



Final Expense Sample Application

This is a sample application, not a promise to issue coverage.

Important Notes:

You cannot buy this policy directly from Baltimore Life.

This policy is sold only via licensed Baltimore Life agencies such as Choice Mutual.

To apply, call us at  **1-800-644-2926**



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 [Simplified Whole Life]

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? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Date of Birth (MM/DD/YYYY) / /	Age	Social Security No. or TIN - -		Gender <input type="checkbox"/> F <input type="checkbox"/> M	Marital Status	
Area Code and Telephone Number () -		Is this a mobile phone? <input type="checkbox"/> Yes <input type="checkbox"/> No		Email Address		

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? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Email Address				Relationship to Proposed Insured		

FACE AMOUNT, PREMIUM AND BILLING INFORMATION

Face Amount: \$ _____

Modal Premium \$ _____

Automatic Premium Loan: Yes No

Plan Selection:

- Whole Life – Level Benefit
 - Life Pay 20 Pay Single Pay
- Modified Whole Life – Return of Premium
(Life-Pay Only)

Premium Methods:

- Electronic Funds Transfer (EFT) - *Complete EFT Authorization*
 - Draft Premium Immediately
 - Future Draft Date

- Direct Bill (*Initial premium must be by check*):

Quarterly Semiannual Annual
Initial Premium paid with the application \$ _____

Riders:

- Accidental Death Benefit Rider – *Life-Pay Only*
- Accelerated Death Benefit Rider – **To decline, check here**
- Other _____

- Single Pay Only: 1035 \$ _____ Non-1035 \$ _____

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			

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		

**HEALTH QUESTIONS FOR PROPOSED INSURED
ISSUE AGES 18-89 - INSURANCE COVERAGE UP THROUGH \$150,000**

1. Proposed Insured: Have you used any nicotine or tobacco-based products in the last 12 months? Yes No
2. Does the proposed insured 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: (MM/YYYY) _____

3. What is your height and weight? Feet ____ Inches ____ Pounds ____

Part A – All Ages – If all questions in Part A are "No", complete part B and C

1. Has the proposed insured **ever** been diagnosed, treated, tested positive for, or been given medical advice by a member of the medical profession for any of the following:
 - a. Congestive Heart Failure, or Cardiomyopathy? Yes No
 - b. Any Organ Transplant? Yes No
 - c. Multiple Sclerosis, Muscular Dystrophy, Cerebral Palsy, or Parkinson's Disease? Yes No
 - d. Memory Loss, Cognitive Impairment, Alzheimer's or Dementia? Yes No
 - e. ALS, Lupus, Acquired Immune Deficiency Syndrome (AIDS), or tested positive for HIV? Yes No
 - f. Chronic Kidney Failure, Dialysis Treatment, Hepatitis B or C, Liver Failure, Cirrhosis or Fibrosis of the Liver, or Sickle Cell Anemia? Yes No
 - g. Schizophrenia or Psychosis? Yes No
2. In the past **2 years**, have you:
 - a. Been convicted of driving under the influence of drugs or alcohol? Yes No
 - b. Plead guilty to, or been convicted of, a felony? Yes No
 - c. Experienced any of the following for which advice of a medical professional was not sought: Chest Pain, Blood in urine, Rectal Bleeding, Loss of consciousness, Shortness of Breath? Yes No
3. In the past **2 years**, under the advice of a medical professional have you:
 - a. Been confined to a hospital for 5 days or more? Yes No
 - b. Been recommended to have any surgery that has not yet been complete? Yes No
 - c. Had any diagnostic testing recommended but not complete, or completed diagnostic testing for which a diagnosis or results are not yet known? Yes No
 - d. Been diagnosed as permanently disabled due to a chronic disease? Yes No

Part B – All Ages – For any "Yes" answer(s), complete the applicable secondary questions in the Supplemental Health Questionnaire form

4. In the last **5 years** has the proposed insured been diagnosed, treated, tested positive for, or been given medical advice by a member of the medical profession for any of the following:
 - a. Coronary Artery Disease, Heart Attack, High Blood pressure, or Atrial Fibrillation? Yes No
 - b. Diabetes, COPD or Sleep Apnea? Yes No
 - c. Any Cancer, Leukemia or Lymphoma? (Excluding squamous or basal cell carcinoma) Yes No
 - d. Seizures, Blood Clots, Stroke or TIA? Yes No
 - e. Pancreatitis, Ulcerative Colitis or Crohn's Disease? Yes No
 - f. Depression or Bipolar Disorder? Yes No
 - g. Recreational Drug use, or Drug or Alcohol Abuse? Yes No
 - h. Rheumatoid Arthritis, Fibromyalgia, or Chronic Kidney Disease? Yes No

Part C - For age 70+ Only – Any "Yes" answer is ineligible for coverage

5. In the past **12 months**, has the proposed insured:
 - a. Lived in an assisted living facility or nursing home? Yes No
 - b. Had a fall resulting in a fracture of your Femur, Neck, Back, Skull or Hip, or been bed-ridden for 3 weeks or more for any reason? Yes No
 - c. Required assistance in walking, eating, bathing, toileting, transferring from a bed or chair, or getting dressed? Yes No
6. Has it been more than 3 years since you have seen or consulted with a doctor, nurse practitioner or any member of the medical profession for a physical examination or any preventative health screenings? Yes No

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 %

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)

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 _____ and _____ day of _____, _____
CITY STATE DAY MONTH YEAR

 Signature of Proposed Insured

 Signature of Owner (If other than Proposed Insured)