONLY
New Policy No. _____
☐ LIFE ☐ ANN. ☐ NQ ☐ SPAIR
☐ New issue pending approval ☐ Existing contract
Primary Insured _____
Above section must be complete before submitting to existing company.

	Life Insurance 100%	Annuity ____% of Cash Value
Policy No.*	_____	_____
Policy No.*	_____	_____
Policy No.*	_____	_____

**Existing policy must be on the same Primary Insured and Owner as the new policy to qualify as a tax-free exchange.*

☐ Lost Policy	My policy was ☐ lost ☐ stolen ☐ destroyed. My policy is not now in the possession of any person or corporation, and if subsequently found, will be returned to the issuing company.

ABSOLUTE ASSIGNMENT OF OWNERSHIP

I hereby transfer and assign to The Baltimore Life Insurance Company ("Company") all or part of my ownership rights in the policy (policies) listed above. I attest that:

1. I have not made any other assignment of the policy (policies) which is (are) now in effect.
2. No legal proceedings are pending against me by creditors or others.
3. A petition for bankruptcy has not been filed by or against me.

The Company is entering into this agreement at my request. The Company makes no representations concerning, nor is it liable for, my tax treatment either for this exchange under Section 1035 or any other section of the Internal Revenue Code. The Company is not liable in the event this assignment is invalid. If the surrendering company does not provide a cost basis, the Company will determine the basis based on the best information available. A pro-rated basis should be provided for a partial exchange of an annuity.

The Company will not take any action to surrender all or part of my policy (policies) until it has issued the new insurance as I applied for or which I have accepted.

POLICY EXCHANGE AGREEMENT

The following is agreed to in consideration for the Company issuing the new policy which I have applied for:

1. I understand that only transfer of the existing policy proceeds to the new policy on the same primary insured will qualify as a tax-free exchange under Section 1035 of the Internal Revenue Code. I do not want any money paid as a result of the surrender or partial withdrawal of my existing policy (policies) to be included in my gross income under Section 72 (e) of the Internal Revenue Code.
2. I am responsible for paying the first premium on the new policy and continuing my existing policy (policies) in effect until surrendered (approximately two to four months). If this is a partial exchange of annuity, I will continue to pay premiums if due on the existing policy.
3. The Company will use my assignment to request surrender or complete a partial withdrawal of my existing policy (policies) and apply any proceeds to my new policy. If I am a Baltimore Life policyowner, the Company WILL CHARGE the percent of premium fee on the cash value transferred to an interest sensitive product. The Company will withdraw the dividends from the Baltimore Life policy (policies) listed above and apply them to the premium but WILL CHARGE the percent of premium fee on the dividends.
4. The Company will not change the beneficiary of my existing policy (policies).

I agree that this assignment and agreement shall be voidable at the option of the Company if for any reason the Company is unable to obtain the proceeds under the existing policy (policies) at the time the Company requests them thereof (for example, because of bankruptcy, conservatorship, or receivership proceedings relating to the existing insurer). In the event the Company declares this assignment and agreement void, the Company will return the existing policy (policies) to me, and I will be responsible for paying all premiums on the new policy if I want that policy. **The IRS does not require your consent to any provision of this document other than this certification to avoid backup withholding.**

Policyowner _____
(SIGNATURE - DO NOT PRINT)

Date signed _____

Address _____

Witness _____

City/State/Zip _____

This is to serve as a letter of acceptance from The Baltimore Life Companies to receive proceeds from the surrender of your policy to be placed in a new policy with our company.

Agent's Name _____

Corporate Officer _____
(SIGNATURE - TITLE)

AUTHORIZATION TO SEND FUNDS TO: The Baltimore Life Insurance Company

Home Office: 10075 Red Run Boulevard, Owings Mills, Maryland 21117-4871

Mail All Payments to the New Business Department at the above address.

FUNDS FROM:

Company Name _____ Phone Number _____

Company Address _____

Account/Contract Number _____ Maturity Date (if applicable) _____

Owner's Name _____ Social Security Number _____
I CERTIFY THAT THE TIN ON THIS FORM IS TRUE, CORRECT, AND COMPLETE

Joint Owner's Name (if applicable) _____ Social Security Number _____
I CERTIFY THAT THE TIN ON THIS FORM IS TRUE, CORRECT, AND COMPLETE

The undersigned hereby requests and directs that the following action be taken. These are not tax-deferred distributions.

☐ **Section 1 – Certificate of Deposit**
- ☐ LIQUIDATE CERTIFICATES OF DEPOSIT UPON RECEIPT OF THIS REQUEST
- ☐ LIQUIDATE CERTIFICATES OF DEPOSIT ON THE MATURITY OF _____

☐ **Section 2 – Mutual Funds or Stocks (*Signature Guarantee Required*)**
- ☐ LIQUIDATE ENTIRE ACCOUNT (Attach copy of recent statement)
- ☐ PARTIAL LIQUIDATION OF MY ACCOUNT IN THE AMOUNT OF $ _____

☐ **Section 3 – Money Market Account**
- ☐ LIQUIDATE ENTIRE ACCOUNT (Attach copy of recent statement)
- ☐ PARTIAL LIQUIDATION OF MY ACCOUNT IN THE AMOUNT OF $_____

Section 4 – Annuity Contract Withdrawal
- ☐ FULL SURRENDER OF CONTRACT (Attach Annuity Contract or sign lost contract statement below)
- ☐ Lost Contract Statement: I/we certify that the numbered contract indicated on this form has been lost or destroyed and, to the best of my/our knowledge and belief, is not in anyone's possession.
- ☐ PARTIAL WITHDRAWAL OF MY CONTRACT IN THE AMOUNT OF $_____

Withholding of Federal and State Income Tax

WITHHOLDING ELECTION: I understand that if I elect not to have federal or state income tax withheld, I am liable for payments of federal and state income tax on the taxable portion of my withdrawal or distribution. I may also be subject to tax penalties under the estimated tax payment rules if my payments of estimated tax and withholding, if any, are not adequate. If this is an Annuity or Modified Endowment, there may be additional consequences.

IF YOU DO NOT COMPLETE THE WITHHOLDING ELECTION BELOW, WE WILL WITHHOLD FEDERAL AND/OR STATE INCOME TAX ON THE TAXABLE PORTION OF YOUR WITHDRAWAL OR DISTRIBUTION.

☐ **I DO** want to have Federal income tax withheld from my withdrawal or distribution. (10% unless other amount noted below). State income taxes should also be withheld if required by my State of residence.

☐ **I DO NOT** want to have Federal or State income taxes withheld from my withdrawal or distribution.

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, 3) I am a U.S. person (including a U.S. Resident Alien), and 4) I am exempt from FACTA and the FACTA Code _____(if applicable) is correct.

The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to avoid backup withholding. **(If we are required to report this transaction to the IRS, we will notify you and IRS next January.)**

Please make check payable to: ***The Baltimore Life Insurance Company*** ***FBO:*****_____**

Mail all Payments to: The Baltimore Life Insurance Company, New Business Department, 10075 Red Run Boulevard, Owings Mills, MD 21117-4871

_____ _____ Date _____
Print Owner's Name Owner's Signature

_____ _____ Date _____
Print Joint Owner's Name Joint Owner's Signature

Signature Guarantee (if required) Witness Signature _____

This form is not intended for IRA or pension rollovers.

TO BE COMPLETED BY THE BALTIMORE LIFE INSURANCE COMPANY

Section 5 – ACCEPTANCE: This is to certify that the above individual has established a ☐ life insurance policy ☐ annuity on:

Name _____ Soc. Sec. No. _____ New Policy No. _____

The authorized signature below certifies acceptance of the assignment and surrender or exchange of funds as instructed in this request. After deducting any sums as are permitted under the plan, please complete this transaction and send a check with a copy of this form to:

Issuer/Assignee: THE BALTIMORE LIFE INSURANCE COMPANY

By: _____ _____
(Officer's Signature/Title) (Date)

File "pdf/1483-ma.pdf" is missing.

Please report this to the Helpdesk.

Processing web page:
/BlcPortalPages/IsdSharepoint/ISAppFormPackPrt.asp