

SERFF Tracking Number: LLNS-125680903 State: Arkansas  
Filing Company: Illinois Mutual Life Insurance Company State Tracking Number: 39253  
Company Tracking Number: 5600  
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other  
Product Name: Payor Waiver of Premium Rider  
Project Name/Number: Payor Waiver of Premium Rider/5600

## Filing at a Glance

Company: Illinois Mutual Life Insurance Company

Product Name: Payor Waiver of Premium Rider SERFF Tr Num: LLNS-125680903 State: ArkansasLH  
TOI: L08 Life - Other SERFF Status: Closed State Tr Num: 39253  
Sub-TOI: L08.000 Life - Other Co Tr Num: 5600 State Status: Approved-Closed  
Filing Type: Form Co Status: Reviewer(s): Linda Bird  
Author: Hollie Henderson Disposition Date: 06/16/2008  
Date Submitted: 06/10/2008 Disposition Status: Approved  
Implementation Date Requested: On Approval Implementation Date:

State Filing Description:

## General Information

Project Name: Payor Waiver of Premium Rider  
Project Number: 5600  
Requested Filing Mode: Review & Approval  
Explanation for Combination/Other:  
Submission Type: New Submission  
Overall Rate Impact:  
Filing Status Changed: 06/16/2008  
State Status Changed: 06/16/2008  
Corresponding Filing Tracking Number:

Status of Filing in Domicile: Pending  
Date Approved in Domicile:  
Domicile Status Comments:  
Market Type: Individual  
Group Market Size:  
Group Market Type:  
Deemer Date:

Filing Description:

The enclosed is a new Supplemental Benefit Rider Providing Payor Waiver of Premium. This rider will be illustrated.

This Rider will be used with Form 617(AR) Whole Life Insurance. The 617(AR) Whole Life Policy approval dates are shown in the cover letter.

This rider provides for waiver of policy premiums on the death or total disability of the policy owner (Payor) when the Insured is not the Payor. This rider can be issued on Payors aged 18-55 where the Insureds are aged 0-17.

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 Project Name/Number: Payor Waiver of Premium Rider/5600

An Actuarial Memorandum and a readability certificate for this form are enclosed.

This rider will be marketed through licensed agents.

We look forward to you approval of this rider form

## Company and Contact

### Filing Contact Information

David Storlie, Vice President and General Counsel  
 300 SW Adams Street  
 Peoria, IL 61634  
 dcstorlie@illinoismutual.com  
 (309) 674-8255 [Phone]  
 (309) 674-2076[FAX]

### Filing Company Information

Illinois Mutual Life Insurance Company  
 300 SW Adams Street  
 Peoria, IL 61634  
 (309) 674-8255 ext. [Phone]  
 CoCode: 64580  
 Group Code: -99  
 Group Name:  
 FEIN Number: 37-0344290  
 State of Domicile: Illinois  
 Company Type:  
 State ID Number:

-----

## Filing Fees

Fee Required? No  
 Retaliatory? No  
 Fee Explanation:  
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Illinois Mutual Life Insurance Company	\$20.00	06/10/2008	20757069

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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved	Linda Bird	06/16/2008	06/16/2008

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## Disposition

Disposition Date: 06/16/2008

Implementation Date:

Status: Approved

Comment:

Rate data does NOT apply to filing.

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<b>Item Type</b>	<b>Item Name</b>	<b>Item Status</b>	<b>Public Access</b>
<b>Supporting Document</b>	Certification/Notice		Yes
<b>Supporting Document</b>	Application		Yes
<b>Supporting Document</b>	Cover Letter		Yes
<b>Supporting Document</b>	Actuarial Memo		No
<b>Form</b>	Payor Waiver of Premium Rider		Yes

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## Form Schedule

**Lead Form Number:** 5600

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	5600	Other	Payor Waiver of Premium Rider	Initial		48	5600.pdf



300 S.W. Adams Street Peoria, IL 61634  
Phone 309.674.8255

**SUPPLEMENTAL BENEFIT**  
Providing  
**PAYOR WAIVER OF PREMIUM**

This Benefit and its terms as herein contained form a part of the Policy to which it is attached. All terms of the Policy which do not conflict with the terms of this Benefit shall apply to this Benefit.

**EFFECTIVE DATE.** This Benefit is effective on the date shown on the Schedule of Benefits and Premiums.

**THE PAYOR** referred to herein is the Primary Owner named in the application for the Policy.

**DEATH OF PAYOR.** We will waive the payment of all premiums falling due under the Policy from the date of death of the Payor to the Policy Anniversary following the 25th birthday of the Insured. The death must occur while both the Policy and this Benefit are in force. If the Payor commits suicide, while sane or insane, within 2 years from the Effective Date of this Benefit, only a limited benefit will be paid. The limited benefit will be equal to the actual Premium paid for this Benefit.

**DISABILITY OF PAYOR.** We will waive the payment of all premiums falling due under the Policy after the start and during the continuance of total and permanent disability of the Payor as defined below. The total disability must begin while both the Policy and this Benefit are in force and prior to the Policy Anniversary following the 60th birthday of the Payor. The Payor must be totally disabled for at least 6 continuous months before any Premium will be waived. No Premium will be waived for a period that is (a) more than 6 months prior to the date of receipt by us at our Home Office of written notice and proof of claim hereunder, or (b) on or after the Policy Anniversary following the 25th birthday of the Insured.

**DEFINITION OF TOTAL DISABILITY.** Total disability shall mean a disability caused by accidental bodily injury which is sustained or by disease which first manifests itself while the Policy is in force. Such disability must totally and continuously prevent the Payor from performing all of the substantial and material duties of any occupation for wage or profit in which he might reasonably be expected to be engaged with due regard to his education, training and experience. However, during the first 24 months of any period of disability, total disability shall mean disability which totally and continuously prevents the Payor from performing the substantial and material duties of his occupation.

**NOTICE AND PROOF OF DISABILITY CLAIM.** Notice in writing of a claim must be received by us during the continuance of total disability. It must be received while the Payor is alive. It must be received prior to the termination of this Benefit. Failure to give notice shall not invalidate any claim if it is shown that: (1) it was not reasonably possible to give it within such time; and (2) notice in writing was given as soon as was reasonably possible. Due proof of disability, however, must be submitted within 6 months after written notice of claim. Such proof must be on forms furnished by us. We must be in receipt of such proof of claim before we have any liability under this Benefit.

**PROOF OF CONTINUANCE OF DISABILITY.** We may require proof on forms furnished by us of the continuance of such disability. We shall have the right and opportunity to examine the Payor. We may exercise this right when and so often as we may reasonably require. But we may not exercise this right more often than one time per year after the first 2 years of such disability have passed. In the event of failure to permit such examination or furnish said proof or if the Payor is no longer disabled as defined above, no further Premiums will be waived.

**THE CONSIDERATION** for this Benefit is the application, a copy of which is attached to and made a part of said Policy, and the payment of premium therefor. The premium is shown in the Schedule of Benefits and Premiums. It is also included in the premiums shown in the Policy Schedule. The total premium for the policy will be reduced so as not to include the premium for this Benefit in 2 cases:

- (1) after the premium for this Benefit has been paid for the full Number of Years Premium Payable as shown in the Schedule of Benefits and Premiums.
- (2) upon prior termination of this Benefit.

**RISKS NOT ASSUMED.** This Benefit shall not be allowed if the disability of the Payor is a result of: (1) committing or attempting to commit a felony; (2) intentionally self-inflicted injury; (3) war or any act of war, whether or not such war be declared; (4) participating or attempting to participate in an illegal activity and/or being incarcerated in a penal institution; or (5) bodily injury or disease occurring before the effective date of this Benefit or before reinstatement of the Policy with this Benefit.

**TERMINATION.** This Benefit will terminate on the first to occur of the following: (1) upon written request by the Owner; (2) when any premium for this Benefit or for the Policy is not paid when due or within the grace period; (3) the Policy anniversary following the 25th birthday of the Insured; (4) on the Policy anniversary following the 60th birthday of the Payor, unless premiums are being waived due to the death or total and permanent disability of the Payor; or (5) when the Policy is surrendered or terminates for any reason. The acceptance of money by us after such termination shall not make us liable for benefits hereunder. Nor shall it act as a waiver of such termination. Any such money or portion thereof paid for a period subsequent to such termination will be refunded.



Secretary



President

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## Rate Information

Rate data does NOT apply to filing.

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## Supporting Document Schedules

### Review Status:

**Satisfied -Name:** Certification/Notice 06/04/2008

**Comments:**

**Attachment:**

Readability Certification.pdf

### Review Status:

**Satisfied -Name:** Application 06/04/2008

**Comments:**

This rider will be used with policy 617(AR) which was approved 08/13/2007. That policy uses application Tel5409F which was approved 07/07/2006 and submitted in SERFF #LLNS-125237732.

**Attachment:**

TEL5409F.pdf

### Review Status:

**Satisfied -Name:** Cover Letter 06/10/2008

**Comments:**

**Attachment:**

AR.pdf

**CERTIFICATION**

Re: Form 5600, Payor Waiver of Premium Rider

On behalf of Illinois Mutual Life Insurance Company, I hereby certify that we have carefully analyzed and scored the forms submitted with this certification in accord with the Flesch score analysis readability procedures and we certify that the forms have a Flesch score as follows:

Rider 5600	48.322
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ILLINOIS MUTUAL LIFE INSURANCE COMPANY



By:  
David C. Storlie  
Vice President  
General Counsel

Dated: June 6, 2008



300 S.W. Adams Street Peoria, IL 61634  
Phone 309.674.8255

# Application for Life Insurance

(The questions and declarations must be read in person to the Proposed Insured and/or Applicant.)

## PART A

### 1. Proposed Insured

- a. Name \_\_\_\_\_  
LAST FIRST MI MAIDEN/FORMER MARITAL STATUS SEX
- b. Address \_\_\_\_\_  
STREET CITY STATE ZIP CODE
- c. Home Ph. ( \_\_\_\_\_ ) \_\_\_\_\_ Bus. Ph. ( \_\_\_\_\_ ) \_\_\_\_\_ Other Ph. ( \_\_\_\_\_ ) \_\_\_\_\_
- d. E-mail address (optional) \_\_\_\_\_
- e. Soc. Sec. # \_\_\_\_\_ f. Date of Birth \_\_\_\_\_ g. Place of Birth (State/Country) \_\_\_\_\_
- h. Are you a U.S. Citizen?  Yes  No If no, how long have you resided in the U.S.? \_\_\_\_\_
- i. Do you or any other proposed insured(s) have any life insurance in force or pending with another company?  Yes  No If yes, list below.
- | Name  | Company or Source | Pending or In Force (P/I) | Face Amount | ADB      | Will coverage be replaced?                               |
|-------|-------------------|---------------------------|-------------|----------|----------------------------------------------------------|
| _____ | _____             | _____                     | \$ _____    | \$ _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| _____ | _____             | _____                     | \$ _____    | \$ _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| _____ | _____             | _____                     | \$ _____    | \$ _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No |
- j. If replacement is indicated, give company address and policy number. Forward replacement forms, if required.  
 \_\_\_\_\_

k. Have you used any form of tobacco products during the past 12 months?  Yes  No

- l. Beneficiary Designation: \_\_\_\_\_  
PRIMARY RELATIONSHIP TO PROPOSED INSURED
- \_\_\_\_\_ CONTINGENT RELATIONSHIP TO PROPOSED INSURED

### 2. Ownership

Primary Owner(s) (if other than Proposed Insured)

- a. Name \_\_\_\_\_ b. Soc. Sec./Tax I.D.# \_\_\_\_\_
- c. Address \_\_\_\_\_
- Contingent Owner(s) (if any)
- d. Name \_\_\_\_\_ e. Soc. Sec./Tax I.D.# \_\_\_\_\_
- f. Address \_\_\_\_\_

### 3. Plan Information UL=Universal Life WL=Whole Life T=Term

a. Life Plan \_\_\_\_\_ Amount \$ \_\_\_\_\_ **UL:**  Option 1  Option 2

Increase Specified Amount for UL Policy # \_\_\_\_\_ by amount stated above

Term Plans:  10 Yr.  15 Yr.  20 Yr.  30 Yr.

#### b. Optional Benefits/Riders

- |                                                                                                 |                                                                                                                                                                          |
|-------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Waiver of Monthly Deductions (UL)                                      | <input type="checkbox"/> Spouse Insurance Rider (UL/WL) \$ _____<br>(WL) <input type="checkbox"/> 10 Yr. <input type="checkbox"/> 15 Yr. <input type="checkbox"/> 20 Yr. |
| <input type="checkbox"/> Waiver of Monthly Amount (UL) \$ _____                                 | <input type="checkbox"/> Paid Up Additions Rider (WL)                                                                                                                    |
| <input type="checkbox"/> Payor Waiver of Monthly Amount (UL) \$ _____                           | Initial Payment (optional) \$ _____                                                                                                                                      |
| <input type="checkbox"/> Waiver of Premium (WL/T)                                               | Scheduled Payment (optional) \$ _____                                                                                                                                    |
| <input type="checkbox"/> Accidental Death (UL/WL) \$ _____                                      | <input type="checkbox"/> Waiver of Specified Amount \$ _____                                                                                                             |
| <input type="checkbox"/> Guaranteed Insurability/OPI (UL/WL) \$ _____                           | <input type="checkbox"/> Surrender Benefit Rider (T) (15, 20 and 30 Yr. Plans only)                                                                                      |
| <input type="checkbox"/> Annually Renewable Term Rider (UL) \$ _____                            | <input type="checkbox"/> Child Insurance Rider (UL/WL/T) \$ _____                                                                                                        |
| Proposed Insured _____ \$ _____                                                                 | <input type="checkbox"/> Other _____                                                                                                                                     |
| Other Insured _____ \$ _____                                                                    | _____                                                                                                                                                                    |
| <input type="checkbox"/> Term Insurance Rider (WL) \$ _____                                     | _____                                                                                                                                                                    |
| <input type="checkbox"/> 10 Yr. <input type="checkbox"/> 15 Yr. <input type="checkbox"/> 20 Yr. | _____                                                                                                                                                                    |

c. Dividend Option (WL)  Cash  Accumulate at Interest  Reduce Premium  Buy Paid-Up Additions

**4. Billing and Payment**

- a. Effective Date:  Application Date  Issue Date  Special Requests \_\_\_\_\_
- b. Premium Notices To:  Insured at Residence  Owner at address shown in 2.c.  
 Insured at Business  Other \_\_\_\_\_
- c. Premiums Payable:  Annual  Semi-Annual  Quarterly  
 Monthly Authorized Check  Special Billing (number if known \_\_\_\_\_)
- d. Premium Amount \$ \_\_\_\_\_
- e. Cash with application?  Yes  No \$ \_\_\_\_\_
- f. Additional Initial Premium Amount \$ \_\_\_\_\_
- g.  Automatic Premium Loan Elected (WL)

**5. Other Insured Rider, Spouse Rider or Payor Benefit**

- a. Name \_\_\_\_\_  
LAST FIRST MI MARITAL STATUS SEX
- b. Address \_\_\_\_\_  
STREET CITY STATE ZIP CODE
- c. Home Ph. ( \_\_\_\_\_ ) \_\_\_\_\_ Bus. Ph. ( \_\_\_\_\_ ) \_\_\_\_\_ Other Ph. ( \_\_\_\_\_ ) \_\_\_\_\_
- d. Soc. Sec. # \_\_\_\_\_ e. Date of Birth \_\_\_\_\_
- f. Place of Birth (State/Country) \_\_\_\_\_
- g. Are you a U.S. Citizen?  Yes  No If no, how long have you resided in the U.S.? \_\_\_\_\_
- h. Have you used any form of tobacco products during the past 12 months?  Yes  No
- i. Beneficiary Designation: \_\_\_\_\_  
PRIMARY RELATIONSHIP TO PROPOSED INSURED  
\_\_\_\_\_  
CONTINGENT RELATIONSHIP TO PROPOSED INSURED

**6. Child Insurance Rider**

- a. Proposed Insured Children (must be unmarried and under age 19)

Full Name	Date of Birth	Relationship	Full Name	Date of Birth	Relationship
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

- b. Are all dependent children listed?  Yes  No
- c. Are all dependent children living with the proposed insured?  Yes  No
- If b. or c. is no, explain: \_\_\_\_\_

**Home Office Endorsement Only.** Question # \_\_\_\_\_ corrected to read as follows:

**Agreement and Declaration**

I represent and agree that all statements and answers recorded in this application are true, complete and correctly recorded to the best of my knowledge and belief. I understand that this application and any medical examination which may be required will become a part of any policy issued. I understand that acceptance of any policy issued on this application indicates my agreement to any amendments made by the Company in the "Home Office Endorsement Only" space except changes in the amounts of insurance or premium, classification of risk, and plan of insurance shall require my written acceptance. I understand and agree that no policy issued on this application shall become effective until I have received and accepted it and the first full premium paid. However, if a Life Insurance Receipt has been delivered, then liability of the Company shall be as stated in the receipt. I have received a Medical Information Bureau Notice and Fair Credit Reporting Act Notice.

I declare that I paid to Illinois Mutual Life Insurance Company the sum of \$ \_\_\_\_\_ and that I hold a receipt for same. I agree to the terms of such receipt.

**Authorization:** I hereby authorize the Veteran's Administration, Social Security Administration, my employer, or any consumer reporting agency, who possess information on me to furnish such information to Illinois Mutual Life Insurance Company, hereinafter called the Company, or its legal representative upon presenting this Authorization or a photocopy. The Company or its authorized representatives may obtain information, in order to evaluate my application for insurance.

I have read this Authorization and understand that I may receive a copy upon request. I understand and agree that this Authorization shall be valid for two years from the date shown below.

Signed at \_\_\_\_\_  
CITY AND STATE

\_\_\_\_\_  
SIGNATURE OF PROPOSED INSURED OR PARENT  
IF PROPOSED INSURED UNDER AGE 18

\_\_\_\_\_  
SIGNATURE OF PROPOSED JOINT INSURED OR PROPOSED RIDER INSURED

\_\_\_\_\_  
SIGNATURE OF OWNER/APPLICANT, IF OTHER THAN PROPOSED INSURED  
(If business insurance, show title of person signing for business.)

Date \_\_\_\_\_

**NOTICE:** 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 and criminal penalties.

**Agent's Certification**

I certify that I asked the above questions of the Proposed Insured(s) in person and have recorded the information correctly. I  do  do not have knowledge that the insurance applied for will replace any existing life insurance.

\_\_\_\_\_  
PRINT WRITING AGENT'S NAME

\_\_\_\_\_  
AGENT'S SIGNATURE

Agent's Code # \_\_\_\_\_ Agent's Phone # \_\_\_\_\_

Is Proposed Insured/Owner related to Agent?  Yes  No Relationship \_\_\_\_\_

**Split Commission Information**

For proper recording of split commission business, please complete the following: (Print all names.)

Name \_\_\_\_\_ Code # \_\_\_\_\_ % of Commission \_\_\_\_\_  
Name \_\_\_\_\_ Code # \_\_\_\_\_ % of Commission \_\_\_\_\_



**PART B (continued)**

- |                                                                                                                                                                                                          | <b>Yes</b>               | <b>No</b>                |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------|
| <b>e.</b> In the past 5 years, other than previously stated, have you:                                                                                                                                   |                          |                          |
| <b>(1)</b> had an electrocardiogram, stress test, echocardiogram, angiography, x-ray, blood studies or other diagnostic test?                                                                            | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>(2)</b> had any medical advice, hospitalization, physical exam, illness or injury?                                                                                                                    | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>(3)</b> been advised to have any consultation, diagnostic test, hospitalization or surgery which was not completed?                                                                                   | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>f.</b> In the past 10 years, have you ever been diagnosed or treated by a medical practitioner for Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) or AIDS related conditions? | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>g.</b> In the past 10 years, have you ever tested positive for antibodies to the AIDS virus?                                                                                                          | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>h.</b> Have you had any parent, brother or sister who has had cancer, heart trouble, stroke, high blood pressure, diabetes or tuberculosis?                                                           | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>i.</b> Other than previously stated, are you currently:                                                                                                                                               |                          |                          |
| <b>(1)</b> receiving any medical advise or treatment?                                                                                                                                                    | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>(2)</b> taking any medication?                                                                                                                                                                        | <input type="checkbox"/> | <input type="checkbox"/> |

I represent and agree that all statements and answers recorded in this application Part B are true, complete and correctly recorded to the best of my knowledge and belief. I understand that this application Part B will become a part of any policy issued.

\_\_\_\_\_

Date

\_\_\_\_\_

Proposed Insured



300 S.W. Adams Street Peoria, IL 61634  
Phone 309.674.8255

# Application for Life Insurance

**PART C** (Complete if Insured is applying for Child Insurance Rider)

Proposed Insured(s) \_\_\_\_\_

Name of person completing interview: \_\_\_\_\_

Relationship to Proposed Insured: \_\_\_\_\_

- a. If child is under age 1, was his/her birth abnormal or premature?  Yes  No
- b. In the past 10 years has the child been hospitalized for an injury or sickness or received treatment by a medical practitioner?  Yes  No
- c. Has the child ever been declined, postponed or rated for life insurance?  Yes  No

I represent and agree that all statements and answers recorded in this application Part B are true, complete and correctly recorded to the best of my knowledge and belief. I understand that this application Part B will become a part of any policy issued.

\_\_\_\_\_

Date Proposed Insured



300 S.W. Adams Street Peoria, IL 61634  
Phone 309.674.8255

# Application for Life Insurance

## PART D (Complete if Insured is applying for Disability Income Insurance)

Proposed Insured(s) \_\_\_\_\_

### 10. Employment Information

- a. When did you begin working for your current employer? \_\_\_\_\_
- b. Describe the job duties of your primary occupation. \_\_\_\_\_  
\_\_\_\_\_
- c. Indicate the percentage of time spent in:  
 Professional practice: \_\_\_\_\_%                      Administrative/managerial/clerkal/sales: \_\_\_\_\_%  
 On-site supervision/estimation: \_\_\_\_\_%                      Performing trade, service or manual labor: \_\_\_\_\_%
- d. How many hours are you currently working per week in your primary occupation? \_\_\_\_\_
- e. What product or service do you provide? \_\_\_\_\_
- f. How many employees work for your employer or business? \_\_\_\_\_
- g. What is the number of employees you directly supervise? \_\_\_\_\_
- h. Do you intend to change occupation, employer or employment status in the next 6 months?  Yes  No
- i. Do you work from your home?  Yes  No
- j. Do you have other employment currently or in the past 5 years, full or part-time?  Yes  No

### 11. Income Information

- a. What is your current wage or salary from your primary occupation? \$\_\_\_\_\_  Hourly  Weekly  Monthly  Annually
- b. What was your wage or salary reported last year on Form W2 for federal income tax purposes? \$\_\_\_\_\_
- c. Are you self-employed or an owner of a corporation? \_\_\_\_\_

### 12. Other Disability Coverage

- a. Do you have or are you applying for other individual disability income coverage or business expense insurance?  Yes  No
- b. Do you have or will you become eligible for a sick pay, salary continuation plan or group disability income coverage through your employer?  
 Yes  No

### 13. Medical Information

- a. Have you ever received or been refused any disability benefits?  Yes  No
- b. In the past 5 years, other than previously stated, have you had any chiropractic treatment, including routine maintenance?  Yes  No
- c. Are you pregnant?  Yes  No
- d. Have you ever had a Cesarean Section or other complications of pregnancy?  Yes  No

I represent and agree that all statements and answers recorded in this application Part B are true, complete and correctly recorded to the best of my knowledge and belief. I understand that this application Part B will become a part of any policy issued.

\_\_\_\_\_ Date \_\_\_\_\_ Proposed Insured



300 S.W. Adams Street Peoria, IL 61634

Phone 309.674.8255

[www.IllinoisMutual.com](http://www.IllinoisMutual.com)

June 4, 2008

Arkansas Department of Insurance  
Life & Health Section Rate & Form Filing  
1200 W Third ST  
Little Rock AR 72201

Ref: Illinois Mutual Life Insurance Company  
NAIC #64580; FEIN 37-0344290

RE: Form 5600, Payor Waiver of Premium Rider

Dear Sir or Madam:

The enclosed is a new Supplemental Benefit Rider Providing Payor Waiver of Premium. This rider will be illustrated.

This Rider will be used with Form 617(AR) Whole Life Insurance which was previously approved by your department on August 13, 2007.

This rider provides for waiver of policy premiums on the death or total disability of the policy owner (Payor) when the Insured is not the Payor. This rider can be issued on Payors aged 18-55 where the Insureds are aged 0-17.

An Actuarial Memorandum and a readability certificate for this form are enclosed.

This rider will be marketed through licensed agents.

We look forward to your approval of this rider form.

Sincerely,

A handwritten signature in cursive script that reads 'David C. Storlie'.

David C. Storlie  
Vice President and  
General Counsel  
1-800-437-7355 Ext. 426  
[dcstorlie@illinoismutual.com](mailto:dcstorlie@illinoismutual.com)

DCS:jmr