Application Forms Package Checklist

Form Requirement Details

No Additional Form Requirements

Fully Underwritten: Yes
Fund Source: Non-Annuity
1035 Exchange: Yes
Product: Sing. Prem. Whole Life
Existing Insurance or Annuity: Don't Know
InSpeed App: No
State: AL
Replacement: Don't Know

There will be a 1035 tax-free exchange on the policy.

Form	Description
8402(ISD)	Cover Sheet
8003(AL)	Application
3994	Disclosures
8033	Disclosures
8038	Acknowledgement - Non-annuity Funds
8771	HIPAA Form
8907	COVID-19 Screening

Agent's Name: _____

Client's Name: _____

Baltimore Life's Single Premium Whole Life (SPWL) Point-of-Sale Underwriting Decision Process

Baltimore Life's SPWL 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 8003-0411 or its 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 SPWL application (Form 8003-0411 and its state-specific variations) is structured into Part A and Part B.

- All "no" answers to Part A and Part B, coupled with a good height/weight, a clean MIB, and an acceptable prescription drug history should result in a Tier 1 issue.
- All "no" answers to Part A, a "yes" answer in Part B, coupled with a good height/weight, a clean MIB, and an acceptable prescription drug history should result in a Tier 2 issue.
- Any "yes" answer in Part A, however, means coverage cannot be issued in either of the available tiers.

Once you have completed the ***entire application*** and pre-qualified the applicant, you will contact the call center at (855) 467-7669 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 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, please submit completed applications and non-medical outstanding requirements through securesubmit.baltlife.com. To log in, use the same credentials you use to access Baltimore Life's secure agent website. 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 (855) 467-7669.
- Call center hours are 10:00 a.m. to 9:00 p.m. Monday–Thursday, and 9:00 a.m. to 6:00 p.m. Friday, EASTERN TIME.
- 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 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 and Riders Applied For

Product _____ Face Amount $ _____ Premium Amount $ _____

Accelerated Death Benefit Rider *Included (if available) unless you check "No" here* ☐ No Other Rider_____

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.

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 restitution fines or confinement in prison, or any combination thereof.

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 the Accelerated Death Benefit Rider may be taxable. Before claiming benefits under this Rider, 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.)*

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

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

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_____

_____

_____

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.

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

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

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

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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 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.

Your benefit.

We will allow you, the owner, to accelerate a minimum of $5,000 up to all of the eligible death benefit, not to exceed $250,000, if the Insured suffers from a Terminal Illness, is Chronically Ill and confined to a licensed Qualified Nursing Facility continuously for at least 90 days and the Insured's stay is certified to be permanent, or requires Extended Care.

Terminal Illness means a medical condition of the Insured resulting from bodily injury, or disease, or both: (a) which has been diagnosed by a physician and (b) which a physician has certified in writing is expected to result in the death of the Insured within twelve (12) months.

Chronically Ill means the Insured is unable to perform, without substantial assistance from another person, at least two out of six Activities of Daily Living; or suffers from a severe organic mental illness.

Activities of Daily Living are: (1) eating; (2) toileting; (3) transferring (i.e., moving into or out of a bed, chair, or wheelchair); (4) bathing; (5) dressing; and (6) continence.

Extended Care means care of the Insured that is required because the Insured is Chronically Ill and has remained Chronically Ill continuously for at least 90 days, as certified in writing by a physician. Extended Care includes care provided by a licensed home health care agency or by a licensed or state-certified adult day care center.

The benefit payable to you.

Upon satisfaction of the requirements under the rider, we will pay to you an amount equal to the percentage of the eligible death benefit you elect to accelerate, multiplied by the Specified Percentage, reduced by an administrative charge of $250.00. The amount of the payment to you will be reduced by the amount of the reduction in any outstanding loan resulting from the acceleration. There are no other costs or liens to the policy associated with the Accelerated Death Benefit Rider.

The Specified Percentages are: 95% for the Terminal Illness benefit, 90% for the Qualified Nursing Facility benefit, and 80% for the Extended Care benefit.

Effects to the policy upon acceleration are as follows:

- the policy's face amount will be reduced by the accelerated percentage of the eligible death benefit; and
- the cash value and any loan balance will also be reduced by the accelerated percentage of the eligible death benefit.

As an example showing the effects on your policy, if you elected to accelerate 70% of the policy's death benefit, assume the following hypothetical amounts and that the Insured is permanently confined to a Qualified Nursing Facility:

Face Amount:	$120,000
Loan Balance:	$10,000
Cash Value:	$58,000

The portion of the death benefit to be accelerated, 70% of $120,000 or $84,000, meets the minimum ($5,000) and maximum ($250,000) requirements. Since the acceleration is based on a Qualified Nursing Facility event, the Specified Percentage (90%) is applied and the result is: $75,600 ($84,000 X .90). The $75,600 amount is reduced by the accelerated proportional amount of the loan and by the administrative fee of $250 ($75,600 minus 70% of the $10,000 loan, then reduced by $250.) The resulting $68,350 benefit amount is payable to you.

Your policy's face amount, loan balance, and cash value would also be reduced by your elected acceleration percentage of 70% as shown below:

	Before Acceleration	After Acceleration
Face Amount:	$120,000	$36,000
Loan Balance:	$10,000	$3,000
Cash Value:	$58,000	$17,400

Conditions for the benefit.

- The policy and rider must be in force and the Insured is living at the time you make a written request for benefits.
- Written proof satisfactory to us that the Insured suffers from a Terminal Illness, or is Chronically Ill and has been certified as such in writing by a physician, and has been confined to a Qualified Nursing Facility continuously for at least 90 days with written certification by a physician that such confinement is expected to be permanent, or requires Extended Care.
- Any Assignee or Irrevocable Beneficiary under the policy must consent in writing to your election of this benefit.
- A request for acceleration will not be approved if you are required by a government agency to use this benefit in order to apply for, obtain, or keep government benefits or entitlements.
- The death benefit amount accelerated must be no less than $5,000 and no more than $250,000.
- Only one benefit election is allowed under this rider. Once a benefit is paid, this rider ends.

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 Agent Number

_____

Application or Policy Number

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.

Your benefit.

We will allow you, the owner, to accelerate a minimum of $5,000 up to all of the eligible death benefit, not to exceed $250,000, if the Insured suffers from a Terminal Illness, is Chronically Ill and confined to a licensed Qualified Nursing Facility continuously for at least 90 days and the Insured's stay is certified to be permanent, or requires Extended Care.

Terminal Illness means a medical condition of the Insured resulting from bodily injury, or disease, or both: (a) which has been diagnosed by a physician and (b) which a physician has certified in writing is expected to result in the death of the Insured within twelve (12) months.

Chronically Ill means the Insured is unable to perform, without substantial assistance from another person, at least two out of six Activities of Daily Living; or suffers from a severe organic mental illness.

Activities of Daily Living are: (1) eating; (2) toileting; (3) transferring (i.e., moving into or out of a bed, chair, or wheelchair); (4) bathing; (5) dressing; and (6) continence.

Extended Care means care of the Insured that is required because the Insured is Chronically Ill and has remained Chronically Ill continuously for at least 90 days, as certified in writing by a physician. Extended Care includes care provided by a licensed home health care agency or by a licensed or state-certified adult day care center.

The benefit payable to you.

Upon satisfaction of the requirements under the rider, we will pay to you an amount equal to the percentage of the eligible death benefit you elect to accelerate, multiplied by the Specified Percentage, reduced by an administrative charge of $250.00. The amount of the payment to you will be reduced by the amount of the reduction in any outstanding loan resulting from the acceleration. There are no other costs or liens to the policy associated with the Accelerated Death Benefit Rider.

The Specified Percentages are: 95% for the Terminal Illness benefit, 90% for the Qualified Nursing Facility benefit, and 80% for the Extended Care benefit.

Effects to the policy upon acceleration are as follows:

- the policy's face amount will be reduced by the accelerated percentage of the eligible death benefit; and
- the cash value and any loan balance will also be reduced by the accelerated percentage of the eligible death benefit.

As an example showing the effects on your policy, if you elected to accelerate 70% of the policy's death benefit, assume the following hypothetical amounts and that the Insured is permanently confined to a Qualified Nursing Facility:

Face Amount:	$120,000
Loan Balance:	$10,000
Cash Value:	$58,000

The portion of the death benefit to be accelerated, 70% of $120,000 or $84,000, meets the minimum ($5,000) and maximum ($250,000) requirements. Since the acceleration is based on a Qualified Nursing Facility event, the Specified Percentage (90%) is applied and the result is: $75,600 ($84,000 X .90). The $75,600 amount is reduced by the accelerated proportional amount of the loan and by the administrative fee of $250 ($75,600 minus 70% of the $10,000 loan, then reduced by $250.) The resulting $68,350 benefit amount is payable to you.

Your policy's face amount, loan balance, and cash value would also be reduced by your elected acceleration percentage of 70% as shown below:

	Before Acceleration	After Acceleration
Face Amount:	$120,000	$36,000
Loan Balance:	$10,000	$3,000
Cash Value:	$58,000	$17,400

Conditions for the benefit.

- The policy and rider must be in force and the Insured is living at the time you make a written request for benefits.
- Written proof satisfactory to us that the Insured suffers from a Terminal Illness, or is Chronically Ill and has been certified as such in writing by a physician, and has been confined to a Qualified Nursing Facility continuously for at least 90 days with written certification by a physician that such confinement is expected to be permanent, or requires Extended Care.
- Any Assignee or Irrevocable Beneficiary under the policy must consent in writing to your election of this benefit.
- A request for acceleration will not be approved if you are required by a government agency to use this benefit in order to apply for, obtain, or keep government benefits or entitlements.
- The death benefit amount accelerated must be no less than $5,000 and no more than $250,000.
- Only one benefit election is allowed under this rider. Once a benefit is paid, this rider ends.

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 Agent Number

_____

Application or Policy Number

The Baltimore Life
COMPANIES

Acknowledgment
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 savings 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. Form 8038-0419

The Baltimore Life
COMPANIES

Acknowledgment
Single Premium Whole Life

Source of Funds

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

HIPAA Authorization to Obtain and Disclose Information

The purpose of this Authorization is to permit The Baltimore Life Insurance Company to obtain and release nonpublic personal information about me or my child(ren), the Proposed Insured(s) named below, for the purpose of determining my eligibility for and obtaining insurance products and services pursuant to this Authorization shall include any and all information, to the extent permitted by applicable law.

Name of Proposed Insured: _____

Social Security Number_____ Date of Birth _____

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

Name	Social Security Number	Date of Birth

Information to be Released

The information to be released pursuant to the Authorization includes any personal health information, records or data concerning my past, present or future mental, physical or behavioral health or conditions ("Information"), to the extent permitted by law. Specifically, information includes all information, records or data relating to my: physical or mental health history or condition; medical treatment, diagnosis or prognosis; including medications prescribed to me; other insurance coverage(s); hazardous activities; general character and general reputation; finances; occupation; avocation, including any hazardous hobbies; driving records; aviation activities and other personal traits. I understand that this Information may include results from blood, saliva, urine and other tests. I further understand that this Information may, if applicable, include information regarding diagnosis, prognosis and treatment of: alcohol or drug abuse (including records protected under federal law, 42 CFR Part 2); serious communicable disease or infection, including sexually transmitted diseases; HIV infection, including medical test results.

Authorization

I authorize any physician or other medical practitioner, any hospital, clinic, or other health-related facility, any medical testing laboratory, Pharmacy Benefits Manager, any insurer, any state motor vehicle department, my past or current employer(s), the Social Security Administration, and any other organization, institution or person that has Information about me to release such Information to The Baltimore Life Insurance Company ("the Company"). I also specifically authorize the Company to release Information about me to their reinsurers, underwriters or other persons or organizations performing business, professional or insurance functions for them. I understand that Information disclosed to the Company may be re-disclosed to individuals or entities that are not subject to health information privacy laws, in such case my medical information may no longer be protected by federal health information privacy laws. I understand that if I refuse to sign this Authorization to release my complete medical records, the Company may not be able to process my request. I also authorize my Agent, named

below, to receive Information and I authorize the Company to disclose such Information to my Agent to assist in the purpose of this Authorization to the extent permitted by law. A photocopy of this Authorization shall be as valid as the original. This Authorization shall be effective for two (2) years after the date signed below, unless revoked by me in writing and written notice of the revocation is provided to the Company at 10075 Red Run Boulevard, Owings Mills, MD 21117-4871. Any action taken in reliance on this Authorization prior to the notice of the revocation shall be valid.

_____ _____

Signature of Proposed Insured (or that of Authorized Representative) Date

_____ _____

Print Name of Proposed Insured If signed by Authorized Representative of Proposed Insured, describe authority, e.g., parent or guardian of minor child.

_____

Print Name of Agent

A Copy of the Notification Appearing Below Must be Given to the Proposed Insured Before or At the Time of Signature

In the course of properly underwriting, administering and evaluating your insurance coverage, the Company will rely heavily on information provided by you. The Company may also seek information from others such as medical professions who have treated you. In some situations, and in compliance with applicable law, the Company may disclose necessary items of information to third parties without your specific authorization.

You have the right to be told about, and to see a copy, if you wish, of items of personal information about you which appear in the Company's files. You also have the right to seek correction of information you believe to be inaccurate.

For underwriting and claims purposes, I permit:

Any physician or other medical practitioner, hospital, clinic or other medically related facility to give the Company data of a medical nature. This data includes findings on medical care, psychiatric or psychological care and examination, or surgery. I specifically authorize the disclosure to the companies listed above any information, or surgery. I specifically authorize the disclosure to the Company any information concerning sexually transmitted diseases including venereal diseases, any Human Immunodeficiency Virus (HIV) test results, or information about Acquired Immune Deficiency Syndrome (AIDS) or AIDS related conditions, or confidential HIV related information, and any information concerning a serious communicable disease, use of drugs or alcohol and any information concerning mental health.

_____ _____

Signature of Proposed Insured Date

_____

Print Name of Proposed Insured

Notice of Information Practices

Investigative Consumer Report

In addition to requesting a report from MIB, as part of our underwriting process, the Company may request an investigative consumer report to confirm and supplement the information about your general health, employment and occupation, finances, smoking habits, and hazardous activities. Such a report may also cover your mode of living, except as may be related directly or indirectly to your sexual orientation, but including alcohol and drug use, general reputation, and driving record. Some of this information may be obtained through personal interviews with you or your family, friends, associates, or other with whom you are acquainted. If a consumer information report is requested, you may request to be personally interviewed if you can be contacted during normal business hours. An interview is normally conducted, but you are entitled to make a specific request. The Company keeps such information reports confidential and uses them only to evaluate and underwrite your application. You have a right under the Fair Credit Reporting Act to make a written request to inspect and obtain a copy of a consumer information report. If we request a report and the report has an adverse effect on your insurability, we will notify you in writing and give you the name and address of the reporting company.

Disclosure of Information

The Company treats what we know about you confidentially. Our employees are told to take care in handling your information. They may receive information about you only when there is good reason to do so. We take steps to make our computer database secure and to safeguard the information we have. We may disclose personal information about you without prior authorization under certain circumstances. For example, we may disclose information about you to persons or organizations to allow such persons or organizations to perform a business, professional or insurance function for us, or an insurance support organization, or to provide information to determine eligibility for insurance benefits or detect fraud, misrepresentation, or material non-disclosure. The Company may provide information to accounting firms performing audits, governmental agencies reviewing our practices, or attorneys hired to protect our legal interest. Information may be disclosed to reinsurance companies or other insurance company to which you have applied for coverage or benefits. Information may be given to your agents to aid them in providing adequate service to you. Other disclosures may be made as permitted or required by law. The Company may also disclose information to medical professionals where required by law for the purpose of informing you of a medical problem of which you may not be aware or to persons or organizations for the purpose of conducting research, including actuarial, marketing, and underwriting studies. This may include various insurance industry groups that conduct studies about risk experience or medical backgrounds of insured's lives. No medical record information or personal information relating to your character, personal habits, mode of living or general reputation will be released to anyone who receives personal information for the purpose of marketing a product or service.

You Can Review and Correct Your Information

Generally, the Company will allow you to review what we know about you if you request to do so in writing. Because of its legal sensitivity, we will not show you anything we learned in connection with a claim or lawsuit. Also, if the law allows, we may decide to disclose what we know about your health only through your health care provider. If you advise that what we know about you in incorrect, we will review it. If we agree with you, we will correct our records. If we do not agree with you, you may tell us in writing, and we will include your statement when we provide your information to anyone outside of the Company.

If you would like to know more about our privacy policy, you can visit our website at baltlife.com or contact the Company at The Baltimore Life Insurance Company, 10075 Red Run Boulevard, Owings Mills, MD 21117-4871.

Eligibility Review Form

THE PURPOSE OF THIS FORM IS TO REVIEW YOUR ELIGIBILITY TO COMPLETE AN APPLICATION FOR INSURANCE.

THE PROPOSED INSURED MUST COMPLETE ALL SECTIONS ON THIS FORM.

Proposed Insured _____ Date of Birth _____

1. Within the past 30 days, have you tested positive for Covid-19?	☐ Yes ☐ No
2. If you have recently taken a Covid-19 test, are you still waiting for results?	☐ Yes ☐ No
3. Have you consulted a medical professional for any flu-like symptoms or concerns with contact with another infected person?	☐ Yes ☐ No
4. Have you traveled outside of the U.S. (including a cruise) within the past 30 days?	☐ Yes ☐ No

Notice: I understand that my answers may be used to determine my eligibility to request an apply for life insurance with the Baltimore Life Insurance Company. I declare that the answers I have given are, to the best of my knowledge, true and that I have not withheld any material information that may influence my eligibility to apply for life insurance.

_____ _____

Proposed Insured's Signature
(Unless under age 15)

Date

_____

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

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

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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.**

OWNER/INSURED

Name of Insured _____

Social Security No. _____

Name of Owner _____

Social Security No. _____

I certify that the tax identification number on this form is true, correct and complete.

CURRENT INSURER

Existing Insurer _____

Address _____

City, State, ZIP _____

Telephone 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 INFORMATION

☐ 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.

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

FOR HOME OFFICE USE ONLY – Section must be complete before submitting to existing company.

New Policy No.	Primary Insured

☐ LIFE ☐ ANN. ☐ NQ ☐ SPAIR ☐ New issue pending approval ☐ Existing contract

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.

Please make check(s) payable to: **The Baltimore Life Insurance Company**
FBO (Current Policy Owner):

Signatures		
Policy Owner's Signature X		Date
Street	*City, State*	*ZIP*
Agent's Signature X		Date
Printed Agent Name	Agency	

This form serves 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 at our company.

_____
Corporate Officer's Signature

Mail Distribution To:

The Baltimore Life Insurance Company
ATTN: NEW BUSINESS DEPT
10075 Red Run Boulevard | Owings Mills, MD 21117-4871

Medallion Signature Guarantee
Place medallion stamp below.