

<i>SERFF Tracking Number:</i>	<i>LLNS-126397147</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Illinois Mutual Life Insurance Company</i>	<i>State Tracking Number:</i>	<i>44170</i>
<i>Company Tracking Number:</i>	<i>WSL-EAPP</i>		
<i>TOI:</i>	<i>L071 Individual Life - Whole</i>	<i>Sub-TOI:</i>	<i>L071.101 Fixed/Indeterminate Premium - Single Life</i>
<i>Product Name:</i>	<i>Workplace Life Application</i>		
<i>Project Name/Number:</i>	<i>WSL-EAPP/WSL-EAPP</i>		

## Filing at a Glance

Company: Illinois Mutual Life Insurance Company

Product Name: Workplace Life Application

SERFF Tr Num: LLNS-126397147 State: Arkansas

TOI: L071 Individual Life - Whole

SERFF Status: Closed-Approved-Closed  
State Tr Num: 44170

Sub-TOI: L071.101 Fixed/Indeterminate  
Premium - Single Life

Co Tr Num: WSL-EAPP

State Status: Approved-Closed

Filing Type: Form

Author: Hollie Henderson

Reviewer(s): Linda Bird

Date Submitted: 11/24/2009

Disposition Date: 11/30/2009

Disposition Status: Approved-Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

## General Information

Project Name: WSL-EAPP

Status of Filing in Domicile: Pending

Project Number: WSL-EAPP

Date Approved in Domicile:

Requested Filing Mode: Review & Approval

Domicile Status Comments:

Explanation for Combination/Other:

Market Type: Individual

Submission Type: New Submission

Group Market Size:

Overall Rate Impact:

Group Market Type:

Filing Status Changed: 11/30/2009

Explanation for Other Group Market Type:

State Status Changed: 11/30/2009

Deemer Date:

Created By: Hollie Henderson

Submitted By: Hollie Henderson

Corresponding Filing Tracking Number:

Filing Description:

Referenced forms are submitted for your review and approval. These forms are in final print.

Application Form WSL-EAPP is an application used with Interest Sensitive Whole Life Policy Form WSL07, which was approved by your department on 1/24/07 under SERFF filing# LLNS-125074246 .

Application Form WSL-EAPP will be used in addition to Application Form WSL-APP07, which was approved by your department on 1/24/07 under SERFF filing# LLNS-125074246 . Application Form WSL-APP07 is to be used for paper

SERFF Tracking Number: LLNS-126397147 State: Arkansas  
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 Project Name/Number: WSL-EAPP/WSL-EAPP

enrollments where an agent is present to assist and receive the application. Application Form WSL-EAPP is to be used for web-based enrollments where the applicant is completing the application online and there is no agent present. The only difference between WSL-EAPP and previously approved WSL-APP07 is that the agent certification statement has been removed from Form WSL-EAPP and replaced with a statement that this is an electronic application completed without the presence or assistance of an agent. Form WSL-APP07 is attached to this filing as reference with the Agent Certification red lined to indicate the removal.

Illinois Mutual, working alone, and/or with a licensed insurance agent, will provide applicants with the ability to apply for our insurance products via a web-browser-based software application. Access to this web-browser-based software application will be communicated, and/or made available, to the applicants in a variety of forms and distribution mediums, including, but not limited to, one or more web-based Universal Resource Locator (URL) addresses and/or hyperlinked content (text, images, etc.).

Employees will be notified by their employer of the availability of a interest sensitive whole life insurance product and will be directed to a secure website where they can make application. The application process will be done electronically including an electronic signature of the applicant. The completed application will be submitted to Illinois Mutual electronically using appropriate encryption standards.

A copy of the application is attached to the policy at the time the policy is issued and delivered to the policyholder.

Thank you in advance for your assistance in reviewing this filing.

## Company and Contact

### Filing Contact Information

Hollie Henderson, Executive and Legal Coordinator  
 300 SW Adams Street Peoria, IL 61634  
 hghenderson@illinoismutual.com  
 309-674-8255 [Phone] 436 [Ext]  
 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:

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SERFF Tracking Number: LLNS-126397147 State: Arkansas  
Filing Company: Illinois Mutual Life Insurance Company State Tracking Number: 44170  
Company Tracking Number: WSL-EAPP  
TOI: L071 Individual Life - Whole Sub-TOI: L071.101 Fixed/Indeterminate Premium - Single Life  
Product Name: Workplace Life Application  
Project Name/Number: WSL-EAPP/WSL-EAPP

## Filing Fees

Fee Required? Yes  
Fee Amount: \$50.00  
Retaliatory? Yes  
Fee Explanation: 50/form  
Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Illinois Mutual Life Insurance Company	\$50.00	11/24/2009	32281160

SERFF Tracking Number: LLNS-126397147 State: Arkansas  
Filing Company: Illinois Mutual Life Insurance Company State Tracking Number: 44170  
Company Tracking Number: WSL-EAPP  
TOI: L071 Individual Life - Whole Sub-TOI: L071.101 Fixed/Indeterminate Premium - Single Life  
Product Name: Workplace Life Application  
Project Name/Number: WSL-EAPP/WSL-EAPP

## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	11/30/2009	11/30/2009

*SERFF Tracking Number:*      *LLNS-126397147*                      *State:*                      *Arkansas*  
*Filing Company:*              *Illinois Mutual Life Insurance Company*              *State Tracking Number:*      *44170*  
*Company Tracking Number:*      *WSL-EAPP*  
*TOI:*                      *L071 Individual Life - Whole*                      *Sub-TOI:*                      *L071.101 Fixed/Indeterminate Premium - Single*  
*Product Name:*                      *Workplace Life Application*  
*Project Name/Number:*              *WSL-EAPP/WSL-EAPP*  
*Life*

## **Disposition**

Disposition Date: 11/30/2009

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

*SERFF Tracking Number:* LLNS-126397147      *State:* Arkansas  
*Filing Company:* Illinois Mutual Life Insurance Company      *State Tracking Number:* 44170  
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*Product Name:* Workplace Life Application  
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<b>Schedule</b>	<b>Schedule Item</b>	<b>Schedule Item Status</b>	<b>Public Access</b>
<b>Supporting Document</b>	Flesch Certification		Yes
<b>Supporting Document</b>	Application		No
<b>Supporting Document</b>	Life & Annuity - Acturial Memo		No
<b>Supporting Document</b>	WSL-APP07		Yes
<b>Form</b>	Workplace Llife Application		Yes

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## Form Schedule

**Lead Form Number: WSL-EAPP**

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	WSL-EAPP	Application/Workplace Life Enrollment Application Form		Initial		51.311	WSL-EAPP.pdf



# Application for Workplace Voluntary Life Insurance

## 1. Employee Information (Complete All)

a. Name \_\_\_\_\_  
LAST FIRST MI MAIDEN/FORMER MARITAL STATUS SEX

b. Address \_\_\_\_\_  
STREET CITY STATE ZIP CODE

c. Home Ph. ( \_\_\_\_\_ ) \_\_\_\_\_ d. E-mail Address \_\_\_\_\_

e. Soc. Sec. # \_\_\_\_\_ f. Employer's Name \_\_\_\_\_

g. Date of Employment \_\_\_\_\_ h. Are you actively at work?  Yes  No i. Employee/Payroll # \_\_\_\_\_

## 2. Additional Employee Information (To be completed if Employee is applying for coverage)

a. Date of Birth \_\_\_\_\_ b. State of Birth \_\_\_\_\_

c. Occupation \_\_\_\_\_

d. Hours worked per week \_\_\_\_\_ e. Monthly Salary \$ \_\_\_\_\_ (excluding bonuses and overtime)

## 3. Spouse (To be completed only if applying for Spouse coverage)

a. Name \_\_\_\_\_  
LAST FIRST MI MAIDEN/FORMER SEX

b. Address (if different) \_\_\_\_\_

c. Soc. Sec. # \_\_\_\_\_ d. Date of Birth \_\_\_\_\_

e. Does spouse live in the U.S.?  Yes  No

f. During the past 12 months, has your spouse been hospitalized or treated, including prescription medication, for an injury or sickness (excluding pregnancy, colds, allergies, flu and back problems)?  Yes  No If "Yes," answer Questions under Section 7 & 8 on page 3.

## 4. Child and/or Grandchild (To be completed if applying for Child and/or Grandchild coverage)

Full Name	Social Security No.	Date of Birth	Relationship	Sex	Policy or Rider
1. _____	_____	_____	_____	_____	_____
2. _____	_____	_____	_____	_____	_____
3. _____	_____	_____	_____	_____	_____
4. _____	_____	_____	_____	_____	_____

Do all of the Children/Grandchildren listed above live in the U.S.?  Yes  No If "No," which ones do not live in the U.S.? \_\_\_\_\_

Have any of the Children/Grandchildren listed above been diagnosed with or treated for Down's Syndrome, Cerebral Palsy, Muscular Dystrophy or Cystic Fibrosis?  Yes  No If "Yes," which ones? \_\_\_\_\_

**5. Policy Information** (Complete All)

	Employee		Spouse		#1		Child/Grandchild #2		#3		#4	
	Yes	No										
a. Has any proposed insured used any tobacco products (such as cigarettes, cigars, snuff, dip, chew or pipe) or any nicotine delivery system in the past 12 months?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	n/a		n/a		n/a		n/a	
b. (1) Do any proposed insureds have existing individual life insurance coverage?	<input type="checkbox"/>											
(2) Will coverage applied for replace any existing individual life insurance coverage?	<input type="checkbox"/>											

If "Yes," list: Full Name \_\_\_\_\_ Company \_\_\_\_\_ Policy Number \_\_\_\_\_

	Employee	Spouse	#1	#2	#3	#4
c. Face/Specified Amount	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____
d. Base Policy Weekly Premium	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____

e. Riders and Premiums

(1) Term Insurance Rider	<input type="checkbox"/>	<input type="checkbox"/>				
Coverage Amount	\$ _____	\$ _____				
Weekly Premium	\$ _____	\$ _____				
(2) Child Term Insurance Rider	<input type="checkbox"/>	<input type="checkbox"/>				
Coverage Amount	\$ _____	\$ _____				
Weekly Premium	\$ _____	\$ _____				
(3) Accidental Death Benefit	<input type="checkbox"/>	<input type="checkbox"/>				
Weekly Premium	\$ _____	\$ _____				
(4) Waiver of Premium	<input type="checkbox"/>					
Weekly Premium	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____

f. Payroll Frequency:  Weekly  Bi-Weekly  Semi-Monthly  Monthly  Other

TOTAL PAYROLL PREMIUM DEDUCTED: \$ \_\_\_\_\_

g.  Automatic Premium Loan Elected

h. **Dividend Option**  Cash  Accumulate at Interest  Reduce Premium

**6. Beneficiary Information** (Complete All)

**Employee**

Primary \_\_\_\_\_ Relationship to Insured \_\_\_\_\_  
 Contingent \_\_\_\_\_ Relationship to Insured \_\_\_\_\_

**Spouse**

Primary \_\_\_\_\_ Relationship to Insured \_\_\_\_\_  
 Contingent \_\_\_\_\_ Relationship to Insured \_\_\_\_\_

**Children/Grandchildren**

The Children/Grandchildren's Beneficiary will automatically be the employee, if living, otherwise the Spouse named in the application. If another beneficiary is preferred, please indicate below in special requests.

Special Request \_\_\_\_\_

**7. Modified Issue**

	<b>Employee</b>		<b>Spouse</b>		<b>#1</b>		<b>Child/Grandchild #2</b>		<b>#3</b>		<b>#4</b>	
	<b>Yes</b>	<b>No</b>	<b>Yes</b>	<b>No</b>	<b>Yes</b>	<b>No</b>	<b>Yes</b>	<b>No</b>	<b>Yes</b>	<b>No</b>	<b>Yes</b>	<b>No</b>
a. Has any proposed insured tested positive for exposure to the Human Immunodeficiency Virus (HIV), been diagnosed as having Acquired Immune Deficiency Syndrome (AIDS), AIDS related complex (ARC), or other sickness or condition derived from such infection?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						
b. In the past 12 months, has any proposed insured for any reason other than vacation, colds, flu, pregnancy, allergies or back problems been hospitalized more than 5 consecutive days, or if employed, missed more than 10 consecutive days of work?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						
c. In the past 5 years, has any proposed insured been diagnosed, received medical advice, sought treatment including surgery, or taken medication for any of the following:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						
• Atrial Fibrillation, chest pain, heart attack, coronary artery disease or surgery on the heart or heart valves												
• Congestive Heart Failure or cardiomyopathy												
• Stroke or transient ischemic attack (TIA)												
• High blood pressure treated with 3 or more medications												
• Alcohol or drug abuse												
• Diabetes (excluding gestational or diet controlled)												
• Chronic obstructive pulmonary disease (COPD), emphysema or chronic lung disease (excluding asthma)												
d. In the past 10 years, have you or any proposed insured been diagnosed, received medical advice, sought treatment, or taken medication for cancer or malignancy of any kind, excluding basal cell carcinoma?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						

**8. Simplified Issue**

<b>a. Provide Height and Weight</b>		<b>Employee</b>		<b>Spouse</b>		<b>#1</b>		<b>Child/Grandchild #2</b>		<b>#3</b>		<b>#4</b>	
<b>Employee</b>	_____ ft. _____ in. _____ lbs.	<b>Yes</b>	<b>No</b>	<b>Yes</b>	<b>No</b>	<b>Yes</b>	<b>No</b>	<b>Yes</b>	<b>No</b>	<b>Yes</b>	<b>No</b>	<b>Yes</b>	<b>No</b>
<b>Spouse</b>	_____ ft. _____ in. _____ lbs.												
b. Has any proposed insured ever been diagnosed, received medical advice, sought treatment including surgery, or taken medication for any of the following:		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						
• Cirrhosis of the liver or hepatitis B or C													
• Kidney disease or failure (excluding kidney stones, sponge, horseshoe or ectopic kidney and kidney removal due to trauma)													
• Atrial fibrillation, chest pain, heart attack, coronary artery disease or surgery on the heart or heart valve(s)													
• Congestive heart failure or cardiomyopathy													
• Stroke or transient ischemic attack (TIA)													
• Peripheral Vascular Disease													
• Cancer (excluding basal cell carcinoma)													
• Any condition requiring an organ transplant (excluding corneal)													
• Diabetes (excluding gestational or diet controlled)													
• Chronic obstructive pulmonary disease (COPD), emphysema or chronic lung disease (excluding asthma)													
c. In the past 5 years, has any proposed insured been diagnosed, received medical advice, sought treatment including surgery, or taken medication for any of the following:		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						
• Multiple Sclerosis, Muscular Dystrophy, or Parkinson's disease, amyotrophic lateral sclerosis (ALS or Lou Gehrig's Disease) or Huntington's Disease													
• Schizophrenia, psychosis, bipolar disorder or post traumatic stress disorder													
• Crohn's disease or ulcerative colitis													
• Systemic lupus or any connective tissue disease													
d. In the past 2 years, has any proposed insured:		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						
• Pled guilty or no contest or been convicted of a felony or misdemeanor													
• Been charged with operating a motor vehicle under the influence of drugs and/or alcohol													

**Agreement:** I represent and agree that: (1) all statements and information found in the application are deemed representations and not warranties; (2) all statements and answers herein are true and correctly recorded to the best of my knowledge and belief; (3) this application will be a part of any contract issued; (4) **the insurance applied for shall become effective as of the date the payroll deduction authorization or authorized check form is signed by me.** The Company may modify coverage applied for depending upon eligibility of each insured person. The representations on this application must be true and correct for coverage to begin before the policy effective date and such interim coverage will not extend beyond 90 days; and (5) I have received a Medical Information Bureau Notice.

**Authorization:** I hereby authorize my employer, Medical Information Bureau, Inc., or any consumer reporting agency who possesses 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 signed below.

I understand that this is an electronic application that has been completed and signed by me without the presence or assistance of an agent. I verify that the unique identifier used to sign this application is mine and that by clicking the "Submit" button, I am signing the application electronically. I hereby authorize my employer to deduct the premiums for this policy from my paycheck.

**NOTICE:** Any person who knowingly and with the intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Signed at \_\_\_\_\_  
CITY AND STATE SIGNATURE OF EMPLOYEE

Date \_\_\_\_\_

SERFF Tracking Number: LLNS-126397147 State: Arkansas  
 Filing Company: Illinois Mutual Life Insurance Company State Tracking Number: 44170  
 Company Tracking Number: WSL-EAPP  
 TOI: L071 Individual Life - Whole Sub-TOI: L071.101 Fixed/Indeterminate Premium - Single Life  
 Product Name: Workplace Life Application  
 Project Name/Number: WSL-EAPP/WSL-EAPP

## Supporting Document Schedules

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Flesch Certification		
<b>Comments:</b>		
<b>Attachment:</b> Readability.pdf		

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Bypassed - Item:</b> Application		
<b>Bypass Reason:</b> Submitting application only form approval. see form tab		
<b>Comments:</b>		

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Bypassed - Item:</b> Life & Annuity - Acturial Memo		
<b>Bypass Reason:</b> Not applicable. submitting application only		
<b>Comments:</b>		

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> WSL-APP07		
<b>Comments:</b>		
<b>Attachment:</b> WSL-APP07.pdf		

**CERTIFICATION**

Re: Form WSL-EAPP, Workplace Life Application

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:

Form WSL-EAPP

51.311

ILLINOIS MUTUAL LIFE INSURANCE COMPANY

By: 

David C. Storlie  
Vice President  
General Counsel

Dated: November 20, 2009



# Application for Workplace Voluntary Life Insurance

## 1. Employee Information (Complete All)

a. Name \_\_\_\_\_  
LAST FIRST MI MAIDEN/FORMER MARITAL STATUS SEX

b. Address \_\_\_\_\_  
STREET CITY STATE ZIP CODE

c. Home Ph. ( \_\_\_\_\_ ) \_\_\_\_\_ d. E-mail Address \_\_\_\_\_

e. Soc. Sec. # \_\_\_\_\_ f. Employer's Name \_\_\_\_\_

g. Date of Employment \_\_\_\_\_ h. Are you actively at work?  Yes  No i. Employee/Payroll # \_\_\_\_\_

## 2. Additional Employee Information (To be completed if Employee is applying for coverage)

a. Date of Birth \_\_\_\_\_ b. State of Birth \_\_\_\_\_

c. Occupation \_\_\_\_\_

d. Hours worked per week \_\_\_\_\_ e. Monthly Salary \$ \_\_\_\_\_ (excluding bonuses and overtime)

## 3. Spouse (To be completed only if applying for Spouse coverage)

a. Name \_\_\_\_\_  
LAST FIRST MI MAIDEN/FORMER SEX

b. Address (if different) \_\_\_\_\_

c. Soc. Sec. # \_\_\_\_\_ d. Date of Birth \_\_\_\_\_

e. Does spouse live in the U.S.?  Yes  No

f. During the past 12 months, has your spouse been hospitalized or treated, including prescription medication, for an injury or sickness (excluding pregnancy, colds, allergies, flu and back problems)?  Yes  No If "Yes," answer Questions under Section 7 & 8 on page 3.

## 4. Child and/or Grandchild (To be completed if applying for Child and/or Grandchild coverage)

Full Name	Social Security No.	Date of Birth	Relationship	Sex	Policy or Rider
1. _____	_____	_____	_____	_____	_____
2. _____	_____	_____	_____	_____	_____
3. _____	_____	_____	_____	_____	_____
4. _____	_____	_____	_____	_____	_____

Do all of the Children/Grandchildren listed above live in the U.S.?  Yes  No If "No," which ones do not live in the U.S.? \_\_\_\_\_

Have any of the Children/Grandchildren listed above been diagnosed with or treated for Down's Syndrome, Cerebral Palsy, Muscular Dystrophy or Cystic Fibrosis?  Yes  No If "Yes," which ones? \_\_\_\_\_

**5. Policy Information** (Complete All)

	<b>Employee</b>		<b>Spouse</b>		<b>#1</b>		<b>Child/Grandchild #2</b>		<b>#3</b>		<b>#4</b>	
	<b>Yes</b>	<b>No</b>	<b>Yes</b>	<b>No</b>	<b>Yes</b>	<b>No</b>	<b>Yes</b>	<b>No</b>	<b>Yes</b>	<b>No</b>	<b>Yes</b>	<b>No</b>
<b>a.</b> Has any proposed insured used any tobacco products (such as cigarettes, cigars, snuff, dip, chew or pipe) or any nicotine delivery system in the past 12 months?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	n/a		n/a		n/a		n/a	
<b>b.</b> (1) Do any proposed insureds have existing individual life insurance coverage?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						
(2) Will coverage applied for replace any existing individual life insurance coverage?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						

If "Yes," list: Full Name \_\_\_\_\_ Company \_\_\_\_\_ Policy Number \_\_\_\_\_

	<b>Employee</b>		<b>Spouse</b>		<b>#1</b>		<b>Child/Grandchild #2</b>		<b>#3</b>		<b>#4</b>	
<b>c.</b> Face/Specified Amount	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____
<b>d.</b> Base Policy Weekly Premium	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____

**e. Riders and Premiums**

(1) Term Insurance Rider	<input type="checkbox"/>	<input type="checkbox"/>										
Coverage Amount	\$ _____	\$ _____										
Weekly Premium	\$ _____	\$ _____										
(2) Child Term Insurance Rider	<input type="checkbox"/>	<input type="checkbox"/>										
Coverage Amount	\$ _____	\$ _____										
Weekly Premium	\$ _____	\$ _____										
(3) Accidental Death Benefit	<input type="checkbox"/>	<input type="checkbox"/>										
Weekly Premium	\$ _____	\$ _____										
(4) Waiver of Premium	<input type="checkbox"/>											
Weekly Premium	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____

**f.** Payroll Frequency:  Weekly  Bi-Weekly  Semi-Monthly  Monthly  Other

TOTAL PAYROLL PREMIUM DEDUCTED: \$ \_\_\_\_\_

**g.**  Automatic Premium Loan Elected

**h. Dividend Option**  Cash  Accumulate at Interest  Reduce Premium

**6. Beneficiary Information** (Complete All)

**Employee**

Primary \_\_\_\_\_ Relationship to Insured \_\_\_\_\_  
 Contingent \_\_\_\_\_ Relationship to Insured \_\_\_\_\_

**Spouse**

Primary \_\_\_\_\_ Relationship to Insured \_\_\_\_\_  
 Contingent \_\_\_\_\_ Relationship to Insured \_\_\_\_\_

**Children/Grandchildren**

The Children/Grandchildren's Beneficiary will automatically be the employee, if living, otherwise the Spouse named in the application. If another beneficiary is preferred, please indicate below in special requests.

Special Request \_\_\_\_\_

**7. Modified Issue**

	<b>Employee</b>		<b>Spouse</b>		<b>#1</b>		<b>Child/Grandchild #2</b>		<b>#3</b>		<b>#4</b>	
	<b>Yes</b>	<b>No</b>	<b>Yes</b>	<b>No</b>	<b>Yes</b>	<b>No</b>	<b>Yes</b>	<b>No</b>	<b>Yes</b>	<b>No</b>	<b>Yes</b>	<b>No</b>
a. Has any proposed insured tested positive for exposure to the Human Immunodeficiency Virus (HIV), been diagnosed as having Acquired Immune Deficiency Syndrome (AIDS), AIDS related complex (ARC), or other sickness or condition derived from such infection?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						
b. In the past 12 months, has any proposed insured for any reason other than vacation, colds, flu, pregnancy, allergies or back problems been hospitalized more than 5 consecutive days, or if employed, missed more than 10 consecutive days of work?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						
c. In the past 5 years, has any proposed insured been diagnosed, received medical advice, sought treatment including surgery, or taken medication for any of the following:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						
• Atrial Fibrillation, chest pain, heart attack, coronary artery disease or surgery on the heart or heart valves												
• Congestive Heart Failure or cardiomyopathy												
• Stroke or transient ischemic attack (TIA)												
• High blood pressure treated with 3 or more medications												
• Alcohol or drug abuse												
• Diabetes (excluding gestational or diet controlled)												
• Chronic obstructive pulmonary disease (COPD), emphysema or chronic lung disease (excluding asthma)												
d. In the past 10 years, have you or any proposed insured been diagnosed, received medical advice, sought treatment, or taken medication for cancer or malignancy of any kind, excluding basal cell carcinoma?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						

**8. Simplified Issue**

<b>a. Provide Height and Weight</b>		<b>Employee</b>		<b>Spouse</b>		<b>#1</b>		<b>Child/Grandchild #2</b>		<b>#3</b>		<b>#4</b>	
<b>Employee</b>	_____ ft. _____ in. _____ lbs.	<b>Yes</b>	<b>No</b>	<b>Yes</b>	<b>No</b>	<b>Yes</b>	<b>No</b>	<b>Yes</b>	<b>No</b>	<b>Yes</b>	<b>No</b>	<b>Yes</b>	<b>No</b>
<b>Spouse</b>	_____ ft. _____ in. _____ lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						
b. Has any proposed insured ever been diagnosed, received medical advice, sought treatment including surgery, or taken medication for any of the following:		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						
• Cirrhosis of the liver or hepatitis B or C													
• Kidney disease or failure (excluding kidney stones, sponge, horseshoe or ectopic kidney and kidney removal due to trauma)													
• Atrial fibrillation, chest pain, heart attack, coronary artery disease or surgery on the heart or heart valve(s)													
• Congestive heart failure or cardiomyopathy													
• Stroke or transient ischemic attack (TIA)													
• Peripheral Vascular Disease													
• Cancer (excluding basal cell carcinoma)													
• Any condition requiring an organ transplant (excluding corneal)													
• Diabetes (excluding gestational or diet controlled)													
• Chronic obstructive pulmonary disease (COPD), emphysema or chronic lung disease (excluding asthma)													
c. In the past 5 years, has any proposed insured been diagnosed, received medical advice, sought treatment including surgery, or taken medication for any of the following:		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						
• Multiple Sclerosis, Muscular Dystrophy, or Parkinson's disease, amyotrophic lateral sclerosis (ALS or Lou Gehrig's Disease) or Huntington's Disease													
• Schizophrenia, psychosis, bipolar disorder or post traumatic stress disorder													
• Crohn's disease or ulcerative colitis													
• Systemic lupus or any connective tissue disease													
d. In the past 2 years, has any proposed insured:		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						
• Pled guilty or no contest or been convicted of a felony or misdemeanor													
• Been charged with operating a motor vehicle under the influence of drugs and/or alcohol													

**Agreement:** I represent and agree that: (1) all statements and information found in the application are deemed representations and not warranties; (2) all statements and answers herein are true and correctly recorded to the best of my knowledge and belief; (3) this application will be a part of any contract issued; (4) **the insurance applied for shall become effective as of the date the payroll deduction authorization or authorized check form is signed by me.** The Company may modify coverage applied for depending upon eligibility of each insured person. The representations on this application must be true and correct for coverage to begin before the policy effective date and such interim coverage will not extend beyond 90 days; and (5) I have received a Medical Information Bureau Notice.

**Authorization:** I hereby authorize my employer, Medical Information Bureau, Inc., 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 signed below

Signed at \_\_\_\_\_  
CITY AND STATE SIGNATURE OF EMPLOYEE

Date \_\_\_\_\_

**NOTICE:** Any person who knowingly and with the intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

**Agent's Certification**

~~I certify that I asked the above questions of the Employee 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 # \_\_\_\_\_