

SERFF Tracking Number: LLNS-126390083 State: Arkansas
Filing Company: Illinois Mutual Life Insurance Company State Tracking Number: 44130
Company Tracking Number: WSA-EAPP
TOI: H02I Individual Health - Accident Only Sub-TOI: H02I.000 Health - Accident Only
Product Name: Workplace Accident Application
Project Name/Number: Workplace Accident Application/WSA-EAPP

Filing at a Glance

Company: Illinois Mutual Life Insurance Company

Product Name: Workplace Accident Application SERFF Tr Num: LLNS-126390083 State: Arkansas

TOI: H02I Individual Health - Accident Only SERFF Status: Closed-Approved-
Closed State Tr Num: 44130

Sub-TOI: H02I.000 Health - Accident Only Co Tr Num: WSA-EAPP State Status: Approved-Closed

Filing Type: Form

Author: Hollie Henderson

Reviewer(s): Rosalind Minor

Date Submitted: 11/19/2009

Disposition Date: 12/01/2009

Disposition Status: Approved-
Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: Workplace Accident Application

Status of Filing in Domicile: Pending

Project Number: WSA-EAPP

Date Approved in Domicile:

Requested Filing Mode: Review & Approval

Domicile Status Comments: Filing submitted on
11/18/09

Explanation for Combination/Other:

Market Type: Individual

Submission Type: New Submission

Group Market Size:

Overall Rate Impact:

Group Market Type:

Filing Status Changed: 12/01/2009

Explanation for Other Group Market Type:

State Status Changed: 12/01/2009

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 WSA-EAPP is an application used with Accident Policy Form WSA07, which was approved by your department on 2/26/07 under SERFF Tracking #LLNS-125093222 .

Application Form WSA-EAPP will be used in addition to Application Form WSA-APP07, which was approved by your department on 2/26/07 under SERFF Tracking #LLNS-125093222. Application Form WSA-APP07 is to be used for paper enrollments where an agent is present to assist and receive the application. Application Form WSA-EAPP is to be

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used for web-based enrollments where the applicant is completing the application online and there is no agent present. The only difference between WSA-EAPP and previously approved WSA-APP07 is that the agent certification statement has been removed from Form WSA-EAPP and replaced with a statement that this is an electronic application completed without the presence or assistance of an agent. Form WSA-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 an accident insurance policy 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:

Filing Fees

SERFF Tracking Number: LLNS-126390083 State: Arkansas
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Fee Required? Yes
Fee Amount: \$50.00
Retaliatory? Yes
Fee Explanation: 1 Form = \$50.00
Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Illinois Mutual Life Insurance Company	\$50.00	11/19/2009	32162667

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	12/01/2009	12/01/2009

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Disposition

Disposition Date: 12/01/2009

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	Yes
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Supporting Document	WSA-APP07	Approved-Closed	Yes
Form	Workplace Accident Form	Approved-Closed	Yes

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Form Schedule

Lead Form Number: WSA-EAPP

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed	WSA-EPP	Application/Workplace Accident Enrollment Form	Form	Initial		58.450	WSA_EAPP.pdf



300 S.W. Adams Street Peoria, IL 61634
800.437.7355

ESP

Application for Workplace Voluntary Accident 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. Date of Birth _____ g. State of Birth _____
- h. Employer's Name _____
- i. Date of Employment _____ j. Are you actively at work? Yes No k. Employee/Payroll # _____
- l. Occupation _____
- m. Hours worked per week _____ n. Monthly Salary \$ _____ (excluding bonuses and overtime)

2. Spouse (Complete 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

3. Child (To be completed if applying for Child coverage)

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

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

4. Policy Information (Complete All)

a. Base Accident Plan: Premium \$ _____

- Employee
- Employee/Spouse
- Employee/Children
- Employee/Spouse/Children

b. Additional Riders

Wellness Benefit Rider

Number of Units _____ Benefit Amount \$ _____ Premium \$ _____

Sickness Confinement Rider (if selected, answer Section 6 questions)

Number of Units _____ Benefit Amount \$ _____ Premium \$ _____

Off-the-Job Accident Disability Rider (Employee only)

Benefit Period: 6 month 12 month

Number of Units _____ Benefit Amount \$ _____ Premium \$ _____

Catastrophic Accident Rider Premium \$ _____

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

TOTAL PAYROLL PREMIUM DEDUCTED: \$ _____

d. Will coverage applied for replace any existing individual accident insurance? Yes No If "Yes," please list
Company Policy No.

e. If applying for Off-the-Job Accident Disability Rider, do you have any group or individual disability income insurance? Yes No
If "Yes," give details

Insurance Company	Monthly Benefit	Elimination/Benefit Period
_____	_____	_____
_____	_____	_____
_____	_____	_____

5. Beneficiary Information (Complete All)

Employee

Primary _____ Relationship to Insured _____

Contingent _____ Relationship to Insured _____

Spouse

Primary _____ Relationship to Insured _____

Contingent _____ Relationship to Insured _____

Children

The Children'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 _____

6. Medical Information (To be completed only if applying for Sickness Confinement Rider)

- a. In the past 12 months, other than colds, flu or normal pregnancy, have you taken time off from work or taken vacation for 10 or more consecutive days due to an injury, sickness, back, neck, knee, shoulder, joints, or muscular disorder?..... Yes No
- b. 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? Yes No
- c. In the past 12 months, has any proposed insured received medical advice, sought treatment, including medication, or been hospitalized for any of the following? Yes No

- Heart Attack/Heart Surgery
- Congestive Heart Failure
- Stroke/Transient Ischemic Attack (TIA)
- High Blood Pressure treated with 3 or more Medications
- Kidney disease (except stones)
- Respiratory disorders (including asthma)
- Seizures
- Insulin Dependent Diabetes
- Cirrhosis
- Hepatitis B or C
- Cancer (other than skin cancer)
- Cystic Fibrosis

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Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification	Approved-Closed	12/01/2009
Comments:			
Attachment:			
genreadability.pdf			

		Item Status:	Status Date:
Bypassed - Item:	Application	Approved-Closed	12/01/2009
Bypass Reason:	Filing includes approval for application only. No policy is included. Application is attached to From Schedule Tab.		
Comments:			

		Item Status:	Status Date:
Bypassed - Item:	Health - Actuarial Justification	Approved-Closed	12/01/2009
Bypass Reason:	Filing includes application only, no policy.		
Comments:			

		Item Status:	Status Date:
Bypassed - Item:	Outline of Coverage	Approved-Closed	12/01/2009
Bypass Reason:	Filing includes applcation only, no policy		
Comments:			

		Item Status:	Status Date:
Satisfied - Item:	WSA-APP07	Approved-Closed	12/01/2009
Comments:			
Attachment:			
WSA_APP07.pdf			

CERTIFICATION

Re: Form WSA-EAPP, Application for Voluntary Accident Policy

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 WSA-EAPP

58.45

ILLINOIS MUTUAL LIFE INSURANCE COMPANY



By:

David C. Storlie
Vice President
General Counsel

Dated: November 18, 2009

Application for Workplace Voluntary Accident 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. Date of Birth _____ g. State of Birth _____

h. Employer's Name _____

i. Date of Employment _____ j. Are you actively at work? Yes No k. Employee/Payroll # _____

l. Occupation _____

m. Hours worked per week _____ n. Monthly Salary \$ _____ (excluding bonuses and overtime)

2. Spouse (Complete 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

3. Child (To be completed if applying for Child coverage)

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

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

4. Policy Information (Complete All)

a. Base Accident Plan: Premium \$ _____

- Employee
- Employee/Spouse
- Employee/Children
- Employee/Spouse/Children

b. Additional Riders

Wellness Benefit Rider

Number of Units _____ Benefit Amount \$ _____ Premium \$ _____

Sickness Confinement Rider (if selected, answer Section 6 questions)

Number of Units _____ Benefit Amount \$ _____ Premium \$ _____

Off-the-Job Accident Disability Rider (Employee only)

Benefit Period: 6 month 12 month

Number of Units _____ Benefit Amount \$ _____ Premium \$ _____

Catastrophic Accident Rider Premium \$ _____

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

TOTAL PAYROLL PREMIUM DEDUCTED: \$ _____

d. Will coverage applied for replace any existing individual accident insurance? Yes No If "Yes," please list
Company Policy No.

e. If applying for Off-the-Job Accident Disability Rider, do you have any group or individual disability income insurance? Yes No
If "Yes," give details

Insurance Company	Monthly Benefit	Elimination/Benefit Period
_____	_____	_____
_____	_____	_____
_____	_____	_____

5. Beneficiary Information (Complete All)

Employee

Primary _____ Relationship to Insured _____

Contingent _____ Relationship to Insured _____

Spouse

Primary _____ Relationship to Insured _____

Contingent _____ Relationship to Insured _____

Children

The Children'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 _____

6. Medical Information (To be completed only if applying for Sickness Confinement Rider)

a. In the past 12 months, other than colds, flu or normal pregnancy, have you taken time off from work or taken vacation for 10 or more consecutive days due to an injury, sickness, back, neck, knee, shoulder, joints, or muscular disorder?..... Yes No

b. 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? Yes No

c. In the past 12 months, has any proposed insured received medical advice, sought treatment, including medication, or been hospitalized for any of the following? Yes No

- Heart Attack/Heart Surgery
- Congestive Heart Failure
- Stroke/Transient Ischemic Attack (TIA)
- High Blood Pressure treated with 3 or more Medications
- Kidney disease (except stones)
- Respiratory disorders (including asthma)
- Seizures
- Insulin Dependent Diabetes
- Cirrhosis
- Hepatitis B or C
- Cancer (other than skin cancer)
- Cystic Fibrosis

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. An Outline of Coverage was given to the Applicant. I do do not have knowledge that the insurance applied for will replace any existing disability income insurance.~~

PRINT WRITING AGENT NAME _____ AGENT'S SIGNATURE _____

Agent's Code # _____ Agent's Phone # _____

Form WSA-APP07

Proxy (Do not use in IA, OK, SC or TN)

Having made application for policy in Illinois Mutual Life Insurance Company and if same is issued; KNOW ALL MEN BY THESE PRESENTS, that I, the undersigned, holder of said policy, do hereby constitute and appoint M. A. McCord, K. M. Jenkins, M. E. Martin, J. K. McCord, and T. P. Jenkins, or a majority of them in attendance, my proxy for me and in my name, place and stead to vote for me and cast the number of votes to which I am or may be entitled at all regular and special meetings of the policyholders of the Company, at which I am not personally present, upon all matters coming before any such meeting with like effect as if I had been personally present and voting. I hereby waive notice of any regular or special meeting of the policyholders of the Company, unless further request in writing is made that notice be given to me. This proxy shall remain in force until revoked in writing or superseded by written proxy of later date given to any other policyholder or policyholders of the Company. I agree to notify the Secretary of the Company of such change in proxy, and to abide by the by-laws of the Company governing proxy voting.

Date _____ Signature _____

Address _____

Form 561-K (1/06)