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.**

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? ☐ Yes ☐ No

Date of Birth (MM/DD/YYYY) / / | Age | Social Security No. or TIN – – | Gender ☐ F ☐ M | Marital Status

Area Code and Telephone Number ( ) – | Is this a mobile phone? ☐ Yes ☐ 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? ☐ 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

FACE AMOUNT, PREMIUM AND BILLING INFORMATION

Face Amount: $_____

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)

Riders:

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

☐ Other _____

Modal Premium $_____

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 $ _____

☐ 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 _____ (City) and _____ (State) _____ (Day) day of _____ (Month), _____ (Year)

_____
Signature of Proposed Insured

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