

SERFF Tracking Number: LLNS-126920833 State: Arkansas
Filing Company: Illinois Mutual Life Insurance Company State Tracking Number: 47405
Company Tracking Number: APP105-L
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
Product Name: Life Insurance Application
Project Name/Number: Life Insurance Application/APP105-L

Filing at a Glance

Company: Illinois Mutual Life Insurance Company

Product Name: Life Insurance Application

SERFF Tr Num: LLNS-126920833 State: Arkansas

TOI: L08 Life - Other

SERFF Status: Closed-Approved-
Closed State Tr Num: 47405

Sub-TOI: L08.000 Life - Other

Co Tr Num: APP105-L

State Status: Approved-Closed

Filing Type: Form

Reviewer(s): Linda Bird

Author: Hollie Henderson

Disposition Date: 12/01/2010

Date Submitted: 11/29/2010

Disposition Status: Approved-
Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: Life Insurance Application

Status of Filing in Domicile: Pending

Project Number: APP105-L

Date Approved in Domicile:

Requested Filing Mode: Review & Approval

Domicile Status Comments:

Explanation for Combination/Other:

Market Type: Individual

Submission Type: New Submission

Individual Market Type:

Overall Rate Impact:

Filing Status Changed: 12/01/2010

State Status Changed: 12/01/2010

Deemer Date:

Created By: Hollie Henderson

Submitted By: Hollie Henderson

Corresponding Filing Tracking Number:

Filing Description:

Re: Form APP105-L, Application for Life Insurance

The above form is being submitted for your review and approval.

Form APP105-L is a new form that will be used in conjunction with Form APP105(AR). These two forms together will be used to qualify applicants for the policies listed below. Form APP105-L is specific to life sales. Form APP105(AR) provides the additional underwriting information which is applicable to both life and disability insurance. Form APP105(AR) was approved by the Department on 5/5/2010 under SERFF filing No. LLNS-126599604. The approved Form APP105(AR) is attached as a supporting document to this filing.

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This two part application form will be used by licensed agents to sell the following products that have been previously approved by the Department.

Form 614, Renewable Term Life Insurance To Age 95 which was approved on 10/19/2006 under SERFF Filing# SERT 6U3PZZ533

Form 617, Whole Life Insurance to Age 121 which was approved on 8/13/2007 under SERFF Filing# LLNS 125237732

Form 618, Flexible Premium Life Insurance which was approved on 8/28/2007 under SERFF Filing# LLNS 125240980

Form 620, Renewable Level Benefit Term Endowment Policy which was approved on 3/2/2009 under SERFF Filing# 126035901

Also, enclosed is the Flesch score analysis certification for this filing.

Thank you for your assistance with 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

Fee Required? Yes
 Fee Amount: \$50.00
 Retaliatory? Yes
 Fee Explanation: 1 form at \$50 per form
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
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Illinois Mutual Life Insurance Company \$50.00 11/29/2010 42379227

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	12/01/2010	12/01/2010

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Disposition

Disposition Date: 12/01/2010

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: LLNS-126920833 *State:* Arkansas
Filing Company: Illinois Mutual Life Insurance Company *State Tracking Number:* 47405
Company Tracking Number: APP105-L
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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		Yes
Supporting Document	APP105(AR)		Yes
Form	Application for Life Insurance		Yes

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Form Schedule

Lead Form Number: APP105-L

Schedule Item Status	Form Number	Form Type Form Name	Action	Action Specific Data	Readability	Attachment
	APP105-L	Application/ Enrollment Form	Application for Life Insurance	Initial	66.500	App105-L.pdf

Application for Life Insurance

PART A

1. Proposed Insured

a. Name _____
LAST FIRST MI MAIDEN/FORMER MARITAL STATUS GENDER

b. Address _____
STREET CITY STATE ZIP CODE

c. Primary Ph. _____ Other Ph. _____ E-mail _____

d. Social Security Number _____ e. Driver's License Number & State _____

f. Date of Birth _____ g. Place of Birth (State/Country) _____ h. Annual Income _____

i. Are you a U.S. Citizen? Yes No
 (1) If no, have you resided in the U.S. for the past 2 years? Yes No
 (1a.) If yes, have you been granted permanent resident (green card) status? Yes No

j. In the past 12 months, have you used any form of tobacco or nicotine-based product? Yes No Never
 If no, date last used _____

k. If proposed insured(s) is under age 1, was his/her birth abnormal or premature? Yes No
 If yes, specify: Weight at birth _____ lbs.

2. Beneficiary Designation

a. Primary _____ Relationship to Proposed Insured _____
 b. Contingent _____ Relationship to Proposed Insured _____

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

a. Life Plan _____ Amount \$ _____

Term Plans: 10 Year 15 Year 20 Year 30 Year
ROP Term Plans: 15 Year 20 Year 30 Year
Whole Life Plans: Single Pay 10 Pay 20 Pay To Age 65 To Age 121
UL: Option 1 Option 2 Increase Specified Amount for UL Policy # _____ by amount stated above

b. Optional Benefits/Riders

Accidental Death (UL/WL) \$ _____ Waiver of Premium (WL/T)
 Critical Illness Rider (UL/WL/T) \$ _____ Waiver of Monthly Amount (UL) \$ _____
 Guaranteed Insurability Option/OPI (UL/WL) \$ _____ Waiver of Monthly Deductions (UL)
 Child Insurance Rider (UL/WL/T) \$ _____ Payor Waiver of Premium (WL)
 Term Insurance Rider (UL/WL) \$ _____ 10 Year 15 Year 20 Year
 Other Insured Term Rider (UL/WL) \$ _____ 10 Year 15 Year 20 Year
 Paid Up Additions Rider (WL) Single Premium \$ _____
 Paid Up Insurance Rider (WL) Modal Premium \$ _____
 Other _____

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

4. Other Insured Rider or Payor Benefit

a. Name _____
LAST FIRST MI MAIDEN/FORMER MARITAL STATUS GENDER

b. Address _____
STREET CITY STATE ZIP CODE

c. Home Ph. (_____) _____ Bus. Ph. (_____) _____ E-mail _____

d. Social Security Number _____ e. Driver's License Number & State _____

f. Date of Birth _____ g. Place of Birth (State/Country) _____ h. Annual Income _____

i. Are you a U.S. Citizen? Yes No
 (1) If no, have you resided in the U.S. for the past 2 years? Yes No
 (1a.) If yes, have you been granted permanent resident (green card) status? Yes No

j. In the past 12 months, have you used any form of tobacco or nicotine-based product? Yes No Never
 If no, date last used _____

k. Beneficiary Designation
 (1) Primary _____ Relationship to Proposed Insured _____
 (2) Contingent _____ Relationship to Proposed Insured _____

5. 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: _____

d. If proposed insured(s) is under age 1, was his/her birth abnormal or premature? Yes No
 If yes, specify: Weight at birth _____ lbs.

e. In the past 10 years, has the child been hospitalized for any injury or sickness or received treatment by a medical practitioner? Yes No If yes, provide child's name, dates and details. _____

f. Has the child ever been declined, postponed or rated for life insurance? Yes No If yes, provide child's name, dates and details. _____

6. Other Life Coverage

a. Do you, or any other proposed insured(s), have any life insurance in force or pending? Yes No If yes, list below.

Name	Company or Source	Pending (P) or In Force (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
_____	_____	_____	\$ _____	\$ _____	<input type="checkbox"/> Yes <input type="checkbox"/> No

b. If replacement is indicated, provide company address and policy number. Forward replacement forms, if required.

7. Ownership

Primary Owner (If other than the Proposed Insured)

a. Name _____

b. Address _____
STREET CITY STATE ZIP CODE

c. E-mail _____ d. Social Security or Tax ID Number _____

Contingent Owner (If any)

e. Name _____ f. Social Security or Tax ID Number _____

g. Address _____
STREET CITY STATE ZIP CODE

8. Billing and Payment

a. Effective Date: Application Date Issue Date Other _____

b. Premium Notices: Insured at residence Owner at address shown above.
 Insured at business Other _____

c. Premium Mode: Annual Semi-Annual Quarterly Monthly Authorized Check
 Special Bill (Indicate billing number if known.) _____

d. Premium Amount Quoted: \$ _____

e. Initial Premium Payment: Cash with Application \$ _____ Cash on Delivery (C.O.D.)
 Draft First Month's Premium (Monthly Authorized Check mode only.)
 At issue Other Date _____

f. Automatic Premium Loan Elected (WL)

If using the traditional application process, complete Parts B and C. Use a separate Part B for Proposed Insured listed under Section 4. If using the teleapplication process, complete Part C.

<i>SERFF Tracking Number:</i>	<i>LLNS-126920833</i>	<i>State:</i>	<i>Arkansas</i>
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<i>Company Tracking Number:</i>	<i>APP105-L</i>		
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<i>Project Name/Number:</i>	<i>Life Insurance Application/APP105-L</i>		

Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification		
Comments:			
Attachment:			
Readability.pdf			

		Item Status:	Status Date:
Satisfied - Item:	Application		
Comments:			
See Form schedule tab			

		Item Status:	Status Date:
Satisfied - Item:	APP105(AR)		
Comments:			
Attachment:			
App105 (AR).pdf			

READABILITY CERTIFICATION

On behalf of Illinois Mutual Life Insurance Company, I hereby certify that we have carefully analyzed and scored the form 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:

66.5% Form APP105-L, Application for Life Insurance

ILLINOIS MUTUAL LIFE INSURANCE COMPANY



By:

David C. Storlie
Vice President and General Counsel
Illinois Mutual Life Insurance Company
300 SW Adams ST
Peoria, IL 61634
(800)437-7355, Ext. 426
Dated: November 29, 2010

Application for Insurance

Proposed Insured _____ D.O.B. ____ / ____ / ____

PART B (All references to "you" mean the Proposed Insured.)

1. Employment Information (For DI, complete questions 1a thru 1l. For Life, complete questions 1a thru 1c.)

- a. Primary occupation _____ b. Years of experience _____
- c. Employer's name and address _____
- d. Date employed with current employer _____ e. No. of employees _____
- f. Describe exact duties of occupation and percentage of time spent in each. _____

- g. How many hours are you currently working per week in your primary occupation? _____
- h. Are you self-employed or an owner of a corporation or partnership? Yes No
If yes, indicate percentage of ownership and type of business entity. _____
- i. Do you work from your home? Yes No If yes, specify number of hours per week. _____
- j. Do you intend to change occupation, employer or employment status in the next 6 months? Yes No
If yes, provide details. _____
- k. Do you have other employment currently, full or part-time? Yes No
If yes, specify number of hours per week, dates employed and occupational duties performed. _____

- l. Did you have other employment within the past 5 years, full or part time? Yes No
If yes, specify number of hours per week, dates employed and occupational duties performed. _____

2. General Information

- a. What is your current: (1) Height: _____ feet _____ inches (2) Weight: _____ pounds
- b. Have you lost more than 10 pounds in the past 12 months? Yes No
If yes, specify number of pounds lost and reason. _____
- c. In the past 10 years, have you consumed alcoholic beverages? Yes No If yes, specify type, amount and frequency, and date of last use. _____
- d. In the past 10 years, have you used heroin, cocaine, marijuana, barbiturates or any other controlled substance not prescribed by a physician? Yes No If yes, specify type, frequency and date of last use. _____
- e. Have you ever been advised to limit or discontinue the use of alcohol or drugs, or received counseling or treatment because of alcohol or drug use? Yes No If yes, provide dates and details. _____
- f. In the past 10 years, have you been convicted of a felony? Yes No If yes, provide dates and details. _____
- g. In the past 5 years, have you been charged with driving while intoxicated, had more than 3 moving violations, or had your driver's license suspended or revoked? Yes No If yes, provide dates and details. _____
- h. In the past 2 years, have you traveled or worked outside the United States for more than 30 days? Yes No
If yes, provide details. _____
- i. In the next 2 years, do you plan to travel or work outside the United States for more than 30 days? Yes No
If yes, provide details. _____
- j. Do you engage in personal aviation activity, mountain or rock climbing, motor-powered racing, scuba or sky diving, hang gliding or any other hazardous activity? Yes No If yes, provide details. _____
- k. In the past 5 years, have you had any insurance application modified or declined? Yes No If yes, provide details. _____
- l. In the past 5 years, have you requested or received any disability benefits? Yes No If yes, provide details. _____

PART C

Home Office Endorsement Only. Question No. _____ corrected to read as follows:

Agreement and Declaration

I represent and agree that all statements and information found in the application are deemed representations and not warranties. I further 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 Receipt has been delivered, then liability of the Company shall be as stated in the Receipt. I have received a MIB Notice, Fair Credit Reporting Act Notice and an Outline of Coverage if applying for disability insurance.

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 any licensed physician, medical practitioner, hospital, clinic, or other medical or medically related facility, pharmacy benefit manager, insurance company, MIB, Inc. or other organization, institution or person, that has any records or knowledge of me or my health, to give to Illinois Mutual Life Insurance Company, or its reinsurers, any such information.

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.

When completed electronically, 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.

Signed at _____
CITY AND STATE

SIGNATURE OF PROPOSED INSURED
(OR PARENT IF PROPOSED INSURED UNDER AGE 18)

Date _____

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

SIGNATURE OF PROPOSED RIDER INSURED

Notice: Any person who, knowingly and with 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: An Outline of Coverage was given to the Proposed Insured for disability insurance. I, do do not, have knowledge that the insurance applied for will replace any existing disability insurance and/or life insurance.

PRINT WRITING AGENT NAME

WRITING AGENT'S SIGNATURE

Agent's Code # _____

Agent's Phone # _____

Agent's E-mail _____

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

Does the Proposed Insured prefer to receive future correspondence in Spanish? Yes No

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 _____

Examination Requirements

- Non-Medical Abbreviated Paramedical Exam (Urinalysis required.) Full Paramedical Exam (Urinalysis required.)
- Blood Profile (Informed Consent must be signed.) EKG
- Agent will schedule. Exam completed on ____/____/____ Home Office will schedule.