Application Forms Package Checklist

Form Requirement Details

No Additional Form Requirements

Fully Underwritten: Yes
Existing Insurance or Annuity: Don't Know
InSpeed App: No

Product: Silver Guard
Replacement: Don't Know

State: OH
1035 Exchange: No

Form	Description
8473	Cover Sheet
8684	Application
5122	Credit/Debit Card Authorization
8771	HIPAA Form
8683	MIB, FCRA and Conditional Receipt
8685	Agent's Statement
2907	EFT Authorization
8733	Consent to Do Business Electronically
8683 Pre-App	MIB Pre-Notice
8727 Pre-App	Pre-App HIPAA
8728 Pre-App	Pre-App eConsent
8907	COVID-19 Screening

Agent's Name: _____

Client's Name: _____

Baltimore Life's Silver Guard®
Paper Application and Underwriting Process

While most of Baltimore Life's Silver Guard® applications are written using IN*Speed*® NOW underwriting process, an innovative point-of-sale application and underwriting process, Silver Guard can also be written using a paper application.

The Decision Process

You will qualify your client by completing application Form ICC17-8684 or its state specific variation. The applicant can qualify for either Silver Guard I and II based upon the Option C medical questions Parts A, B, and C on the application. Make sure that all necessary information is gathered that is required to underwrite and issue the application.

To assist you in classifying a condition, we need to start with the application, which includes:

- A series of health questions follows. While diagnosis, symptom(s) and hospitalization are easily understood, the concept of treatment may require some clarification.
- Treatment applies to any medical condition(s) that has existed within the timeframe of the question.
- Medication for certain conditions named on the application must always be considered ongoing and current treatment.
- Congestive heart failure, chest pain (angina), Alzheimer's/dementia, and chronic renal insufficiency/failure (kidney disease), though not an exhaustive listing, are major examples of such conditions. People currently taking medication for, or otherwise receiving treatment for these conditions should NEVER answer any health question that relates to their individual condition "No", regardless of when the condition was initially diagnosed. The appropriate answer to any question relating to these conditions is "Yes".
- In addition to the application, the following forms are required and can be printed or ordered from the secure area of our website.
    - Authorization of Release of Health-Related Information (HIPAA), Form 8771
    - In Pennsylvania only, Pennsylvania Disclosure, Form 1589
- Other forms may be required such as state-specific replacement forms or the NAIC replacement form, Form 7296-1201-NAIC, if applicable.

Once the appointment is finished and the decision has been given, please submit the completed application and required forms 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 Baltimore Life Insurance Company
10075 Red Run Boulevard | Owings Mills, MD 21117-4871
(800) 628-5433 | (410) 581-6600 | baltlife.com

APPLICATION FOR INDIVIDUAL LIFE INSURANCE

PROPOSED INSURED INFORMATION

First Name	Middle Name /Initial	Last Name	Suffix

Street Address

City | State | ZIP

Country of Birth	State of Birth	Are the Proposed Insured and the proposed Policy Owner U.S. citizens or permanent legal residents of the United States? ☐ Yes ☐ No

Date of Birth (MM/DD/YYYY)	Age	Height	Weight	Social Security No. or TIN	Gender
/ /		ft. in.	lbs.	– –	☐ F ☐ M

Marital Status	State Identification or Driver's License Number

Area Code and Telephone Number
( ) –

Is this a mobile phone?
☐ Yes ☐ No

Email Address	Occupation

FOR JUVENILE INSURANCE POLICY ONLY: Parent or Legal Guardian please complete the following information if the Proposed Insured is under age 15 *(State variations may apply):*

Parent/Guardian

Name	
Street Address	
City, State ZIP	
Date of Birth	/ /
Social Security No.	– –
Email	

Mod 1

COMPLETE ONLY IF APPLYING FOR CHILDREN'S INSURANCE BENEFIT RIDER(S)

Please complete for any child age 0-14

Health questions must be completed for each child applying for a rider.

First Name	Middle Name/Initial		Last Name		Suffix
Date of Birth (MM/DD/YYYY) / /	Age	Height ft. in.	Weight lbs.	Gender ☐ F ☐ M	Social Security Number or TIN – –

Is this proposed insured child a U.S. citizen or permanent legal resident of the United States? ☐ Yes ☐ No

First Name	Middle Name/Initial		Last Name		Suffix
Date of Birth (MM/DD/YYYY) / /	Age	Height ft. in.	Weight lbs.	Gender ☐ F ☐ M	Social Security Number or TIN – –

Is this proposed insured child a U.S. citizen or permanent legal resident of the United States? ☐ Yes ☐ No

First Name	Middle Name/Initial		Last Name		Suffix
Date of Birth (MM/DD/YYYY) / /	Age	Height ft. in.	Weight lbs.	Gender ☐ F ☐ M	Social Security Number or TIN – –

Is this proposed insured child a U.S. citizen or permanent legal resident of the United States? ☐ Yes ☐ No

First Name	Middle Name/Initial		Last Name		Suffix
Date of Birth (MM/DD/YYYY) / /	Age	Height ft. in.	Weight lbs.	Gender ☐ F ☐ M	Social Security Number or TIN – –

Is this proposed insured child a U.S. citizen or permanent legal resident of the United States? ☐ Yes ☐ No

First Name	Middle Name/Initial		Last Name		Suffix
Date of Birth (MM/DD/YYYY) / /	Age	Height ft. in.	Weight lbs.	Gender ☐ F ☐ M	Social Security Number or TIN – –

Is this proposed insured child a U.S. citizen or permanent legal resident of the United States? ☐ Yes ☐ No

First Name	Middle Name/Initial		Last Name		Suffix
Date of Birth (MM/DD/YYYY) / /	Age	Height ft. in.	Weight lbs.	Gender ☐ F ☐ M	Social Security Number or TIN – –

Is this proposed insured child a U.S. citizen or permanent legal resident of the United States? ☐ Yes ☐ No

First Name	Middle Name/Initial		Last Name		Suffix
Date of Birth (MM/DD/YYYY) / /	Age	Height ft. in.	Weight lbs.	Gender ☐ F ☐ M	Social Security Number or TIN – –

Is this proposed insured child a U.S. citizen or permanent legal resident of the United States? ☐ Yes ☐ No

First Name	Middle Name/Initial		Last Name		Suffix
Date of Birth (MM/DD/YYYY) / /	Age	Height ft. in.	Weight lbs.	Gender ☐ F ☐ M	Social Security Number or TIN – –

Is this proposed insured child a U.S. citizen or permanent legal resident of the United States? ☐ Yes ☐ No

NOTICE: *The beneficiary for the child rider is the Insured unless changed by the Owner. If additional space is needed, attach an application amendment form.*

Mod 2

PROPOSED INSURED AUTHORIZATION

Authorization: I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, pharmacy or pharmacy benefit manager, insurance company, MIB, Inc, (MIB) or other organization, institution or person, that has any paper or electronic records possesses prescription history, or knowledge of me or my child(ren)'s health, to give to the Baltimore Life Insurance Company, or its reinsurers, any such information for the purpose of evaluating me or my child(ren's) application for insurance. This medical or health information may include information related to diagnosis, testing or treatment for mental illness, HIV, AIDS, alcohol or drug use. Health information obtained will be kept confidential and not be redisclosed other than as permitted by law.

I authorize the Baltimore Life Insurance Company, or its reinsurers, to make a brief report of me or my child(ren)'s personal health information to MIB. A photographic copy of this authorization shall be as valid as the original.

This authorization shall be valid for two years or a different time frame as required by applicable laws in the state where the policy is delivered or issued for delivery from this date and may be revoked by sending written notice to the Baltimore Life Insurance Company.

_____ _____

Signature of Proposed Insured or Parent/Legal Guardian Date
(If Proposed Insured is under age 15. State variations may apply)

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

First Name	*Middle Name/Initial*	*Last*	*Suffix*

Mod 3

HEALTH QUESTIONS FOR PROPOSED INSURED
ISSUE AGES 50-80
INSURANCE COVERAGE UP THROUGH $100,000

1. Proposed Insured: Have you used any nicotine or tobacco-based products in the last 12 months? ☐ Yes ☐ No
2. Do you have a primary care physician? ☐ Yes ☐ No

If "yes", provide the contact information for the proposed insured's primary care physician (* denotes required fields):

a. Physician Name*:_____

b. Physician Address:_____

Address City* State* ZIP Code

c. Date of last visit:_____

Month/Year (MM/YYYY)

Part A

1. Within the past 12 months have you:		
a. Required constant human assistance or supervision with any of the following normal activities of daily living: dressing, eating, bathing, toileting, transferring from bed to chair, walking or maintaining continence?	☐ Yes	☐ No
b. Been hospitalized, for 5 or more consecutive days, confined to a bed or nursing facility, received hospice care or been advised to receive hospice care?	☐ Yes	☐ No
c. Been treated for cancer or recurrence of cancer (excluding Basal cell or Squamous cell skin cancer)?	☐ Yes	☐ No
d. Plead guilty to or been convicted of a felony or misdemeanor or do you have such charge currently pending against you?	☐ Yes	☐ No
2. Have you ever:		
a. Had, or been medically advised to have, an organ transplant, or been diagnosed by a member of the medical profession as having a terminal medical condition that is expected to result in death within the next 12 months?	☐ Yes	☐ No
b. Been medically diagnosed, treated, or taken medication for chronic kidney disease (including dialysis), kidney or liver failure, cirrhosis, congestive heart failure, cardiomyopathy, organic brain syndrome, Alzheimer's, dementia, Lou Gehrig's disease (ALS), schizophrenia, or mental incapacity?	☐ Yes	☐ No
c. 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
d. Had more than one occurrence or any metastasis of any cancer in your lifetime (excluding Basal or Squamous cell skin cancer), or had an amputation caused by cancer?	☐ Yes	☐ No
e. 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
3. Within the past 12 months have you been medically diagnosed, advised to have treatment for, hospitalized for, or started taking medications for stroke, transient ischemic attack (TIA or mini-stroke), or Hepatitis C?	☐ Yes	☐ No
4. Within the past 24 months have you been medically diagnosed, treated for, advised to have treatment for, hospitalized for, or taken medication for:		
a. Chronic obstructive pulmonary disease (COPD) or lung disease, emphysema, chronic bronchitis, or required oxygen to assist in breathing?	☐ Yes	☐ No
b. Angina, heart attack, heart or vascular surgery (including coronary artery bypass, initial pacemaker placement, defibrillator, heart valve replacement, abdominal aortic aneurysm, but excluding angioplasty, stent placement or varicose vein stripping) or any procedure to improve circulation to the heart or brain?	☐ Yes	☐ No
c. 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
d. Attempted suicide, alcohol abuse or drug abuse?	☐ Yes	☐ No
5. Within the past 24 months, have you been convicted of operating a vehicle while intoxicated or impaired?	☐ Yes	☐ No

Part B

1.	Within the past 36 months have you been medically diagnosed, hospitalized for, treated for, or taken medication for:	
a.	Lymphoma, melanoma, leukemia, any internal cancer, Hodgkin's disease, Parkinson's disease, stroke, transient ischemic attack (TIA or mini-stroke), or liver disease?	☐ Yes ☐ No
b.	Angina, heart disease, heart attack, heart or vascular surgery, angioplasty, cardiac or vascular stent placement or graft, pacemaker replacement, defibrillator, or any procedure to improve circulation to the heart or brain?	☐ Yes ☐ No
c.	Chronic obstructive pulmonary disease (COPD) or lung disease, emphysema, chronic bronchitis, or required oxygen to assist in breathing?	☐ Yes ☐ No
d.	Diabetic complications (including neuropathy, retinopathy, uncontrolled blood sugar)?	☐ Yes ☐ No
e.	Insulin Dependent diabetes accompanied by heart disease or peripheral arterial disease (PAD)?	☐ Yes ☐ No
2.	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 Additional information may be required for some questions.

1.	Are you taking any prescription medication for any impairment listed above?	☐ Yes ☐ No
2.	Have you been medically diagnosed with or treated for uncontrolled high blood pressure?	☐ Yes ☐ No
2a.	If yes, are you taking all prescribed medication(s) for uncontrolled high blood pressure as directed by your physician?	☐ Yes ☐ No
3.	In the last 2 years, has a member of the medical profession recommended diagnostic testing that has not yet been complete, or completed diagnostic testing for which a diagnosis or results are not yet known?	☐ Yes ☐ No

Part D **If you are over age [60] and applying for [$50,001] and above, please complete the following.**
Additional underwriting is required.

1.	Are you currently taking any medication (opiate) for chronic pain syndrome or any other pain control?	☐ Yes ☐ No
2.	Have you ever been medically treated for any condition listed in Parts A, B, or C above?	☐ Yes ☐ No

If "Yes", please describe:

Mod 4 – **OPTION C**

PRODUCT SELECTION FOR NEW INSURANCE

Please select **only one** product.

Note: *Rider availability is based on the product selected, the policy face amount, and state availability.*

☐ **Whole Life Policy With Dividends**	☐ **Whole Life Policy Without Dividends** (Issue ages 50 – 80)	☐ **Graded Whole Life Policy Without Dividends** (Issue ages 50 – 80)	☐ **Term Life Policy**	☐ **Flexible Premium Adjustable Life Policy**
Face Amount $	Face Amount $	Face Amount $	Face Amount $	Face Amount $
Select One ☐ Life Pay ☐ Limited Pay Years _____	Select One ☐ Life Pay ☐ Limited Pay Years _____		_____ Years Initial Payment Period	
Nonforfeiture Option ☐ Extended Term ☐ Reduced Paid Up	Nonforfeiture Option ☐ Extended Term ☐ Reduced Paid Up	Nonforfeiture Option ☐ Reduced Paid Up		
Automatic Premium Loan: ☐ Yes ☐ No	Automatic Premium Loan: ☐ Yes ☐ No	Automatic Premium Loan: ☐ Yes ☐ No		
Accelerated Death Benefit Rider: **To decline, check here: ☐** ☐ Accidental Death Benefit Rider Amount _____ ☐ Children's Insurance Benefit Rider ☐ Guaranteed Insurability Option Rider Amount _____ ☐ Non-Occ Disability Income Monthly Benefit Amount $_____ ☐ Single Premium Additional Insurance Rider ☐ Waiver of Premium Rider ☐ Other_____ Select ONE Dividend Option**:** ☐ Accumulation ☐ Cash ☐ Paid-Up Additions ☐ Premium Reduction	☐ Accidental Death Benefit Rider – *Life Pay Only* ☐ Other_____	☐ Other_____	Accelerated Death Benefit Rider: **To decline, check here: ☐** ☐ Accidental Death Benefit Rider Amount _____ ☐ Children's Insurance Benefit Rider ☐ Non-Occ Disability Income Monthly Benefit Amount $_____ ☐ Waiver of Premium Rider ☐ Other_____	Accelerated Death Benefit Rider: **To decline, check here: ☐** ☐ Accidental Death Benefit Rider Amount _____ ☐ Children's Insurance Benefit Rider ☐ Non-Occ Disability Income Monthly Benefit Amount $_____ ☐ Waiver of Premium Rider ☐ Other_____

Complete for Children's Insurance Benefit Rider as identified in Mod 2:

Child's Name	*Face Amount*
	$
	$
	$
	$
	$
	$
	$
	$

Mod 5

PREMIUM AND BILLING INFORMATION

Premium Methods *(All methods may not be available for all products)*

☐ Electronic Funds Transfer (EFT):
☐ Monthly ☐ Semiannual ☐ Annual

☐ Direct Bill *(Initial premium must be check or credit card)*:
☐ Quarterly ☐ Semiannual ☐ Annual

Initial Premium paid with the application $ _____

☐ Planned Premium $_____
☐ Draft Premium Immediately
☐ Future Draft Date Request:
☐1st ☐2nd ☐3rd ☐4th/Day: ☐Mon ☐Tues ☐Weds ☐Thur ☐Fri
☐ Draft Day (1-28) _____
☐ Pay by Check
☐ Charge to Credit Card *(Must complete Baltimore Life Form)*
☐ Init. Lump Sum Prem. ☐ 1035 $_____ ☐ Non-1035 $_____
☐ SPAIR Premium (Dividend WL Only)
☐ 1035 $_____ ☐ Non-1035 $_____

Mod 6

OWNER INFORMATION

POLICY OWNER *(If Other than Proposed Insured)*

First Name	Middle Name/Initial	Last Name	Suffix

Street Address

City | State | ZIP

Date of Birth (MM/DD/YYYY)	Social Security No. or TIN	Marital Status
/ /	– –	

Area Code and Telephone Number
( ) –

Is this a mobile phone?
☐ Yes ☐ No

Email Address	Relationship to Proposed Insured

CONTINGENT OWNER *(This option is only available when the Proposed Insured is not the Owner.)*

First Name	Middle Name/Initial	Last Name	Suffix

Street Address

City | State | ZIP

Date of Birth (MM/DD/YYYY)	Social Security No. or TIN	Marital Status
/ /	– –	

Area Code and Telephone Number
( ) –

Is this a mobile phone?
☐ Yes ☐ No

Email Address	Relationship to Proposed Insured

Mod 7

OPTIONAL SECONDARY ADDRESSEE

For notification of a past due premium payment and/or possible lapse in coverage, do you want to designate a secondary addressee? ☐ Yes ☐ No

First Name	Middle Name/Initial	Last Name	Suffix

Street Address

City | State | ZIP

Relationship to Proposed Insured

Mod 8

PRIMARY BENEFICIARY INFORMATION

Notice: *Unless otherwise directed, the insurance proceeds will be divided equally among all persons who are named as Primary Beneficiary and who survive the insured. If no Primary Beneficiary survives, proceeds will be divided equally among all persons who are named as a Contingent Beneficiary and who survive the insured. If additional space is needed, attach an application amendment form.*

Total benefits must equal 100%

First Name	Middle Name/Initial	Last Name	Suffix
Street Address	City	State	ZIP
Date of Birth (MM/DD/YYYY) / /	Social Security No. or TIN – –	Area Code and Telephone Number ( ) –	
Email Address	Relationship to Proposed Insured	Benefit %	

First Name	Middle Name/Initial	Last Name	Suffix
Street Address	City	State	ZIP
Date of Birth (MM/DD/YYYY) / /	Social Security No. or TIN – –	Area Code and Telephone Number ( ) –	
Email Address	Relationship to Proposed Insured	Benefit %	

CONTINGENT BENEFICIARY *(If any)*

First Name	Middle Name/Initial	Last Name	Suffix
Street Address	City	State	ZIP
Date of Birth (MM/DD/YYYY) / /	Social Security No. or TIN – –	Area Code and Telephone Number ( ) –	
Email Address	Relationship to Proposed Insured	Benefit %	

First Name	Middle Name/Initial	Last Name	Suffix
Street Address	City	State	ZIP
Date of Birth (MM/DD/YYYY) / /	Social Security No. or TIN – –	Area Code and Telephone Number ( ) –	
Email Address	Relationship to Proposed Insured	Benefit %	

First Name	Middle Name/Initial	Last Name	Suffix
Street Address	City	State	ZIP
Date of Birth (MM/DD/YYYY) / /	Social Security No. or TIN – –	Area Code and Telephone Number ( ) –	
Email Address	Relationship to Proposed Insured	Benefit %	

First Name	Middle Name/Initial	Last Name	Suffix
Street Address	City	State	ZIP
Date of Birth (MM/DD/YYYY) / /	Social Security No. or TIN – –	Area Code and Telephone Number ( ) –	
Email Address	Relationship to Proposed Insured	Benefit %	

Mod 9

EXISTING INSURANCE REPLACEMENT QUESTIONS

1. Does the Proposed Insured have existing life insurance or annuities currently in force or pending with this company or any other company? ☐ Yes ☐ No
2. Has the Proposed Insured had any policies lapse or surrender within the last six (6) months? ☐ Yes ☐ No
3. Will this policy, if issued, replace or modify life insurance or annuities in force with this or any other company? ☐ Yes ☐ No

If any question is answered "Yes", provide the following information.
(Exclude property, casualty or liability, and employer-paid group life insurance).

Company Name	Policy Number	Name of Insured or Annuitant	Amount (incl. ADB)	Year Issued	Replacing? (Yes or No)

Mod 10

PREMIUM PAYOR INFORMATION

Please check if Premium Payor is the Owner or Insured: ☐ Owner ☐ Insured

If Premium Payor is other than Owner or Insured, please complete the information below:

Full Name: *First* *Middle* *Last* *Suffix*

Street Address City State ZIP

Email Address | Relationship to Proposed Insured

Mod 11

AUTHORIZATION, ACKNOWLEDGMENT AND CERTIFICATION

DECLARATION: I understand that statements and answers in the application are the basis for any policy issued and that no information about them will be considered to have been given to the Baltimore Life Insurance Company ("the Company") unless stated in the application. I understand that if I provide any false or incomplete answers, and/or if the health of the Proposed Insured changes before the policy effective date and I do not notify the Company of such changes, then benefits may be denied or the policy may be rescinded. My policy will not take effect unless the first premium is paid in full while each Proposed Insured is alive and this application is approved by the Company and the policy is delivered to and accepted by the Owner. Only the Company's President, Vice President, or Secretary may: (a) make or change any contract of insurance; (b) make a binding promise about insurance; or (c) change or waive any term of an amendment(s) or supplement(s). Paying my insurance premium more frequently than annually may result in higher yearly out-of-pocket cost or different cash values. This application will expire after 60 days if not received by the Company. I understand that no agent is authorized to advise me that an inaccurate answer is acceptable. I understand that the Company can contest any benefits that provide accidental death benefit coverage or disability coverage. I have read the application and all statements and answers, and they are true and complete to the best of my knowledge and belief.

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.

NOTICE: State insurance law may prohibit the owner of a life insurance policy from entering into any agreement to sell, transfer or assign a life insurance policy **before** the date the policy was issued, or within a period specified by state law after the date the policy was issued. Please consult with legal advisors if you have any questions about these matters.

Tax Notice: Under Federal Tax law, the company is required to ask you to certify your correct Taxpayer Identification Number (TIN) and to include it in any reports of taxable income it makes to the IRS. If you are an individual, your Social Security Number is your Taxpayer Identification Number.

Certification: Under penalties of perjury, I certify that: 1) the number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and 2) I am not subject to backup withholding because: a) I am exempt from backup withholding, or b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or c) the IRS has notified me that I am no longer subject to backup withholding; and 3) I am a U.S. citizen or other U.S. person (defined in the Instructions to the Form W-9); and 4) I am exempt from the Foreign Account Tax Compliance Act (FATCA) reporting.

☐ **Check this box if the IRS has notified you that you are subject to backup withholding.**

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

WARNING: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

This Application was signed at _____ (City) and _____ (State) _____ (Day) day of _____ (Month), _____ (Year)

_____ Signature of Proposed Insured
(Unless under age 15. State variations may apply)

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

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

Mod 12

The Baltimore Life®
COMPANIES

CREDIT/DEBIT CARD AUTHORIZATION

If you wish to take advantage of the Baltimore Life credit or debit card initial payment feature, please complete all information requested below. Upon approval, your credit or debit card will be billed for the initial premium(s) due as set forth on your application or on your policy(ies). Your total charge(s) will then appear on your monthly credit or debit card statement. You may contact us about this authorization by writing to or calling us at:

The Baltimore Life Insurance Company
Attn: New Business Department
10075 Red Run Boulevard
Owings Mills, MD 21117-4871
(877) 533-2468

I AUTHORIZE BALTIMORE LIFE TO AUTOMATICALLY BILL THE CREDIT OR DEBIT CARD LISTED AS SPECIFIED BELOW:

Bill my credit or debit card an amount of $_____.

NAME(S) OF APPLICANT(S) OR INSURED(S)

_____

_____

_____

YOUR BALTIMORE LIFE POLICY NUMBER(S) *(if known)*

_____

_____

_____

CREDIT/DEBIT CARD ACCOUNT

_____
NAME ON CREDIT/DEBIT CARD (EXACTLY AS PRINTED)

( ) ( )
_____
HOME PHONE WORK PHONE

_____
BILLING ADDRESS FOR CREDIT/DEBIT CARD (STREET, APT. #)

_____
CITY STATE ZIP

_____
E-MAIL

_____
CREDIT/DEBIT CARD NUMBER EXPIRATION DATE SECURITY CODE

_____
SIGNATURE TODAY'S DATE

TYPE OF CREDIT/DEBIT CARD

- ☐ Visa
- ☐ MasterCard
- ☐ Discover

(Debit cards must contain the Visa, Mastercard, or Discover logo.)

Form 5122 can only be sent via U.S. postal mail or submitted through securesubmit.baltlife.com using Baltimore Life's secure agent website log in credentials. Please destroy this form once sent or transmitted to the Home Office.

Please print this form in duplicate. Provide a completed copy to the customer and send one to the Home Office.

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.

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

MIB, INC. PRE-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 not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its Members. If you apply to another MIB Member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information in its file. Upon receipt of a request from you MIB will arrange disclosure of any information it may have in your file. Please contact MIB at (866) 692-6901. If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act.

The address of MIB's information office is 50 Braintree Hill Park, Suite 400 Braintree, MA 02184-8734.

The Baltimore Life Insurance Company, or its reinsurers, may also release information in its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.

FAIR CREDIT REPORTING ACT NOTICE

As part of our evaluations of your application for insurance, an investigative 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.

CONDITIONAL RECEIPT

Received from _____ The sum of $_____

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

Under no circumstance will the insurance provided by this receipt, including any insurance in force or applied for with Baltimore Life, or any benefit for accidental death, exceed $150,000.00 for each person proposed for coverage. Any coverage provided by this receipt will terminate when a policy is issued as a result of this application.

_____ _____

Agent Signature Date

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

Mod 15

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

AGENT'S STATEMENT

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

   Please select one: ☐ COD ☐ Family List Bill
   ☐ Salary Savings ☐ Company List Bill

   _____

   _____

9. Special instructions for underwriting telephone interview: If required, this interview can be scheduled starting on day three after the application is submitted. The agent can also elect to call Elite Sales Processing direct during hours of operation starting on day three after the application is submitted and conference the Proposed Insured into the interview. The interview must be completed within 15 days of submitting the application.

   Phone number to call: (_____) _____ - _____

   Requested date for the call: _____/_____/_____

   Requested time to call: _____ ☐ a.m. ☐ p.m. ☐ Eastern ☐ Central ☐ Mountain ☐ Pacific

   Agent's phone number: (_____) _____ - _____
   You will receive an electronic agent notification when the application submission is completed. You will also get a communication with the underwriting decision. Please contact the proposed insured and communicate the underwriting decision that was provided.

Witness (Licensed Agent): I certify that only advertising previously approved by The Baltimore Life Insurance Company was used in conjunction with this sale, and that copies of all sales materials used in this sale have been left with the applicant. If required by the state where this application was completed, I have provided the life insurance buyers guide at the time of application. Any electronically presented sales materials will be provided in printed form to the applicant no later than at the time of policy delivery.

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

Printed Name	Writing Agent Signature	Date

Writing Agent No. _____

If split commissions apply:

	% Split To Be Paid	% Of Production Credits
Writing Agent #1 (*Above*)		
Writing Agent #2 (*Printed Name*)		
Writing Agent No.		
Writing Agent #3 (*Printed Name*)		
Writing Agent No.		

Mod 14

EFT BANK DRAFT AUTHORIZATION

First Name	Middle Name/Initial	Last Name	Suffix

Street Address	City	State	ZIP

Payor Information (If other than Insured or Owner)	
Date of Birth (MM/DD/YYYY)	Social Security No. or TIN
/ /	– –

As a duly authorized check signer on the financial institution account identified below, you hereby authorize:

- The Baltimore Life Insurance Company ("the Company") to initiate recurring electronic funds transfer ("EFT") withdrawal transactions as indicated in this application.
- Your financial institution to transfer the premium amount indicated in this application.
- Adjusting entries to correct errors.

You agree that these debits and any adjustments will be made electronically. If any EFT withdrawal is dishonored for any reason, you release the Company from any and all resulting liabilities even if the dishonor results in cancellation of the applicant's insurance policy. This authorization is to remain in full force and effect until written notification of its termination is given to the Company.

Bank Name	Type of Account: ☐ Checking ☐ Savings
Name of Accountholder (As it appears on the account)	
Bank Routing Number (Must be nine (9) digits)	Account Number

Printed Name

Signature

Form 2907-0318

[Mod 13]

Consent to Do Business Electronically ("Consent")

Reference #_____

Purpose and Scope of Consent

In order to conduct business electronically, you must provide The Baltimore Life Insurance Company (the "Company") with your consent. By accepting the terms of this Consent, you will be providing the Company with your consent to:

- Transmit and submit an application for a life insurance policy or annuity contract ("the Policy") in an electronic manner;
- Have information regarding your Policy made available to you electronically;
- Transmit and submit requests relating to the Policy via electronic means; and
- Agree to all of the terms and conditions set forth in this Consent.

By providing your Consent, you agree as an applicant and/or policy owner to be bound with the same legal effect as if you had signed your name on paper by hand. Finally, you agree that email receipt of any document delivered by the Company constitutes delivery of such document.

Regardless of this Consent, the Company may choose to: (a) deliver documents and information to you on paper, and/or (b) require that certain communications from you be delivered to the Company on paper.

Duration of Consent

This Consent becomes effective once you accept its terms and remains in effect until the earlier of: Policy termination or withdrawal of Consent (as described in the next section). This Consent is subject to change at any time in the Company's sole discretion, without notice.

Withdrawal of Consent

You may elect to withdraw your Consent at any time and without charge by contacting us using one of the contact methods outlined below. The legal validity of electronic transactions or communications occurring prior to our receipt of the withdrawal of Consent will not be affected by this withdrawal.

Updating Your Contact Information

You are responsible for ensuring that we have a current email address for purposes of conducting business electronically. You agree to hold the Company harmless with respect to any emails sent to the incorrect email address due to your failure to provide the Company with a current or valid email address.

How to Contact the Company

You can contact the Company as follows:
Customer Service Telephone: (800) 628-5433
Internet: www.baltlife.com

Hardware and Software Requirements

To access and retain forms, documents and information made available to you electronically by the Company, you must have access to a computer with an Internet connection. You must be able to send and receive emails, and be able to save forms and documents to a storage device for later reference or have the computer connected to a printer so you can print out such documents.

Option to Use Paper

You always have the ability to use paper in lieu of an electronic process. We will send a paper copies of any forms or documents at no charge to you.

Copies

You agree to print or save this Consent and all forms and documents sent or made available to you electronically, and to keep printed or electronic copies of them for your records.

By signing below, you agree that: (1) you have read this information about electronic records and electronic signatures; (2) the agent provided me with a copy of this information or I will be receiving it before I sign the application ; and (3) you consent to using electronic signatures and electronic records.

_____ _____

Signature Date

Reference # _____

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

MIB Pre-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 not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its Members. If you apply to another MIB Member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information in its file. Upon receipt of a request from you MIB will arrange disclosure of any information it may have in your file. Please contact MIB at (866) 692-6901. If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act.

The address of MIB's information office is 50 Braintree Hill Park, Suite 400 Braintree, MA 02184-8734.

The Baltimore Life Insurance Company, or its reinsurers, may also release information in its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.

Fair Credit Reporting Act Notice

As part of our evaluations of your application for insurance, an investigative 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.

Reference # _____

The Baltimore Life Insurance Company
10075 Red Run Boulevard | Owings Mills, MD 21117-4871
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Third Party Authorizations, Acknowledgments and Declarations

Authorization
I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, pharmacy or pharmacy benefit manager, insurance company, MIB, Inc. ("MIB") or other organization, institution or person, that has any records or knowledge of me or my health or possesses prescription history about me, to give to the Baltimore Life Insurance Company, or its reinsurers, any such information for the purpose of evaluating my application for insurance. Health information obtained will not be re-disclosed without my authorization unless permitted by law, in which case it may not be protected under federal privacy rules.

I authorize the Baltimore Life Insurance Company, or its reinsurers, to make a brief report of my personal health information to MIB. A photographic copy of this authorization shall be as valid as the original.

This authorization shall be valid for two years from this date and may be revoked by sending written notice to the Baltimore Life Insurance Company.

_____
Print Name

_____ _____
Signature Date

Reference #_____

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

Electronic Consent

I consent to having The Baltimore Life Insurance Company determine my eligibility in an electronic manner and to having The Baltimore Life Insurance Company take my signatures electronically.

_____
Print Name

_____ _____
Signature Date

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
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