



The Baltimore Life®  
COMPANIES

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# Generation Legacy™

Sample Forms Package

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# Required Forms

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The following forms are necessary if your client applies for a Generation Legacy™ policy. Please note there are state specific variations of many of these forms. Please verify state availability of the product and rider and verify if the state in which you are selling requires a state specific form.

## Required Forms:

- Generation Legacy Application, Form 8232-0411
  - Modified Endowment Contract Information (Issue Ages 75-80), Form 3994
  - Authorization of Release of Health-Related Information (HIPAA), Form 7699
  - Accelerated Death Benefit Rider Disclosure Statement (where available and applicable), Form 8246 and 8248
  - Suitability Questionnaire, Form 8395
  - Pennsylvania Disclosure, Form 1589 *(This form is generated from Secure Solutions® Illustrator, as well as the agent website within the application and forms package section. In addition, you can print this document manually from the forms ordering section of the agent web site.)*
  - Maine Preliminary Statement of Policy Cost, Form 7060(ME) *(This form is generated from Secure Solutions® Illustrator, as well as the agent website within the application and forms package section. In addition, you can print this document manually from the forms ordering section of the agent web site.)*
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# The Baltimore Life Insurance Company

## Application for Life Insurance and Single Premium Annuity

### 1. Proposed Insured/Annuitant and Beneficiary Information

Last Name Buyer		First Name Bill		MI A.	
Social Security Number 400-22-0000	Age 65	Sex M	Date of Birth 5/1/1944	State or Country of Birth Maryland	Height 6' 0"
Weight 180 lbs		Telephone: Day 500-324-0000		Evening Same	Email Address billbuyer@aol.com
Street Address 1900 Evergreen Avenue		City Lexington		State MD	ZIP Code 21000
Drivers License Number				Drivers License State	

Primary Beneficiary Mary Buyer	Social Security Number 400-33-0000	Relationship Wife
Contingent Beneficiary Susan Buyer	Social Security Number 400-44-0000	Relationship Daughter

### 2. Owner (if other than Proposed Insured)

Last Name	First Name	MI	Relationship
Date of Birth	Tax ID# or Social Security#	Email Address	
Street Address	City	State	ZIP Code

### 3. Contingent Owner

Last Name	First Name	MI	Relationship
Date of Birth	Tax ID# or Social Security#	Email Address	
Street Address	City	State	ZIP Code

### 4. Single Premium Immediate Annuity with Period Certain

1. Payout Period (Predetermined by Annuitant's Issue Age):	Age 60-74 / 10 Years	Age 75-80 / 7 years
2. Estimated Single Premium \$ 50,000		
<input checked="" type="checkbox"/> Non-Qualified Funds <input type="checkbox"/> IRA (Only Qualified Funds Eligible for IRA Rollover/ Transfer)		

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

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

**Notice of Withholding and Election:** I understand that if I elect not to have federal income tax withheld, I am liable for payments of federal and state income tax on the portion of my annuity distribution. I may also be subject to tax penalties under the estimated tax payment rules if my payments of estimated tax and withholding, if any, are not adequate. I understand that if I do not complete the election below, the company is required to withhold federal and or state income tax on the taxable portion of my annuity distribution.

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

(1) Check this box if you do not want any Federal income tax withheld from your annuity

☒ (If you check this box do not complete 2.)

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

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

## 5. Insurance Product and Riders

Product Generation Legacy 10-year

Estimated Face Amount: \$88,496

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

1. Terminal Illness

2. Qualified Nursing Facility and Extended Care

Other Rider(s)

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

Modal Premium: \_\_\_\_\_

## 6. Proposed Insured Medical Questions

### Part A

1. Do you have any impairment, whether physical or mental, for which you need or receive assistance or supervision in performing normal activities of daily living such as bathing, toileting, eating, dressing, taking medications, or moving without any type of physical assistance? ..... ☐ Yes ☒ No
2. Have you ever:
  - a. Been treated or hospitalized for insulin shock, diabetic coma, amputation due to diabetes, or have you taken insulin injections or by other methods prior to age 40 or been diagnosed with diabetes prior to age 25? ..... ☐ Yes ☒ No
  - b. Had, or been medically advised to have, an organ transplant, or been diagnosed as having a terminal medical condition that is expected to result in death within the next 12 months or are you currently hospitalized, confined to a bed or nursing facility, or receiving hospice care? ..... ☐ Yes ☒ No
  - c. Been medically diagnosed, treated, or taken medication for chronic kidney disease (including dialysis), kidney (renal) insufficiency, chronic hepatitis, cirrhosis, liver disease, kidney or liver failure, congestive heart failure, cardiomyopathy, organic brain syndrome, Alzheimer's, dementia, Lou Gehrig's disease (ALS), schizophrenia, bipolar disorder, or mental incapacity? ..... ☐ Yes ☒ No
  - d. Been medically treated or diagnosed by a medical professional as having acquired immune deficiency syndrome (AIDS), AIDS related complex (ARC), or any immune deficiency related disorder or tested positive for the human immunodeficiency virus (HIV)? ..... ☐ Yes ☒ No
  - e. Had more than one occurrence or any metastasis of any cancer in your lifetime (excluding Basal or Squamous cell skin cancer), or are you currently being treated for cancer or recurrence of cancer or had an amputation caused by cancer? ..... ☐ Yes ☒ No
3. Within the past 12 months have you been confined three (3) or more times to a hospital, nursing facility, convalescent care facility or mental health facility? ..... ☐ Yes ☒ No
4. Within the past 24 months have you:
  - a. Been declined or postponed for life or health insurance? ..... ☐ Yes ☒ No
  - b. Been convicted of a felony or are you currently on probation or parole? ..... ☐ Yes ☒ No
  - c. Been convicted of operating a vehicle while intoxicated or impaired? ..... ☐ Yes ☒ No
5. Within the past 24 months have you been diagnosed as having, been treated for, advised to have treatment for or hospitalized for:
  - a. Angina, heart disease, heart attack, uncontrolled high blood pressure, heart or vascular surgery (including heart transplant, coronary artery bypass, pacemaker or replacement pacemaker, heart valve replacement, abdominal aortic aneurysm, angioplasty, stent placement or any procedure to improve circulation to the legs, heart or brain? ..... ☐ Yes ☒ No
  - b. Neuromuscular or brain disease (including cerebral palsy, muscular dystrophy, multiple sclerosis, cystic fibrosis), systemic lupus (SLE) or paralysis of two or more extremities? ..... ☐ Yes ☒ No
6. Within the past 36 months have you been medically diagnosed, treated for or taken medication for:
  - a. Internal cancer, leukemia, lymphoma, melanoma, Hodgkin's disease, Parkinson's disease, stroke, transient ischemic attack (TIA), attempted suicide, alcohol abuse or drug abuse? ..... ☐ Yes ☒ No
  - b. Chronic obstructive pulmonary or lung disease (COPD), emphysema, chronic bronchitis, pulmonary fibrosis, or required oxygen to assist in breathing? ..... ☐ Yes ☒ No

**Part B**

1. Are you taking medication for any impairment listed above? ..... ☐ Yes ☒ No
2. Have you used any nicotine or tobacco based products in the past 12 months? ..... ☐ Yes ☒ No
3. Have you applied for life insurance with any other insurance companies in the last two years? ..... ☐ Yes ☒ No

**Please provide details of all "Yes" answers from Section 6 in the area below.**

Question #	Explanation	Dates/Duration	Name of Medical Professional

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

**7. Replacement Information**

- 1) Does the proposed insured have any existing life insurance or annuities? ..... ☒ Yes ☐ No  
If "Yes", policy status is: \_\_\_\_\_
- 2) Has the proposed insured had any policies lapsed or surrendered within the last six months? ..... ☐ Yes ☒ No
- 3) Will this policy, if issued, replace or modify any existing life insurance or annuities in this or any other company? ..... ☐ Yes ☒ No  
*(This includes the use of dividends or other policy values.)*
- 4) Is any other application for annuity or life insurance pending in this or any other company on the proposed insured? ..... ☐ Yes ☒ No

Existing or Pending Insurance:

Name of Insured	Company	Policy Number	Amount \$	Year Issued	Replace or modify?
					<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No

- 5) Why is this replacement occurring? \_\_\_\_\_  
\_\_\_\_\_

**8. Additional Ownership Information**

1. Has any party to the application, such as the applicant, proposed insured, owner, if other than the applicant, or any beneficiary, entered or made plans to enter into any agreement or contract to sell or assign the ownership of, or a beneficial interest in the applied for policy? ..... ☐ Yes ☒ No
2. Has any person promised or agreed to give or has given to any party to the application, or has any party to the application received or will receive from any person, any inducement, fee or compensation as an incentive to purchase the policy? ..... ☐ Yes ☒ No

Please provide agreement details of all "Yes" answers in the Additional Comments section.

**9. Additional Comments**


## 10. Declarations and Authorizations

**It is understood that The Baltimore Life Insurance Company (the Company) has the right to require a medical examination. If so, this application is not complete until the medical examination has been performed.**

**AGREEMENT:** I am not currently taking and I am not under the influence of any medications or drugs that would affect my ability to fully understand and to fully and accurately complete this application. I have read or had read to me all of the questions and answers contained in this application. This application is complete and true to the best of my knowledge and belief.

**WARNING:** Any person who 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 civil fines and criminal penalties.

It is understood that the President, a Vice President, or the Secretary must sign all agreements made by the Company. No other person, including an insurance agent or broker, can change the terms of any policy or make any promise or agreement binding on the Company. Except as may be provided by the Conditional Receipt bearing the same date and form number as this application, it is agreed that no policy will take effect unless:

1. A policy is delivered to and accepted by the owner while each person proposed for coverage is alive and continues to be insurable, and whose condition of health and occupation, as described in this application, are unchanged from the date of the application.
2. The required premium is paid in full to The Baltimore Life Insurance Company, and the application is approved and accepted by the Company.

**AUTHORIZATION AND ACKNOWLEDGMENT:** I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, pharmacy benefit manager, medical or medically-related facility or health care provider, insurance or reinsuring company, or MIB, Inc., consumer reporting agency or employer having information available as to diagnosis, treatment, prescriptions and/or prognosis of me with respect to any physical or mental condition, including alcoholism and/or use of drugs, and any other nonmedical information about me to give to the Company any and all such information. I understand the information obtained by use of this authorization will be used by the Company to determine eligibility for insurance and/or benefits. Any information obtained will not be released by the Company to any person or organization except to reinsuring companies, MIB, Inc., or other persons or organizations performing business or legal services in connection with my application or claim, or as may be otherwise lawfully required or as I may further authorize. I understand that I may request a copy of this authorization and agree that a photographic copy of this authorization shall be as valid as the original. This authorization shall remain valid for a period of two years and six months following the date of my signature below, regardless of my condition and whether living or deceased, and a copy of this authorization is as valid as the original. I acknowledge receipt of MIB, Inc.'s Pre-Notice and the Fair Credit Reporting Act Notice.

**ACCELERATED DEATH BENEFIT TAX DISCLOSURE:** The receipt of a benefit under an Accelerated Death Benefit Rider may be taxable. Before claiming benefits under these Riders, assistance should be sought from a personal tax advisor.

**IMPORTANT TAX NOTICE FOR POLICYOWNER:** Under federal Tax law, the Company is required to ask you to certify your correct Taxpayer Identification Number (TIN), and to include it in any reports of taxable income it makes to the IRS.

**Certification:** Under penalties of perjury, I certify that: 1) the number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and 2) I am not subject to backup withholding under provisions of section 3406(a)(1)(c) of the Internal Revenue Code because a) I am exempt from backup withholding, or b) I have not been notified that I am subject to backup withholding as a result of a failure to report all interest or dividends, or c) the IRS has notified me that I am no longer subject to backup withholding, and 3) I am a US person (including a US resident alien).

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

**I certify that I have read the medical questions contained on this application and that my responses to these questions have been accurately recorded. I understand that no agent is authorized to advise me that any inaccurate answer is acceptable.**

**If replacement is occurring, please read the following notice:** In many cases, the replacement of an existing life insurance policy, regardless of the issuing company, is not in your best interest. New policies contain contestable and suicide provisions which you should ask your agent to explain. In addition, there are expense charges associated with each new policy. You should ask your agent to explain both the benefits and the drawbacks of the replacement you are considering.

**If you are replacing an existing policy and you are not satisfied with the new policy for any reason, you have the right to return your policy to us within 30 days after you receive it and receive a refund of all premiums paid.**

Application made at Williamsville, MD this 2nd day of March, 2000  
(City, State) (Day) (Month) (Year)

(X) Bill A. Buyer  
Signature of Proposed Insured

(X) \_\_\_\_\_  
Signature of Owner (If other than Proposed Insured)

(X) Sam Selum  
Signature of Licensed Agent (Witness to all signatures)

\_\_\_\_\_  
(Give official capacity if signed on behalf of a corporation, trust etc.)

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**11. Agent Certification**

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I certify that I have asked the person proposed for coverage all of the questions contained in this application and have accurately recorded on this application the information supplied by the persons proposed for coverage.

- a. Did you verify the identity of the applicant by viewing their driver's license or other government issued form of identification? .....☒ Yes ☐ No
- b. Do you have knowledge or reason to believe that replacement of existing life insurance or annuity policies may be involved? .....☒ Yes ☐ No
- c. If replacement is occurring, do you certify that this replacement complies with Baltimore Life's replacement guidelines? .....☒ Yes ☐ No ☐ Not Applicable

I certify that only advertising previously approved by The Baltimore Life Insurance Company was used in conjunction with this sale, and that copies of all sales materials used in this sale have been left with the applicant. Any electronically presented sales materials will be provided in printed form to the applicant no later than at the time of policy delivery. I am unaware of any additional information that might affect the Company's underwriting decision.

I certify that the above statements and responses are true and accurate.

<u>Sam Selum</u>	<u>01529000</u>	(X) <u>Sam Selum</u>	<u>3/2/2010</u>
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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## 12. Conditional Receipt

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(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 \_\_\_\_\_ Dated \_\_\_\_\_ for an application on \_\_\_\_\_.

\_\_\_\_\_  
Signature of Proposed Insured

\_\_\_\_\_  
Signature of Proposed Owner (If other than Proposed Insured)

\_\_\_\_\_  
Signature of Agent

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*Tear here and leave notices below with Applicant*

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## 13. Fair Credit Reporting Act Notice

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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.

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## 14. MIB, Inc. Notice

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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.

Bill A. Buyer  
Name of Applicant and/or Policyholder (Print)

\_\_\_\_\_  
Policy Number

Bill A. Buyer  
Signature of Applicant and/or Policyholder

3/2/10  
Date

Sam Selum  
Name of Agent (Print)

01529000  
Agent Number

Sam Selum  
Signature of Agent

3/2/10  
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.*

## Authorization for Release of Health-Related Information

This authorization complies with the HIPAA Privacy Rule

\_\_\_\_\_  
Printed Name of Proposed Insured

\_\_\_\_\_  
Date of Birth

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy benefit manager, pharmacy, medical facility, or other health care provider that has provided payment treatment or services to me or on my behalf within the past 10 years ("My Providers") to disclose my entire medical record and any other protected health information concerning me to The Baltimore Life Insurance Company and its agents, employees, and representatives. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct any physician, health care professional, hospital, clinic, medical facility, or other health care provider to release and disclose my entire medical record without restriction.

This protected health information is to be disclosed under this Authorization so that The Baltimore Life Insurance Company may:

- 1) Underwrite my application for coverage, make eligibility, risk rating, policy issuance and enrollment determinations;
- 2) Obtain reinsurance;
- 3) Administer claims and determine or fulfill responsibility for coverage and provision of benefits;
- 4) Administer coverage; and
- 5) Conduct other legally permissible activities that relate to any coverage I have or have applied for with The Company.

This authorization shall remain in force for 30 months following the date of my signature below, and a copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by sending a written request for revocation to **The Baltimore Life Insurance Company at 10075 Red Run Boulevard, Owings Mills, MD 21117-4871, Attention: Privacy Official.**

I understand that a revocation is not effective to the extent that any of My Providers has relied on this Authorization or to the extent that The Baltimore Life Insurance Company has a legal right to contest a claim under an insurance policy or to contest the policy itself; any information that is disclosed pursuant to this authorization may be redisclosed and no longer covered by federal rules governing privacy and confidentiality of health information; My Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this authorization; and further, if I refuse to sign this authorization to release my complete medical record, The Baltimore Life Insurance Company may not be able to process my application, or if coverage has been issued may not be able to make any benefit payments.

I acknowledge that I have received a copy of this authorization.

\_\_\_\_\_  
Signature of Proposed Insured or Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Personal Representative's Authority or Relationship to Proposed Insured

\_\_\_\_\_  
Signature of Licensed Agent (Witness)

\_\_\_\_\_  
Printed Name of Licensed Agent

*Please provide one copy to the Home Office and one copy to the Applicant*

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

**ACCELERATED DEATH BENEFIT RIDER DISCLOSURE STATEMENT  
TERMINAL ILLNESS**

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

**Your benefit.**

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

**The benefit payable to you.**

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

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

**Conditions for the benefit.**

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

**Effects to the policy upon acceleration.**

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

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

Maximum Rider Benefit: ..... \$ 75,000  
Service Fee: ..... 100  
Accelerated Death Benefit Lien: ..... 75,100

Benefit Amount Paid To You: ..... \$ 75,000

Death Occurs Immediately after the Accelerated Death Benefit has been Paid  
Policy Death Benefit: ..... \$100,000  
Less Lien: ..... -75,100

Net Death Proceeds Payable at the Death of the Insured:..... \$ 24,900

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

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

Bill A. Buyer  
Signature of Applicant/Owner

Sam Selum  
Signature of Agent

3/2/10  
Date

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

**ACCELERATED DEATH BENEFIT RIDER DISCLOSURE STATEMENT  
QUALIFIED NURSING FACILITY-EXTENDED CARE**

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

**Your benefit.**

You, the policy owner, are eligible to receive an accelerated death benefit under the rider for the insured. A physician must certify that the insured under this policy is permanently confined to a qualified nursing facility or requires extended care.

**The benefit payable to you.**

Upon satisfaction of the requirements under the rider, we will pay you up to 50% of the eligible death benefit if the insured is permanently confined in a qualified nursing facility or requires extended care. However, the rider benefit will not be less than \$5,000 or more than \$250,000.

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

**Conditions for the benefit.**

- You must make a written request for the benefits during the lifetime of the insured and while the policy and rider are in force.
- The policy owner must provide written proof satisfactory to us that the insured has been permanently confined to a qualified nursing facility continuously for at least 90 days 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.
- Only one benefit election is allowed under this rider. Once a benefit is paid, no other benefits will exist under this rider or any accelerated death benefit rider attached to the *policy*.
- The premium amount for this policy will not change and will continue to be payable including any premiums for riders.

**Effects to the policy upon acceleration.**

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

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

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

Maximum Rider Benefit: .....	\$ 50,000
Service Fee: .....	100
Accelerated Death Benefit Lien: .....	50,100

Maximum Benefit Payable: .....	\$ 50,000
Less Policy Loan: .....	<u>-5,000</u>
Benefit Amount Paid To You: .....	\$ 45,000

Death Occurs One Year After Accelerated Death Benefit is Paid

Policy Death Benefit: .....	\$100,000
Less Lien: .....	-50,100
Less Accrued Interest (50,100 x .08): .....	<u>-4,008</u>

Net Death Proceeds Payable at the Death of the Insured:..... \$ 45,892

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

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

Bill A. Buyer  
\_\_\_\_\_  
Signature of Applicant/Owner

Sam Selum  
\_\_\_\_\_  
Signature of Agent

3/2/10  
\_\_\_\_\_  
Date

# Suitability Questionnaire

## Customer Acknowledgement

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

Owner/Applicant Name \_\_\_\_\_ Age \_\_\_\_\_

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

**Please initial next to each statement to confirm your understanding:**

- ☐ I have sufficient other funds for my daily expenses and/or retirement savings. I am buying a product that is designed to be funded with premium that I intend to pass on to my heirs, and not with funds that are needed for present or future living expenses.
- ☐ My insurance agent has explained the impact of any penalties and/or fees that may be applicable to a termination or liquidation of any financial vehicle, such as surrender charges, and whether these fees might reduce with time.
- ☐ I understand that the financial vehicle the funds are coming from may increase at a higher rate than a life insurance policy's cash value.
- ☐ Neither Baltimore Life nor my insurance agent has given me any investment, tax or legal advice.

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

<p align="center"><b>Liquid Asset Information</b></p> <p>Savings/Checking Accounts \$ _____</p> <p>Money Market Accounts \$ _____</p> <p>Mutual Funds \$ _____</p> <p>Stocks And Bonds \$ _____</p> <p>Certificate of Deposit \$ _____</p> <p>Qualified Accounts (401K, IRA) \$ _____</p> <p>Qualified Annuities \$ _____</p> <p>Non-Qualified Annuities \$ _____</p> <p>Life Insurance Cash Value \$ _____</p> <p>Other \$ _____</p> <p><b>Total Liquid Assets</b> \$ _____</p>		<p align="center"><b>Current Annual Income Information</b></p> <p>Annual/Earned Income \$ _____</p> <p>Pension Income \$ _____</p> <p>Social Security \$ _____</p> <p>Income from Liquid Assets \$ _____</p> <p>Other Income \$ _____</p> <p><b>Total Annual Income</b> \$ _____</p> <p><b>Total Annual Expenses</b> \$ _____</p> <p><b>Agent Remarks (please use this space to provide any information you believe may be relevant to the transaction):</b></p> <p>_____</p>	
<p align="center"><b>Non- Liquid Asset Information</b></p> <p>Equity in primary residence \$ _____</p> <p>Equity in other real estate \$ _____</p> <p>Collectibles \$ _____</p> <p>Other \$ _____</p> <p><b>Total Non-Liquid Assets</b> \$ _____</p>			
<p><b>Other Financial Information</b></p> <p>What primary need does the new policy satisfy? _____</p> <p>What is the expected death benefit of the policy being applied for? \$ _____</p> <p>What is your typical financial risk tolerance? <input type="checkbox"/> Conservative (little risk) <input type="checkbox"/> Moderate <input type="checkbox"/> Aggressive (willing to sustain losses)</p> <p>Is there other pertinent financial or other information that you want us to consider? _____</p>			

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

- ☐ I have been advised that at my death, under current tax law, my beneficiary will receive the death benefit proceeds of the product without having to pay federal or state income taxes. In contrast, all or a portion of my annuity values distributed/paid to my beneficiary are generally subject to federal and state income taxes.
- ☐ I have a specific need for life insurance coverage. For example, I want to pass funds to my heirs' income tax-free or I no longer need my annuity for savings or income and would instead like to maximize my estate for whatever reason.
- ☐ I have considered the ultimate after tax benefit of keeping my annuity versus purchasing this product.
- ☐ I understand that I may have less liquidity available to me with life insurance than with an annuity
- ☐ When surrendering an annuity, I understand that:
1. federal and state income taxes may apply to all or a portion of my annuity value when the annuity contract is surrendered to fund the new product.
  2. tax penalties may apply to all or a portion of the withdrawal/distribution from my annuity, and that those penalties may depend upon the type of the annuity contract, the reason for a withdrawal and possibly even my state of residence.
  3. it may have an impact on my ordinary income taxes when due.
- As a result, you should consult your tax adviser if you have not already done so.
- ☐ Should I decide to cancel the product, it may result in a surrender value that may be less than the initial premium submitted. Please list the annuity(s) that will be used to pay the premium for the new policy: (please provide company and product name)

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

Is your agent the same agent who wrote the annuity being surrendered? \_\_\_\_\_

The date the annuity was purchased: \_\_\_\_\_

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

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

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

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

**Applicant Acknowledgement (to be completed by ALL applicants):**

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

Signature of Owner \_\_\_\_\_ Date \_\_\_\_\_

**Agent Certification:**

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

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

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

Signature of Writing Agent \_\_\_\_\_ Date \_\_\_\_\_

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# Additional Forms

---

The following forms are needed in certain instances depending on the needs of each application.

Additional Forms:

- Request to Transfer Qualified Funds, Trustee to Trustee Transfer, IRA Rollover, Form 3917. This form accommodates a qualified funds transfer to IRA.
  - Exchange Agreement, Form 3332. This form accommodates 1035 exchanges.
  - Other state forms may be required, such as state specific or NAIC replacement forms, if applicable.
  - Asset Transfer Analysis, Form 8039. This worksheet will assist you and your client to evaluate your client's situation and asset transfer needs. It is not a required form.
-



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## REQUEST TO TRANSFER QUALIFIED FUNDS TRUSTEE TO TRUSTEE TRANSFER IRA ROLLOVER

### TYPE OF DISTRIBUTION

- ☐ Liquidate All Assets  
☐ Partial distribution (specify amount or percent) \$ \_\_\_\_\_ %

### PLAN TYPE FROM WHICH CUSTODIAN/TRUSTEE IS AUTHORIZED TO TRANSFER FUNDS

- ☐ IRA ☐ Roth IRA ☐ Municipal Pension  
☐ SEP-IRA ☐ Simple IRA ☐ Qualified Pension Plan (401(a) or 401(k)) ☐ TSA (403(b))

DATE TRANSFER SHOULD OCCUR \_\_\_\_\_

### CURRENT CUSTODIAN/TRUSTEE INFORMATION

Custodian Name \_\_\_\_\_ Account Number (if known) \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_  
Account Representative \_\_\_\_\_ Telephone Number \_\_\_\_\_

These funds should be transferred to my tax-qualified account established with The Baltimore Life Insurance Company (BLI), which will act as successor Custodian/Trustee for my plan. I understand that certain transfers, rollovers and conversions are considered distributions by the IRS and could result in taxable income. I certify that I have established a BLI qualified account under:

- ☐ IRA ☐ Roth IRA ☐ Municipal Pension

My account is in the name of \_\_\_\_\_

Address \_\_\_\_\_  
Street City State ZIP

Social Security Number \_\_\_\_\_ Telephone Number \_\_\_\_\_

I CERTIFY THAT THE TIN ON THIS FORM IS TRUE, CORRECT, AND COMPLETE

The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.

Please make check(s) payable to The Baltimore Life Insurance Company

FBO (Present Accountholder) Bill A. Buyer

MAIL DISTRIBUTION TO: The Baltimore Life Insurance Company  
Attn: New Business Department  
10075 Red Run Boulevard  
Owings Mills, MD 21117-4871

Signature Bill A. Buyer Date 3/2/10

Witness Signature Sam Selum Date 3/2/10

Print Agent Name Sam Selum Agency \_\_\_\_\_

COMPLETE PAGE 2 OF THIS DOCUMENT.

HOME OFFICE USE: ☐ Existing Account Number \_\_\_\_\_ ☐ New Application Number Dated \_\_\_\_\_

This is to serve as a letter of acceptance from The Baltimore Life Insurance Company to receive proceeds from the surrender of your policy to be placed in a new policy with our company.

Corporate Officer \_\_\_\_\_



The Baltimore Life<sup>®</sup>  
COMPANIES

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

## IRA ROLLOVER CERTIFICATION

### Account Holder's Name and Address (Individual Client)

Bill A. Buyer  
1900 Evergreen Avenue  
Lexington MD 21000

Social Security Number \_\_\_\_\_

I CERTIFY THAT THE TIN ON THIS FORM IS TRUE, CORRECT, AND COMPLETE.

### New IRA Custodian's Name

The Baltimore Life Insurance Company

**Please complete either Option 1 or 2, whichever is applicable, along with the 70½ Rollover Restriction if you are age 70½ or older, and the signature section.**

### Option 1. IRA to IRA ROLLOVER *(for an eligible rollover, all must be answered NO)*

#### 1. Timeliness - 60 days

Have more than 60 days elapsed since you received the distribution from the distributing IRA? ☐ Yes ☐ No

#### 2. Twelve month Restriction

Did you receive any other distributions from the distributing IRA during the preceding 12 months which you also rolled over? ☐ Yes ☐ No

Have the assets involved in this transaction been previously rolled over from one IRA to another in the past 12 months? ☐ Yes ☐ No

**Caution about commingling funds:** If you roll funds from a conduit IRA into another IRA which at any time contains assets from other sources, you can not roll those conduit IRA funds into a qualified plan or tax sheltered annuity in the future.

### Option 2. QUALIFIED RETIREMENT PLAN OR TSA TO IRA ROLLOVER

#### 1. Eligible person

Indicate your status in the plan from which you received the funds intended for rollover.

☐ Plan participant ☐ surviving spouse beneficiary ☐ alternate payee of Qualified Domestic Relations Order

#### 2. Eligible plan

You received the distribution which you are rolling over from the following: ☐ Qualified Retirement Plan ☐ TSA 403(b)

#### 3. Eligible Rollover Distribution *(for an eligible rollover, all must be answered NO)*

Does the rollover deposit contain any amounts which constitute a required minimum requirement? ☐ Yes ☐ No

Is the distribution which is being rolled over part of a series of substantially equal periodic payments? ☐ Yes ☐ No

Does the rollover deposit include any amounts which represent employee after-tax contributions? ☐ Yes ☐ No

Does the rollover deposit contain any amounts which are eligible for the death benefit exclusion? ☐ Yes ☐ No

Does the rollover deposit include any non-taxable amounts attributable to the purchase of life insurance under the distributing plan (PS58 costs)? ☐ Yes ☐ No

#### 4. Timeliness

Have more than 60 days elapsed since you received the distribution from the distributing IRA? ☐ Yes ☐ No

**Caution about commingling funds:** If you roll funds over to an IRA which at any time contains assets from other sources, you can not roll those conduit IRA funds into a qualified plan or tax sheltered annuity in the future.

### 70½ ROLLOVER RESTRICTIONS *(complete if IRA holder is age 70½ or older this calendar year)*

Does the rollover contribution contain any required minimum distribution amounts? ☐ Yes ☐ No

Have you elected to recalculate your life expectancy on the distributing plan? ☐ Yes ☐ No

**I have read and understand the rollover rules and conditions on this form and I have met the requirements for making a rollover. Due to the important tax consequences of rolling over funds to an IRA, I have been advised to see a tax professional. All information provided me is true and correct and may be relied on by the Trustee or Custodian. I assume full responsibility for this rollover transaction and will not hold the Trustee or Custodian liable for any adverse consequences that may result. The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to backup withholding. (If we are required to report this transaction to the IRS, we will notify you and IRS next January.)**

\_\_\_\_\_  
(Account Holder Signature)

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Witness Signature)

\_\_\_\_\_  
(Date)

## EXCHANGE AGREEMENT

Complete a separate form for each existing insurer. This form must be dated the same date as the application for the new insurance to qualify as a tax-free exchange. If an assignment is now in effect on any existing policy listed below, the person to whom it is assigned must also sign this form. **ALL POLICIES LISTED BELOW MUST BE ATTACHED.**

Name of Insured Bill A. Buyer

Insured's Social Security No. 400 / 22 / 0000

I CERTIFY THAT THE TIN ON THIS FORM IS TRUE, CORRECT, AND COMPLETE.

Name of Owner \_\_\_\_\_

Owner's Social Security No. \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

I CERTIFY THAT THE TIN ON THIS FORM IS TRUE, CORRECT, AND COMPLETE.

Existing Insurer U.S. Life

Address 1000 Riverview Drive

City/State/Zip Evergreen, FL 34000

Telephone No. 800-526-0000

Life Insurance 100% Annuity 100 % of Cash Value

Policy No.\* 123456

Policy No.\* \_\_\_\_\_

Policy No.\* \_\_\_\_\_

FOR HOME OFFICE USE ONLY	
New Policy No. _____	
<input type="checkbox"/> LIFE	<input type="checkbox"/> ANN. <input type="checkbox"/> NQ <input type="checkbox"/> SPAIR
<input type="checkbox"/> New issue pending approval <input type="checkbox"/> Existing contract	
Primary Insured _____	
<i>Above section must be complete before submitting to existing company.</i>	

\*Existing policy must be on the same primary insured as the new policy to qualify as a tax-free exchange.

<input type="checkbox"/> Lost Policy	My policy was <input type="checkbox"/> lost <input type="checkbox"/> stolen <input type="checkbox"/> destroyed. My policy is not now in the possession of any person or corporation, and if subsequently found, will be returned to the issuing company.
--------------------------------------	--

### ABSOLUTE ASSIGNMENT OF OWNERSHIP

I hereby transfer and assign to The Baltimore Life Insurance Company ("Company") all or part of my ownership rights in the policy (policies) listed above. I attest that:

- I have not made any other assignment of the policy (policies) which is (are) now in effect.
- No legal proceedings are pending against me by creditors or others.
- 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:

- 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.
- 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.
- 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.
- The Company will not change the beneficiary of my existing policy (policies).

I agree that this assignment and agreement shall be voidable at the option of the Company if for any reason the Company is unable to obtain the proceeds under the existing policy (policies) at the time the Company requests them thereof (for example, because of bankruptcy, conservatorship, or receivership proceedings relating to the existing insurer). In the event the Company declares this assignment and agreement void, the Company will return the existing policy (policies) to me, and I will be responsible for paying all premiums on the new policy if I want that policy. **The IRS does not require your consent to any provision of this document other than this certification to avoid backup withholding.**

Policyowner Bill A. Buyer  
(SIGNATURE - DO NOT PRINT)

Date signed 3/2/10

Address 1900 Evergreen Avenue

Witness Sam Selum

City/State/Zip Lexington, MD 21000

**This is to serve as a letter of acceptance from The Baltimore Life Companies to receive proceeds from the surrender of your policy to be placed in a new policy with our company.**

Agent's Name Home Office

Corporate Officer \_\_\_\_\_

## IMPORTANT NOTICE: REPLACEMENT OF LIFE INSURANCE OR ANNUITIES

*This document must be signed by the applicant and the producer, if there is one, and a copy left with the applicant.*

You are contemplating the purchase of a life insurance policy or annuity contract. In some cases this purchase may involve discontinuing or changing an existing policy or contract. If so, a replacement is occurring. Financed purchases are also considered replacements.

A replacement occurs when a new policy or contract is purchased and, in connection with the sale, you discontinue making premium payments on the existing policy or contract, or an existing policy or contract is surrendered, forfeited, assigned to the replacing insurer, or otherwise terminated or used in a financed purchase.

A financed purchase occurs when the purchase of a new life insurance policy involves the use of funds obtained by the withdrawal or surrender of or by borrowing some or all of the policy values, including accumulated dividends, of an existing policy, to pay all or part of any premium or payment due on the new policy. A financed purchase is a replacement.

You should carefully consider whether a replacement is in your best interest. You will pay acquisition costs and there may be surrender costs deducted from your policy or contract. You may be able to make changes to your existing policy or contract to meet your insurance needs at less cost. A financed purchase will reduce the value of your existing policy and may reduce the amount paid upon the death of the insured.

We want you to understand the effects of replacements before you make your purchase decision and ask that you answer the following questions and consider the questions on the back of this form.

- Are you considering discontinuing making premium payments, surrendering, forfeiting, assigning to the insurer, or otherwise terminating your existing policy or contract? ☒ YES ☐ NO
- Are you considering using funds from your existing policies or contracts to pay premiums due on the new policy or contract? ☒ YES ☐ NO

If you answered "yes" to either of the above questions, list each existing policy or contract you are contemplating replacing (include the name of the insurer, the insured or annuitant, and the policy or contract number if available) and whether each policy or contract will be replaced or used as a source of financing:

INSURER NAME	CONTRACT OR POLICY #	INSURED OR ANNUITANT	REPLACED (R) OR FINANCING (F)
1. <u>US. Life</u>	<u>123456</u>	<u>Bill A. Buyer</u>	<u>R</u>
2. _____	_____	_____	_____
3. _____	_____	_____	_____

Make sure you know the facts. Contact your existing company or its agent for information about the old policy or contract. If you request one, an in-force illustration, policy summary or available disclosure documents must be sent to you by the existing insurer. Ask for and retain all sales material used by the agent in the sales presentation. Be sure that you are making an informed decision.

The existing policy or contract is being replaced because provide higher death benefit to beneficiary

I certify that the responses herein are, to the best of my knowledge, accurate: \_\_\_\_\_

You have the right to return the policy within 30 days of its delivery and receive an unconditional full refund of all premiums.

Bill A. Buyer  
Applicant's Signature

Bill A. Buyer  
Applicant's Printed Name

3/2/200  
Date

Sam Selum  
Producer's Signature

Sam Selum  
Producer's Printed Name

3/2/200  
Date

I do not want this notice read aloud to me. \_\_\_\_\_ (Applicants must initial only if they do not want the notice read aloud.)

*A copy of this form must be provided to the applicant and a second copy must be provided to the home office along with the application.*

A replacement may not be in your best interest, or your decision could be a good one. You should make a careful comparison of the costs and benefits of your existing policy or contract and the proposed policy or contract. One way to do this is to ask the company or agent that sold you your existing policy or contract to provide you with information concerning your existing policy or contract. This may include an illustration of how your existing policy or contract is working now and how it would perform in the future based on certain assumptions. Illustrations should not, however, be used as a sole basis to compare policies or contracts. You should discuss the following with your agent to determine whether replacement or financing your purchase makes sense:

### **PREMIUMS:**

Are they affordable?

Could they change?

You're older—are premiums higher for the proposed new policy?

How long will you have to pay premiums on the new policy? On the old policy?

### **POLICY VALUES:**

New policies usually take longer to build cash values and to pay dividends.

Acquisition costs for the old policy may have been paid; you will incur costs for the new one.

What surrender charges do the policies have?

What expense and sales charges will you pay on the new policy?

Does the new policy provide more insurance coverage?

### **INSURABILITY:**

If your health has changed since you bought your old policy, the new one could cost you more, or you could be turned down.

You may need a medical exam for a new policy.

Claims on most new policies for up to the first two years can be denied based on inaccurate statements.

Suicide limitations may begin anew on the new coverage.

### **IF YOU ARE KEEPING THE OLD POLICY AS WELL AS THE NEW POLICY:**

How are premiums for both policies being paid?

How will the premiums on your existing policy be affected?

Will a loan be deducted from death benefits?

What values from the old policy are being used to pay premiums?

### **IF YOU ARE SURRENDERING AN ANNUITY OR INTEREST SENSITIVE LIFE PRODUCT:**

Will you pay surrender charges on your old contract?

What are the interest rate guarantees for the new contract?

Have you compared the contract charges or other policy expenses?

### **OTHER ISSUES TO CONSIDER FOR ALL TRANSACTIONS:**

What are the tax consequences of buying the new policy?

Is this a tax-free exchange? (See your tax advisor.)

Is there a benefit from favorable “grandfathered” treatment of the old policy under the federal tax code?

Will the existing insurer be willing to modify the old policy?

How does the quality and financial stability of the new company compare with your existing company?

# Asset Transfer Analysis

## Secure Solutions®

☐ Single Premium Whole Life

☐ Generation Legacy™

Name: \_\_\_\_\_

Age: \_\_\_\_\_

### Key Questions to Consider

Are you concerned about paying taxes on 1099 interest income? ..... ☐ Yes ☐ No

Are you dissatisfied with the rate of return you are earning on your money market accounts, CD's, mutual funds, and annuities? ..... ☐ Yes ☐ No

Do you have money that you would like to leave behind for your family or favorite charities that is not needed for daily living? ..... ☐ Yes ☐ No

Do you like the idea of substantially increasing the money you can leave behind for your heirs? ..... ☐ Yes ☐ No

Would you like to have access to your cash assets in the event of a catastrophic illness? ..... ☐ Yes ☐ No

### Current Assets *(not generating income for daily living needs)*

CDs	\$ _____
Money Market	\$ _____
Savings	\$ _____
Mutual Funds	\$ _____
Investments	\$ _____
Annuities	\$ _____
Other	\$ _____
<b>Total Current Assets</b>	<b>\$ _____</b>

(a) Total Current Assets	\$ _____
(b) Funds to be transferred to Secure Solutions® SPWL or Generation Legacy™	\$ _____
(c) Balance of assets after transfer (a – b)	\$ _____
(d) Secure Solutions® SPWL or Generation Legacy™ Death Benefit	\$ _____
<b>(e) Total Estate at death with Secure Solutions® SPWL or Generation Legacy™ (c + d)</b>	<b>\$ _____</b>
(f) Total Current Assets (a)	\$ _____
<b>Increase to your estate purchasing Secure Solutions® SPWL or Generation Legacy™ (e – f)</b>	<b>\$ _____</b>

My monthly income from sources other than those listed above which I plan to use for my daily living needs include:

Social Security	\$ _____
IRAs, Roth IRAs	\$ _____
Annuities	\$ _____

Pension, 401k, or other Employer Qualified plan	\$ _____
Other Income	\$ _____
<b>Total Monthly Income (for daily living needs)</b>	<b>\$ _____</b>

*Single Premium Whole Life and Generation Legacy™ is issued and underwritten by The Baltimore Life Insurance Company. Refer to the policy for complete terms and conditions. Use with Baltimore Life policy forms 7982, 8243, and 8244 or state specific variations where applicable. Products not available in all states.*

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