Baltimore Life's Generation Legacy™ Point-of-Sale Underwriting Decision Process

Baltimore Life's Generation Legacy™ product is written using an application and underwriting process that provides faster underwriting decisions. After a point-of-sale telephone interview and a prescription drug database check, you will receive a decision for approximately 90 percent of your cases before you hang up the phone!

The Decision Process

You will pre-qualify your client using the application Form 8232-0411 or it's state specific variation. The application has been designed to help you classify your client's risk profile more accurately by following the parameters below.

The Generation Legacy application (Form 8232-0411 and its state specific variations) is structured into a single Part A.

- All "no" answers to Part A, coupled with a good height/weight, a clean MIB, and an acceptable prescription drug history should result in an issue.
- Any "yes" answer in Part A, however, means coverage cannot be issued.

Once you have completed the ***entire application*** and pre-qualified the applicant, you will contact the call center at (888) 368-9678 for an underwriting interview.

- This point-of-sale interview generally lasts 12 minutes or less.
- The call center representative will review the same health questions you used during the pre-qualification.
- During the call, an MIB search and a prescription drug database search will be run "in the background". If there are discrepancies between those results and the answers provided in the interview, your client may be asked a question from the application again in an attempt to clarify the difference in information. This process reduces the need for an APS and allows Baltimore Life and our agents to keep point-of-sale decision rates high.
- After your client has completed the interview, any underwriting decision is communicated to you, NOT to your client. The call center representative will provide you with an underwriting decision of either "approved" or "not approved."
- You will receive a confirmation number. Please write that confirmation number on the front page of the application.
- Fewer than 10 percent of the cases will be referred to the home office for additional underwriting review.

Once the appointment is finished and the decision has been given, ***the application and all required forms must be faxed to our New Business center*** at (866) 892-6428 or newbusiness-independentsales@baltlife.com. **Forms must be sent to the home office in all cases, even when the application has been declined.**

The Call Center Details

- The call center phone number is (888) 368-9678.
- Call center hours are 9:00 a.m. to 10:30 p.m. Monday through Thursday, and 9:00 a.m. to 6:00 p.m. on Friday, EASTERN TIME ZONE.
- Languages supported include English and Spanish. Other languages are available on request.
- TTY available in both English and Spanish.
- If the call center is closed, you may leave a message and request to have the interview completed.
  - > At your requested date/time during business hours, a call center representative will call you, the agent, to gather the needed information.
  - > The call center representative will then call the applicant and conduct the interview.
  - > If you, the agent, are not present during the interview, you will be called and informed of the decision.
- During high call volume periods, you may also reach a voice mail box. The process is the same as if the call center is closed except that a call center representative will call you within ten minutes unless you request another date/time during business hours for the return call.
- The interview must be completed in order to process the application.
- The interview must be completed within five days from the date of the application.

The Baltimore Life Insurance Company

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

Application for Life Insurance and Single Premium Annuity

1. Proposed Insured/Annuitant 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. Contingent Owner

Last Name	First Name	MI	Relationship

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

Street Address	City	State	ZIP Code

4. Single Premium Immediate Annuity with Period Certain

1. Payout Period (Predetermined by Annuitant's Issue Age): Age 60-74 / 10 Years Age 75-80 / 7 years

2. Estimated Single Premium $_____

☐ Non-Qualified Funds ☐ IRA *(Only Qualified Funds Eligible for IRA Rollover/ Transfer)*

3. Annuity Payout Payee: ***The Baltimore Life Insurance Company on Behalf of the Policyowner***

All or a portion of each annual annuity payout from your Single Premium Immediate Annuity (SPIA) is considered taxable income to you depending on whether the source of funds is qualified or non-qualified. **If you elect tax withholding from each SPIA payout, the amount withheld will decrease the SPIA payout amount received by the payee. Using SPIA payouts to fund a life insurance policy, reduced by an amount withheld for tax, will decrease your life insurance death benefit. The amount withheld may change based on changing IRS and state requirements. You would be billed for any additional annual premium in full due on the life insurance policy. If the entire annual premium is not paid, your policy may lapse.**

Notice of Withholding and Election: I understand that if I elect not to have federal income tax withheld, I am liable for payments of federal and state income tax on the portion of my annuity 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. I understand that if I do not complete the election below, the company is required to withhold federal and or state income tax on the taxable portion of my annuity distribution.

Your election will remain in effect until you revoke it. You may change your election each year.

(1) Check this box if you do not want any Federal income tax withheld from your annuity
☐ ***(If you check this box do not complete 2.)***

(2) I do want income tax withheld from my annuity payments. Federal: _____ State: _____

For questions regarding your election options, please consult with your personal tax advisor.

5. Insurance Product and Riders

Product	Estimated Face Amount: $

Accelerated Death Benefit Riders Included (if available) unless you check "No" here ___ No

1. Terminal Illness 2. Qualified Nursing Facility and Extended Care

Other Rider(s)

Nonforfeiture Options: ☐ Extended Term Insurance ☐ Reduced Paid-Up

Modal Premium: _____

6. Proposed Insured 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 been 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 (renal) insufficiency, chronic hepatitis, cirrhosis, liver disease, 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 12 months have you been confined three (3) or more times to a hospital, nursing facility, convalescent care facility or mental health facility? ☐ Yes ☐ No
4. 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
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, angioplasty, stent placement or any procedure to improve circulation to the legs, 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
6. Within the past 36 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), attempted suicide, alcohol abuse or drug abuse? ☐ Yes ☐ No
   b. Chronic obstructive pulmonary or lung disease (COPD), emphysema, chronic bronchitis, pulmonary fibrosis, or required oxygen to assist in breathing? ☐ Yes ☐ No

Part B

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 6 in the area below.

Question #	Explanation	Dates/Duration	Name of Medical Professional

(Use Additional Comments section if more space is needed.)

7. 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

1) Why is this replacement occurring? _____

_____

8. Additional Ownership Information

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.

9. Additional Comments

_____

_____

_____

_____

_____

_____

_____

10. 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, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim or deceptive statement is guilty of insurance fraud.

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. 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.

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.

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.)*

11. 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 am unaware of any additional information that might affect the Company's underwriting decision.

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

_____

_____

_____

_____

_____

_____

12. 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

13. 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.

14. 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.

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

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?

Suitability Questionnaire
Customer Acknowledgement

Please print all information with the exception of signatures or initials where required.

Owner/Applicant Name _____ Age _____

Thank you for your interest in Baltimore Life Insurance Company. Sound financial practices, as well as state regulations dictate that the insurance company and the agents who recommend the product you are considering buying, must have grounds to believe that the transaction is in your best interests and is appropriate for your financial goals. The information collected here is for your benefit and will be used to help determine if this is suitable for you. It will remain confidential and will not be used for any other purpose.

Please initial next to each statement to confirm your understanding:

__ I have sufficient other funds for my daily expenses and/or retirement savings. I am buying a product that is designed to be funded with premium that I intend to pass on to my heirs, and not with funds that are needed for present or future living expenses.

__ My insurance agent has explained the impact of any penalties and/or fees that may be applicable to a termination or liquidation of any financial vehicle, such as surrender charges, and whether these fees might reduce with time.

__ I understand that the financial vehicle the funds are coming from may increase at a higher rate than a life insurance policy's cash value.

__ Neither Baltimore Life nor my insurance agent has given me any investment, tax or legal advice.

Please fill in all information as requested (please do not leave any spaces blank. Insert "none" or "I don't know" as appropriate):

Liquid Asset Information

Savings/Checking Accounts	$ _____
Money Market Accounts	$ _____
Mutual Funds	$ _____
Stocks And Bonds	$ _____
Certificate of Deposit	$ _____
Qualified Accounts (401K, IRA)	$ _____
Qualified Annuities	$ _____
Non-Qualified Annuities	$ _____
Life Insurance Cash Value	$ _____
Other	$ _____
Total Liquid Assets	**$** _____

Non- Liquid Asset Information

Equity in primary residence	$ _____
Equity in other real estate	$ _____
Collectibles	$ _____
Other	$ _____
Total Non-Liquid Assets	**$** _____

Current Annual Income Information

Annual/Earned Income	$ _____
Pension Income	$ _____
Social Security	$ _____
Income from Liquid Assets	$ _____
Other Income	$ _____
Total Annual Income	**$** _____
Total Annual Expenses	**$** _____

Agent Remarks (please use this space to provide any information you believe may be relevant to the transaction:
_____

Other Financial Information

What primary need does the new policy satisfy? _____

What is the expected death benefit of the policy being applied for? $ _____

What is your typical financial risk tolerance? ☐ Conservative (little risk) ☐ Moderate ☐ Aggressive (willing to sustain losses)

If this policy is being funded with a personal check, cashiers check or something other than a direct transfer of funds, please provide the original source of the funds: _____

Is there other pertinent financial or other information that you want us to consider? _____

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

Form 8395-0316

Complete this section ONLY if you are replacing an annuity to fund this product. Please initial and fill in blanks as applicable:

___I have been advised that at my death, under current tax law, my beneficiary will receive the death benefit proceeds of the product without having to pay federal or state income taxes. In contrast, all or a portion of my annuity values distributed/paid to my beneficiary are generally subject to federal and state income taxes.

___ I have a specific need for life insurance coverage. For example, I want to pass funds to my heirs' income tax-free or I no longer need my annuity for savings or income and would instead like to maximize my estate for whatever reason.

___ I have considered the ultimate after tax benefit of keeping my annuity versus purchasing this product.

___ I understand that I may have less liquidity available to me with life insurance than with an annuity

___ When surrendering an annuity, I understand that:

1. federal and state income taxes may apply to all or a portion of my annuity value when the annuity contract is surrendered to fund the new product.
2. tax penalties may apply to all or a portion of the withdrawal/distribution from my annuity, and that those penalties may depend upon the type of the annuity contract, the reason for a withdrawal and possibly even my state of residence.
3. it may have an impact on my ordinary income taxes when due.

As a result, you should consult your tax adviser if you have not already done so.

___ Should I decide to cancel the product, it may result in a surrender value that may be less than the initial premium submitted.

Please list the annuity(s) that will be used to pay the premium for the new policy: (please provide company and product name)

_____

Are these funds qualified? ☐ YES ☐ NO (If yes, type of qualified funds _____)

Is your agent the same agent who wrote the annuity being surrendered? ☐ YES ☐ NO

The date the annuity was purchased: _____

Is there a surrender charge? ☐ YES _____% ☐ NO. If yes, amount of surrender charge: $ _____

What is the account value of the annuity being surrendered (ie. before surrender charges)? $ _____

What is the initial premium being used to purchase the policy? $ _____

Did you pay taxes in the previous tax year? ☐ YES ☐ NO (If yes/known, my federal rate was _____%)

Applicant Acknowledgement (to be completed by ALL applicants):

1. **The information contained herein is true and accurate to the best of my information and belief.**
2. **All information requested by this form that has been provided to the agent has been recorded on this form.**
3. **This purchase is appropriate for my financial needs and objectives, considering my tax status, investments and financial status.**
4. **If I declined to answer one or more of the questions or if I am purchasing this product on my own accord or based upon the advice of my advisor, and not due to the recommendation of a life insurance agent, I have provided notice of this with my application.**
5. **I have considered any future circumstances that might require additional liquidity needs, and still feel this purchase is appropriate for me.**

Signature of Owner _____ Date _____

Agent Certification:

I certify that, prior to making any recommendation to the purchaser(s) I gathered information about their financial situation, tax status, and financial objectives. I agree to make this information available to Baltimore Life at the request of the Company. Where indicated, the purchaser(s) has elected not to provide information. However, my recommendation to the purchaser(s) is reasonable based upon all circumstances known to me. I have not provided any tax or legal advice to the consumer. **I also understand that the information obtained here, along with a financial analysis performed by the Company will be used to determine whether the purchase is suitable for this client. I understand that as a result of its analysis, the Company may request additional information from me or the consumer.**

Please mark the appropriate response if this recommendation involves the termination of a variable contract.

I am a licensed variable contract producer. ☐ Yes ☐ No

Signature of Writing Agent_____ Date_____

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

ACCELERATED DEATH BENEFIT RIDER DISCLOSURE STATEMENT
TERMINAL ILLNESS

This is a brief description of the Accelerated Death Benefit Rider and its effects on your policy. Please refer to the rider form for contract provisions and definitions.

Your benefit.
You, the policy owner, are eligible to receive an accelerated death benefit under the rider for the insured. A physician must certify that the insured under this policy is terminally ill.

The benefit payable to you.
Upon satisfaction of the requirements under the rider, we will pay you up to 75% of the eligible death benefit for a terminal illness. However, the rider benefit will not be less than $5,000 or more than $250,000.

The accelerated death benefit will be considered a lien against the policy and will accrue interest up to an annual rate of 8%. A one-time service fee, not to exceed $100, will be added to the lien. If the rider benefit is not approved, no service fee will be charged. The benefit amount will be reduced by any policy loans prior to the payment of the accelerated death benefit. You can repay all or part of the lien at any time.

Conditions for the benefit.
- You must make a written request for the benefits during the lifetime of the insured and while the policy and rider are in force.
- The policy owner must provide written proof satisfactory to us that the insured suffers from a terminal illness.
- Any assignee or irrevocable beneficiary under the policy must consent in writing to your election of this benefit.
- Only one benefit election is allowed under this rider. Once a benefit is paid, no other benefits will exist under this rider or any accelerated death benefit rider attached to the *policy.*
- The premium amount for this policy will not change and will continue to be payable including any premiums for riders.

Effects to the policy upon acceleration.
- The policy's death benefit will be reduced at the insured's death unless the lien has already been repaid in full at that time.
- After the acceleration date any policy value you withdraw from the policy by any method will be applied first to reduce the lien until it has been eliminated.
- The policy will end if the lien with accrued interest equals or exceeds the policy death benefit.

Benefit Example for a Policy with a $100,000 Death Benefit

Maximum Rider Benefit:	$ 75,000
Service Fee:	100
Accelerated Death Benefit Lien:	75,100
Benefit Amount Paid To You:	$ 75,000
Death Occurs Immediately after the Accelerated Death Benefit has been Paid	
Policy Death Benefit:	$100,000
Less Lien:	-75,100
Net Death Proceeds Payable at the Death of the Insured:	$ 24,900

TAX CONSEQUENCES: A BENEFIT THAT YOU RECEIVE UNDER THIS RIDER MAY BE TAXABLE OR MAY ADVERSELY AFFECT YOUR ELIGIBILITY FOR MEDICAID OR OTHER GOVERNMENT BENEFITS OR ENTITLEMENTS. BEFORE CLAIMING A BENEFIT UNDER THIS RIDER, YOU SHOULD SEEK THE ADVICE OF YOUR PERSONAL TAX ADVISOR.

I acknowledge that I have read and understand this disclosure statement.

_____ _____

Signature of Applicant/Owner Signature of Agent

_____

Date

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

ACCELERATED DEATH BENEFIT RIDER DISCLOSURE STATEMENT

This is a brief description of the Accelerated Death Benefit Rider and its effects on your policy. Please refer to the rider form for contract provisions and definitions.

Your benefit.
You, the policy owner, are eligible to receive an accelerated death benefit under the rider for the insured. A physician must certify that the insured under this policy is chronically ill as defined by the rider.

This is not long term care insurance.

The benefit payable to you.
Upon satisfaction of the requirements under the rider, we will pay you up to 50% of the eligible death benefit if the insured is chronically ill. However, the rider benefit will not be less than $5,000 or more than $250,000.

The accelerated death benefit will be considered a lien against the policy and will accrue interest up to an annual rate of 8%. A one-time service fee, not to exceed $100, will be added to the lien. If the rider benefit is not approved, no service fee will be charged. The benefit amount will be reduced by any policy loans prior to the payment of the accelerated death benefit. You can repay all or part of the lien at any time.

Conditions for the benefit.
- You must make a written request for the benefits during the lifetime of the insured and while the policy and rider are in force.
- The policy owner must provide written proof satisfactory to us that the insured is chronically ill as defined by the rider.
- Any assignee or irrevocable beneficiary under the policy must consent in writing to your election of this benefit.
- Only <u>one</u> benefit election is allowed under this rider. Once a benefit is paid, no other benefits will exist under this rider or any accelerated death benefit rider attached to the *policy.*
- The premium amount for this policy will not change and will continue to be payable including any premiums for riders.

Effects to the policy upon acceleration.
- The policy's death benefit will be reduced at the insured's death unless the lien has already been repaid in full at that time.
- After the acceleration date any policy value you withdraw from the policy by any method will be applied first to reduce the lien until it has been eliminated.
- The policy will end if the lien with accrued interest equals or exceeds the policy death benefit.

Benefit Example for a Policy with a $100,000 Death Benefit

Accelerated Death Benefit Requested on a Policy with a $5,000 Loan:

Maximum Rider Benefit:	$ 50,000
Service Fee:	100
Accelerated Death Benefit Lien:	50,100
Maximum Benefit Payable:	$ 50,000
Less Policy Loan:	-5,000
Benefit Amount Paid To You:	$ 45,000

Death Occurs One Year After Accelerated Death Benefit is Paid

Policy Death Benefit:	$100,000
Less Lien:	-50,100
Less Accrued Interest (50,100 x .08):	-4,008
Net Death Proceeds Payable at the Death of the Insured:	$ 45,892

TAX CONSEQUENCES: A BENEFIT THAT YOU RECEIVE UNDER THIS RIDER MAY BE TAXABLE OR MAY ADVERSELY AFFECT YOUR ELIGIBILITY FOR MEDICAID OR OTHER GOVERNMENT BENEFITS OR ENTITLEMENTS. BEFORE CLAIMING A BENEFIT UNDER THIS RIDER, YOU SHOULD SEEK THE ADVICE OF YOUR PERSONAL TAX ADVISOR.

I acknowledge that I have read and understand this disclosure statement.

_____ _____

Signature of Applicant/Owner Signature of Agent

_____

Date

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

HIV TEST INFORMED CONSENT FORM

In order for us to evaluate your eligibility for insurance coverage, we request that you provide a blood or other bodily fluid sample for HIV testing and analysis. The test that will be performed will determine the presence of antibodies to the HIV virus. By signing and dating this form, you agree that the HIV antibody test may be performed on your blood or other bodily fluid sample and that underwriting decisions may be based on the test results. A positive test result will adversely affect your insurance application. It also may result in uninsurability for life, health, or disability insurance for which you may apply in the future.

HUMAN IMMUNODEFICIENCY VIRUS (HIV): The HIV virus causes a life-threatening disorder of the immune system called Acquired Immune Deficiency Syndrome (AIDS). Antibodies to HIV are found in the blood and other bodily fluids of people who have been exposed to the virus. You do not have to have AIDS to have antibodies against HIV. The virus is spread by sexual contact with an infected person, by exposure to infected blood (as in needle sharing during intravenous drug use or, rarely, as a result of a blood transfusion), or from an infected mother to her new-born infant.

The HIV antibody test is actually a series of tests performed upon your blood or other bodily fluid sample by a medically accepted procedure which is extremely reliable. The testing will be performed by a licensed laboratory.

PRE-TESTING CONSIDERATION: Many public health organizations have recommended that, before taking an HIV virus antibody test, a person seek counseling to become informed about the implications of such tests. You may wish to consider counseling, at your expense, prior to being tested.

DISCLOSURE OF TEST RESULTS: All test results are confidential, except as provided by law. State law requires that the laboratory notify the Ohio Department of Health of positive test results.

The results of the test will be reported to the insurance company named on your application for insurance. The Insurer may not, by law, release positive test results except as provided below:

- If your HIV antibody test result is normal (negative), you will not be notified. You will be notified of an abnormal (positive) test result if you indicate that you desire a positive result be made known to you. You may also identify another person to whom you want the positive results released.
- If you want a physician or other health care provider to be notified of an abnormal HIV antibody test result, you must indicate the name and address of that physician or provider.
- Abnormal test results may be disclosed to persons hired by the Insurer who participate in medical underwriting decisions of the Insurer. Abnormal test results may also be disclosed to affiliates of the Insurer who require the results for medical underwriting purposes.
- In addition, if your HIV antibody test is abnormal, a generic code signifying a non- specific blood, oral fluid (saliva) or urine abnormality may be made known to the Medical Information Bureau, Inc. (MIB). The MIB is an organization of life and health insurance companies which operates as an information exchange on behalf of its members. There will be no record with the MIB that you had a positive HIV antibody test; however, there will be a record at the MIB that you have some blood, oral fluid or urine abnormality. If you apply to another MIB member company for life or health insurance coverage, the MIB, upon request, will supply the information on you in its file to that member.

TEST RESULTS: While a positive test result does not necessarily mean that you have AIDS, it does mean that you are at a greater risk of developing AIDS or AIDS-related conditions if you do not take appropriate medications. If you are infected with HIV, you are infectious to others. You should seek medical follow-up care with your personal health care provider.

HIV test results are highly reliable, but not 100% accurate. If the test gives a positive result, you should consider retesting in order to confirm the result. If the test gives a negative result, there is still a small possibility you may be infected with HIV. This is most likely to happen in recently infected persons. It takes at least 4 to 12 weeks for a positive test result to develop after a person is infected, and may take as long as 6 to 12 months.

OTHER SOURCES OF INFORMATION: For more information about HIV or AIDS you may ask a doctor, a nurse, a counselor, or call the Ohio AIDS Hotline at 1-800-332-AIDS (2437). The hotline is a free call.

CONSENT FOR HIV TESTING: I have read and I understand this HIV Test Informed Consent Form. I voluntarily consent to the withdrawal of blood, or to the providing of another bodily fluid sample, the testing of my blood or other bodily fluid for HIV antibodies, and the disclosure of the test results as described above. I will be given a copy of this form. This consent is valid for ninety (90) days from the day of my signature below. Insurer agrees to complete testing and provide the authorized notifications, as appropriate, within 90 (ninety) day period.

In the event of a positive test result:

_____ **Send the result to me at** _____ (Address)

_____ **I authorize The Baltimore Life Insurance Company to send the result to another person:**

_____ (Name)

_____ (Address)

_____ **I authorize The Baltimore Life Insurance Company to send the result to the following physician or health care provider:**

_____ (Name)

_____ (Address)

AUTHORIZATION

Name of Applicant	**Signature of Applicant** **Date**
Signature of Legal Guardian, if any **Date**	**Signature of Person obtaining consent** **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 7471(OH)-0209

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 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)