

SERFF Tracking Number: LLNS-126599604 State: Arkansas  
 Filing Company: Illinois Mutual Life Insurance Company State Tracking Number: 45575  
 Company Tracking Number: DI105(AR)  
 TOI: H111 Individual Health - Disability Income Sub-TOI: H111.003 Long Term - Unrelated to marketing  
 with employer or association groups  
 Product Name: Disability Income  
 Project Name/Number: Disability Income/DI105

## Filing at a Glance

Company: Illinois Mutual Life Insurance Company

Product Name: Disability Income

SERFF Tr Num: LLNS-126599604 State: Arkansas

TOI: H111 Individual Health - Disability Income

SERFF Status: Closed-Approved-  
Closed State Tr Num: 45575

Sub-TOI: H111.003 Long Term - Unrelated to  
marketing with employer or association groups

Co Tr Num: DI105(AR)

State Status: Approved-Closed

Filing Type: Form/Rate

Author: Hollie Henderson

Reviewer(s): Rosalind Minor

Date Submitted: 05/04/2010

Disposition Date: 05/05/2010

Disposition Status: Approved-  
Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

## General Information

Project Name: Disability Income

Status of Filing in Domicile: Pending

Project Number: DI105

Date Approved in Domicile:

Requested Filing Mode:

Domicile Status Comments: The above forms  
have been submitted to the Illinois Department  
of Insurance for approval.

Explanation for Combination/Other:

Market Type: Individual

Submission Type: New Submission

Group Market Size:

Overall Rate Impact:

Group Market Type:

Filing Status Changed: 05/05/2010

Explanation for Other Group Market Type:

State Status Changed: 05/05/2010

Deemer Date:

Created By: Hollie Henderson

Submitted By: Hollie Henderson

Corresponding Filing Tracking Number:

Filing Description:

RE: Form DI105, Disability Income Policy

Form 9251, Non-Cancelable Policy Rider

Form 9252, Automatic Increase Benefit Rider

Form 9253, Retroactive Injury Rider

Form 9255, Two Year Pure Own Occupation Rider

SERFF Tracking Number: LLNS-126599604 State: Arkansas  
Filing Company: Illinois Mutual Life Insurance Company State Tracking Number: 45575  
Company Tracking Number: DI105(AR)  
TOI: H111 Individual Health - Disability Income Sub-TOI: H111.003 Long Term - Unrelated to marketing  
with employer or association groups  
Product Name: Disability Income  
Project Name/Number: Disability Income/DI105

Form 9256, Five Year Pure Own Occupation Rider  
Form 9257, Five Year Own Occupation Extension Rider  
Form 9258, Own Occupation Extension To Your Renewal Age Rider  
Form 9259, Activities of Daily Living Rider  
Form 9260, Cost of Living Adjustment Rider  
Form 9261, Residual Disability Rider  
Form 9263, Residual Disability Rider with Cost of Living Adjustment Rider  
Form 9264, Integrated Monthly Benefit Rider  
Form 9265, Full Benefits for Mental or Nervous Disorders, Alcoholism or Drug Abuse Rider  
Form 9266, Return of Premium Rider  
Form 9267, Guaranteed Insurability Rider  
Form APP9267, Guaranteed Insurability Application  
Form APP105-D Application for Disability Insurance  
Form APP105, Application for insurance  
Form OCDI105, Outline of Coverage for Disability Income Policy

Enclosed are a new Disability Insurance Policy, Riders, Application and Outlines of Coverage submitted for your review and approval. These forms will be marketed through licensed agents.

Form DI105 provides total disability benefits as defined for benefit periods of 6months, 1 year, 2 years, 5 years, 10 years and to age 67. Partial disability benefits as defined are provided for a benefit period of 6 months. The policy is guaranteed renewable to age 67 and optionally renewable to age 75. Issue ages are 18-60.

Form APP105-D will be used to qualify applicants for DI105 policies. These policies will be sold by licensed agents.

Insurance Application form APP105 is a new form that will be used in conjunction with Form APP105-D, Application for Disability, which is also a new form. These forms together will be used to qualify applicants for DI105 policies.

The following Rider Forms may be issued with Form DI105:

Form 9251 Non-Cancelable Policy Rider. This Rider provides that the policy premium can not be changed prior to the renewal date that follows the insured's 67th birthday.

Form 9252, Automatic Increase Benefit Rider. This Rider provides for an automatic increase of 3% Total Disability Monthly Benefit on each of the first 5 policy anniversaries. The policy owner may decline an increase but will then forfeit any further increases. There is no premium charged for this rider but premiums will be charged for the increase in

SERFF Tracking Number: LLNS-126599604 State: Arkansas  
Filing Company: Illinois Mutual Life Insurance Company State Tracking Number: 45575  
Company Tracking Number: DI105(AR)  
TOI: H111 Individual Health - Disability Income Sub-TOI: H111.003 Long Term - Unrelated to marketing  
with employer or association groups  
Product Name: Disability Income  
Project Name/Number: Disability Income/DI105

benefit.

Form 9253 Retroactive Injury Benefit Rider. This Rider provides that if an injury causes the total disability for at least the entire Elimination Period that benefits will be paid from the first day of total disability.

Form 9255 Two Year Own Occupation Rider. This Rider changes the definition of Total Disability during the first 24 months to your inability to perform the substantial and material duties of your occupation only.

Form 9256 Five Year Pure Own Occupation Rider. This Rider changes the definition of Total Disability during the first 60 months to your inability to perform the substantial and material duties of your occupation only.

Form 9257 Five Year Own Occupation Extension Rider. This Rider changes the definition of Total Disability for your own occupation from 24 months to 60 months.

Form 9258 Own Occupation Extension To Your Renewal Age Rider. This Rider changes the definition of Total Disability for your own occupation from 24 months to age 67.

Form 9259 Activities of Daily Living Rider. This Rider provides additional monthly benefits if the insured is unable to perform two or more Activities of Daily Living without stand-by assistance of they are cognitively impaired.

Form 9260 Cost of Living Adjustment Rider. This Rider provides for an increase in monthly benefit beginning on the second year of continuous total disability based on a increase in the Consumer Price Index.

Form 9261 Residual Disability Benefit Rider. This Rider provides a monthly benefit if the insured returns to his regular job and suffers a loss of 20% or more of his prior income.

Form 9263 Residual Disability Benefit Rider with Cost of Living Adjustment. This Rider provides a monthly benefit if the insured returns to his regular job and suffers a loss of 20 % or more of his prior income and also provides a cost of living adjustment based on an increase in the Consumer Price Index.

Form 9264 Integrated Monthly Benefit Rider. This Rider provides an additional monthly benefit which reduced by the receipt of Social Security, Worker's Compensation, Railroad Retirement and government retirement and disability benefits.

Form 9265 Full Benefits for Mental or Nervous Disorders, Alcoholism or Drug Abuse. This Rider amends the policy to eliminate the limitations for total disability caused by mental or nervous disorder or alcoholism or drug abuse to a maximum of 24 months so that these conditions will be treated as any other sickness.

<i>SERFF Tracking Number:</i>	<i>LLNS-126599604</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Illinois Mutual Life Insurance Company</i>	<i>State Tracking Number:</i>	<i>45575</i>
<i>Company Tracking Number:</i>	<i>DI105(AR)</i>		
<i>TOI:</i>	<i>H111 Individual Health - Disability Income</i>	<i>Sub-TOI:</i>	<i>H111.003 Long Term - Unrelated to marketing with employer or association groups</i>
<i>Product Name:</i>	<i>Disability Income</i>		
<i>Project Name/Number:</i>	<i>Disability Income/DI105</i>		

Form 9266 Return of Premium Rider. This Rider provides a return of premium. The return of premium if any, is the amount by which all premiums paid time the proper percentage based upon how long the policy is in force is greater than the total of all benefits paid.

Form 9267 Guaranteed Insurability Rider. This Rider provides 5 options to purchase additional policy benefit without the insured's health status being considered.

APP9267 is a new application form that will be used to qualify applicants for Rider Form 9267, Guaranteed Insurability Rider.

In addition Form OCDI105 Outline of Coverage for Policy Form DI105 is being submitted for your approval

All policy forms are in final print format. While we may employ type styles, paper or layout different from the enclosed forms, we certify and agree that the content of these forms will not change without prior approval from your department. We also certify that any type style change will be in compliance with your readability requirements.

Actuarial Memorandums and Readability Certificates and checklists for the Policies and Riders are submitted with this filing. We look forward to your review and approval of these new forms.

## Company and Contact

### Filing Contact Information

David Storlie, Vice President and General Counsel	dcstorlie@illinoismutual.com
300 SW Adams Street	309-674-8255 [Phone] 426 [Ext]
Peoria, IL 61634	309-674-2076 [FAX]

### Filing Company Information

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

-----

## Filing Fees

SERFF Tracking Number: LLNS-126599604 State: Arkansas  
Filing Company: Illinois Mutual Life Insurance Company State Tracking Number: 45575  
Company Tracking Number: DI105(AR)  
TOI: H111 Individual Health - Disability Income Sub-TOI: H111.003 Long Term - Unrelated to marketing  
with employer or association groups  
Product Name: Disability Income  
Project Name/Number: Disability Income/DI105

Fee Required? Yes  
Fee Amount: \$1,000.00  
Retaliatory? Yes  
Fee Explanation: 20 forms \* \$50 per form  
Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Illinois Mutual Life Insurance Company	\$1,000.00	05/04/2010	36202017

SERFF Tracking Number: LLNS-126599604 State: Arkansas  
Filing Company: Illinois Mutual Life Insurance Company State Tracking Number: 45575  
Company Tracking Number: DI105(AR)  
TOI: H111 Individual Health - Disability Income Sub-TOI: H111.003 Long Term - Unrelated to marketing  
with employer or association groups  
Product Name: Disability Income  
Project Name/Number: Disability Income/DI105

## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	05/05/2010	05/05/2010

*SERFF Tracking Number:* LLNS-126599604      *State:* Arkansas  
*Filing Company:* Illinois Mutual Life Insurance Company      *State Tracking Number:* 45575  
*Company Tracking Number:* DI105(AR)  
*TOI:* H111 Individual Health - Disability Income      *Sub-TOI:* H111.003 Long Term - Unrelated to marketing  
with employer or association groups  
  
*Product Name:* Disability Income  
*Project Name/Number:* Disability Income/DI105

## **Disposition**

Disposition Date: 05/05/2010

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: LLNS-126599604 State: Arkansas  
 Filing Company: Illinois Mutual Life Insurance Company State Tracking Number: 45575  
 Company Tracking Number: DI105(AR)  
 TOI: H111 Individual Health - Disability Income Sub-TOI: H111.003 Long Term - Unrelated to marketing  
 with employer or association groups

Product Name: Disability Income  
 Project Name/Number: Disability Income/DI105

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	No
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Form	Disability Income Policy	Approved-Closed	Yes
Form	Non-cancelable Policy Rider	Approved-Closed	Yes
Form	Automatic Increase Benefit Rider	Approved-Closed	Yes
Form	Retroactive Injury Rider	Approved-Closed	Yes
Form	Two Year Pure Own Occupation Rider	Approved-Closed	Yes
Form	Five Year Pure Own Occupation Rider	Approved-Closed	Yes
Form	Five year Own Occupation Extension Rider	Approved-Closed	Yes
Form	Own Occupation Extension To Your renewal Age Rider	Approved-Closed	Yes
Form	Activities of Daily Living Rider	Approved-Closed	Yes
Form	Cost of Living Adjustment Rider	Approved-Closed	Yes
Form	Residual Disability Rider	Approved-Closed	Yes
Form	Residual Disability Rider with Cost of Living Adjustment Rider	Approved-Closed	Yes
Form	Integrated Monthly Benefit Rider	Approved-Closed	Yes
Form	Full Benefits for Mental or Nervous Disorder, Alcoholism, or Drug Abuse Rider	Approved-Closed	Yes
Form	Return of Premium Rider	Approved-Closed	Yes
Form	Guaranteed Insurability Rider	Approved-Closed	Yes
Form	Application for Guaranteed Insurability Rider	Approved-Closed	Yes
Form	Application for Insurance	Approved-Closed	Yes
Form	Application for Disability Income Insurance	Approved-Closed	Yes
Form	Outline of Coverage for Disability Income Policy	Approved-Closed	Yes
Rate	DI105 Act Memo	Approved-Closed	No
Rate	9252 Act Memo	Approved-Closed	No
Rate	9253 Act Memo	Approved-Closed	No

SERFF Tracking Number: LLNS-126599604 State: Arkansas  
 Filing Company: Illinois Mutual Life Insurance Company State Tracking Number: 45575  
 Company Tracking Number: DI105(AR)  
 TOI: H111 Individual Health - Disability Income Sub-TOI: H111.003 Long Term - Unrelated to marketing  
 with employer or association groups

Product Name: Disability Income

Project Name/Number: Disability Income/DI105

<b>Rate</b>	9255 Act memo	Approved-Closed	No
<b>Rate</b>	9256 Act memo	Approved-Closed	No
<b>Rate</b>	9257 Act memo	Approved-Closed	No
<b>Rate</b>	9258 Act memo	Approved-Closed	No
<b>Rate</b>	9259 Act memo	Approved-Closed	No
<b>Rate</b>	9260 Act Memo	Approved-Closed	No
<b>Rate</b>	9261-9263 Act memo	Approved-Closed	No
<b>Rate</b>	9264 Act memo	Approved-Closed	No
<b>Rate</b>	9265 Act memo	Approved-Closed	No
<b>Rate</b>	9266 Act Memo	Approved-Closed	No
<b>Rate</b>	9267 Act memo	Approved-Closed	No

SERFF Tracking Number: LLNS-126599604 State: Arkansas  
 Filing Company: Illinois Mutual Life Insurance Company State Tracking Number: 45575  
 Company Tracking Number: DI105(AR)  
 TOI: H111 Individual Health - Disability Income Sub-TOI: H111.003 Long Term - Unrelated to marketing with employer or association groups  
 Product Name: Disability Income  
 Project Name/Number: Disability Income/DI105

## Form Schedule

### Lead Form Number: DI105(AR)

Schedule Item	Form Number	Form Type Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 05/05/2010	DI105(AR)	Policy/Cont Disability Income ract/Fratern Policy al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial		50.000	DI105 (AR).pdf
Approved-Closed 05/05/2010	9251	Policy/Cont Non-cancelable ract/Fratern Policy Rider al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial		50.200	9251.pdf
Approved-Closed 05/05/2010	9252	Policy/Cont Automatic Increase ract/Fratern Benefit Rider al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial		57.200	9252.pdf
Approved-Closed 05/05/2010	9253	Policy/Cont Retroactive Injury ract/Fratern Rider al	Initial		53.800	9253.pdf

SERFF Tracking Number: LLNS-126599604 State: Arkansas  
 Filing Company: Illinois Mutual Life Insurance Company State Tracking Number: 45575  
 Company Tracking Number: DI105(AR)  
 TOI: H111 Individual Health - Disability Income Sub-TOI: H111.003 Long Term - Unrelated to marketing with employer or association groups

Product Name: Disability Income  
 Project Name/Number: Disability Income/DI105

Certificate:

Amendmen  
 t, Insert  
 Page,  
 Endorseme  
 nt or Rider

Approved- 9255 Policy/Cont Two Year Pure Own Initial 50.700 9255.pdf  
 Closed ract/Fratern Occupation Rider  
 05/05/2010 al

Certificate:  
 Amendmen  
 t, Insert  
 Page,  
 Endorseme  
 nt or Rider

Approved- 9256 Policy/Cont Five Year Pure Own Initial 52.900 9256.pdf  
 Closed ract/Fratern Occupation Rider  
 05/05/2010 al

Certificate:  
 Amendmen  
 t, Insert  
 Page,  
 Endorseme  
 nt or Rider

Approved- 9257 Policy/Cont Five year Own Initial 50.000 9257.pdf  
 Closed ract/Fratern Occupation  
 05/05/2010 al Extension Rider

Certificate:  
 Amendmen  
 t, Insert  
 Page,  
 Endorseme  
 nt or Rider

Approved- 9258 Policy/Cont Own Occupation Initial 51.300 9258.pdf  
 Closed ract/Fratern Extension To Your  
 05/05/2010 al renewal Age Rider

Certificate:

SERFF Tracking Number: LLNS-126599604 State: Arkansas  
 Filing Company: Illinois Mutual Life Insurance Company State Tracking Number: 45575  
 Company Tracking Number: DI105(AR)  
 TOI: H111 Individual Health - Disability Income Sub-TOI: H111.003 Long Term - Unrelated to marketing with employer or association groups

Product Name: Disability Income  
 Project Name/Number: Disability Income/DI105

Approval Status	Policy/Cont	Activities of Daily	Initial	Amount	File Name
Approved- 9259 Closed 05/05/2010	Policy/Cont	Activities of Daily	Initial	52.700	9259.pdf
	ract/Fratern Living Rider				
	al				
	Certificate:				
	Amendmen				
	t, Insert				
	Page,				
	Endorseme				
	nt or Rider				
Approved- 9260 Closed 05/05/2010	Policy/Cont	Cost of Living	Initial	50.500	9260.pdf
	ract/Fratern Adjustment Rider				
	al				
	Certificate:				
	Amendmen				
	t, Insert				
	Page,				
	Endorseme				
	nt or Rider				
Approved- 9261 Closed 05/05/2010	Policy/Cont	Residual Disability	Initial	53.500	9261.pdf
	ract/Fratern Rider				
	al				
	Certificate:				
	Amendmen				
	t, Insert				
	Page,				
	Endorseme				
	nt or Rider				
Approved- 9263 Closed 05/05/2010	Policy/Cont	Residual Disability	Initial	53.600	9263.pdf
	ract/Fratern Rider with Cost of				
	al Living Adjustment				
	Certificate: Rider				
	Amendmen				

SERFF Tracking Number: LLNS-126599604 State: Arkansas  
 Filing Company: Illinois Mutual Life Insurance Company State Tracking Number: 45575  
 Company Tracking Number: DI105(AR)  
 TOI: H111 Individual Health - Disability Income Sub-TOI: H111.003 Long Term - Unrelated to marketing with employer or association groups

Product Name: Disability Income  
 Project Name/Number: Disability Income/DI105

Approved- 9264 Closed 05/05/2010	t, Insert Page, Endorseme nt or Rider Policy/Cont Integrated Monthly ract/Fratern Benefit Rider al	Initial	54.500	9264.pdf
Approved- 9265 Closed 05/05/2010	Certificate: Amendmen t, Insert Page, Endorseme nt or Rider Policy/Cont Full Benefits for ract/Fratern Mental or Nervous al Disorder, Alcoholism, Certificate: or Drug Abuse Rider Amendmen t, Insert Page, Endorseme nt or Rider	Initial	50.000	9265.pdf
Approved- 9266 Closed 05/05/2010	Certificate: Amendmen t, Insert Page, Endorseme nt or Rider Policy/Cont Return of Premium ract/Fratern Rider al	Initial	52.400	9266.pdf
Approved- 9267 Closed 05/05/2010	Certificate: Amendmen t, Insert Page, Endorseme nt or Rider Policy/Cont Guaranteed ract/Fratern Insurability Rider al	Initial	58.000	9267.pdf

SERFF Tracking Number: LLNS-126599604 State: Arkansas  
 Filing Company: Illinois Mutual Life Insurance Company State Tracking Number: 45575  
 Company Tracking Number: DI105(AR)  
 TOI: H111 Individual Health - Disability Income Sub-TOI: H111.003 Long Term - Unrelated to marketing with employer or association groups

Product Name: Disability Income  
 Project Name/Number: Disability Income/DI105

Page,  
 Endorseme  
 nt or Rider

Approved- APP9267	Application/ Application for	Initial	56.000	App9267.pdf
Closed	Enrollment Guaranteed			
05/05/2010	Form Insurability Rider			
Approved- APP105(A	Application/ Application for	Initial	53.800	App105
Closed R)	Enrollment Insurance			(AR).pdf
05/05/2010	Form			
Approved- APP105-	Application/ Application for	Initial	58.100	App105-D
Closed D(AR)	Enrollment Disability Income			(AR).pdf
05/05/2010	Form Insurance			
Approved- OCDI105	Application/ Outline of Coverage	Initial	55.000	OCDI105.pdf
Closed	Enrollment for Disability Income			
05/05/2010	Form Policy			



**A Mutual Life Insurance Company**

**This Policy provides benefits, as shown in the Schedule, for loss resulting from injury or sickness. It is renewable until the renewal date that follows your Renewal Age birthday shown in the Schedule, but subject to our right to increase premiums by class. Thereafter, this Policy is renewable at our option.**

**THIRTY DAY RIGHT TO EXAMINE POLICY**

Within 30 days after its delivery to you, you may surrender this Policy by mailing or bringing it to our Home Office or to the agent who sold it to you. We will then return to you all of the premium that you paid. This Policy will then be deemed to be void from the Date of Issue.

**INSURING PROVISION**

In consideration of the application for this Policy, a copy of which is attached to and made a part of this Policy, and of the payment in advance of the premium shown in the Schedule, we promise to pay benefits for your loss caused by injury or sickness as described in this Policy and subject to all of the provisions of this Policy.

**RENEWAL PROVISION**

**Guaranteed Renewable Until Renewal Date  
That Follows Your Renewal Age**

**Premium Subject to Change by Class**

This Policy is issued for the term for which premium is paid starting on the Date of Issue. You may renew it by paying the current premium rate for like policies written or renewed by us until the renewal date that follows your Renewal Age birthday. Then, we have the option of renewing the Policy annually at the current rates for your attained age. This Policy may not be renewed after the renewal date that follows your 75th birthday.

(continued on page 3)

**DISABILITY INCOME POLICY**

**Illinois Mutual Life Insurance Company**

Home Office 300 S.W. Adams Street Peoria, IL 61634 Phone 800.437.7355

**DISABILITY INCOME POLICY**  
**Form DI105 (AR)**

This contract is a legal contract between the contract owner and Illinois Mutual Life Insurance Company.

**READ YOUR CONTRACT CAREFULLY**

This DISABILITY INCOME contract provides benefits for loss resulting from injury or sickness. This contract is guaranteed renewable and premiums are payable until the renewal date that follows the Renewal Age birthday of the Insured as shown on the Schedule. The Company has the right to increase premiums by class. After the Renewal Age birthday of the Insured, this Policy may be renewed only at the option of the Company.

**ALPHABETIC GUIDE TO YOUR CONTRACT**

	<b>Page</b>		<b>Page</b>
Age	Schedule	Notice of Claim	9
Beneficiary	7	Ownership	7
Benefit Provisions	5	Payment of Claims	9
Change of Premium	3	Pre-existing Condition Limitation	7
Claim Forms	9	Proofs of Loss	9
Date of Issue	Schedule	Reinstatement	9
Definitions	3	Renewal	1
Exceptions and Reductions	8	Right to Examine Policy	1
Foreign Travel Limitations	8	Suspension of Policy During Unemployment	6
Grace Period	9	Time Limit on Certain Defenses	9
Insured	Schedule	Time of Payment of Claims	9
Limited Benefits	7	Unpaid Premium	10
Misstatement of Age	10	Waiver of Premium	6

**ADDITIONAL BENEFITS**

The additional benefits, if any, listed on the Schedule are described in the Riders that follow the last page of the Policy.



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

## POLICY SCHEDULE

<p>Insured: John Doe          Age: 35          Rate Classification: 5 Non-Tobacco          Renewal Age: 67</p>	<p>Policy Number: 8-1517299          Date of Issue: 01/28/2010          State of Issue: Any state</p>												
<p>Total Policy Premium, including Riders          Premium Mode chosen for First Premium</p> <p>Elimination Period          Maximum Total Disability Benefit Period*          Maximum Partial Disability Benefit Period</p> <p>*Maximum Period is 24 Months for Total Disability Commencing          after Renewal Date that follows the Insured's 67th Birthday</p>	<p>Annual \$1,606.87          Quarterly \$ 485.67</p> <p>60 Days          5 Years          6 Months</p>												
<p><b>POLICY BENEFITS</b></p> <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 80%;">Total Disability Monthly Benefit</td> <td style="text-align: right;">\$ 2,500.00</td> </tr> <tr> <td>Partial Disability Monthly Benefit</td> <td style="text-align: right;">\$ 1,250.00</td> </tr> <tr> <td>Total Loss of Sight &amp; Double Dismemberment Benefit</td> <td style="text-align: right;">\$ 2,500.00</td> </tr> <tr> <td>Retraining &amp; Home Modification Benefit</td> <td style="text-align: right;">\$15,000.00</td> </tr> <tr> <td>Survivor Benefit</td> <td style="text-align: right;">\$10,000.00</td> </tr> <tr> <td>Waiver of Premium</td> <td style="text-align: right;">INCLUDED</td> </tr> </table>		Total Disability Monthly Benefit	\$ 2,500.00	Partial Disability Monthly Benefit	\$ 1,250.00	Total Loss of Sight & Double Dismemberment Benefit	\$ 2,500.00	Retraining & Home Modification Benefit	\$15,000.00	Survivor Benefit	\$10,000.00	Waiver of Premium	INCLUDED
Total Disability Monthly Benefit	\$ 2,500.00												
Partial Disability Monthly Benefit	\$ 1,250.00												
Total Loss of Sight & Double Dismemberment Benefit	\$ 2,500.00												
Retraining & Home Modification Benefit	\$15,000.00												
Survivor Benefit	\$10,000.00												
Waiver of Premium	INCLUDED												

## POLICY SCHEDULE (cont.)

Insured: John Doe  
 Age: 35  
 Rate Classification: 5 Non-Tobacco  
 Renewal Age: 67

Policy Number: 8-1517299  
 Date of Issue: 01/28/2010  
 State of Issue: Any state

### RIDERS

		Annual Premium	Date of Issue
Automatic Increase Benefit	3%	\$ 0.00	01/28/2010
Non-Cancelable Policy		\$267.82	01/28/2010
Return of Premium		\$415.57	01/28/2010
See Table of Return of Premium Percentages on Schedule Page 3			
Five Year Own Occupation Extension		\$ 56.01	01/28/2010
Two Year Pure Own Occupation		\$ 28.01	01/28/2010
Retroactive Injury Benefit		\$ 39.00	01/28/2010
Integrated Monthly Benefit		\$ 55.49	01/28/2010
Maximum Integrated Monthly Benefit	\$400		
Guaranteed Insurability Option		\$ 8.07	01/28/2010
Maximum Per Purchase	\$400		
Activities of Daily Living		\$ 33.00	01/28/2010
Elimination Period	60 Days		
Maximum Benefit Period	60 Months		
Cost of Living Adjustment		\$ 39.00	01/28/2010
Residual Disability Benefit		\$108.73	01/28/2010
Full Benefits for Mental or Nervous Disorders, Alcoholism or Drug Abuse		\$ 51.53	01/28/2010

## POLICY SCHEDULE (cont.)

Insured: John Doe  
 Age: 35  
 Rate Classification: 5 Non-Tobacco  
 Renewal Age: 67

Policy Number: 8-1517299  
 Date of Issue: 01/28/2010  
 State of Issue: Any state

### RETURN OF PREMIUM RIDER Table of Return of Premium Percentages

This table shows the return of premium percentages at the ends of various policy years. The return of premium percentages for other times will be furnished upon request. The return of premium percentage at any date to which premiums have been paid within a policy year will be obtained by interpolation to the nearest .1% between the percentage for the beginning and end of each year.

Age at Issue	Base Policy at the End of Policy Year									At Age 65	At Age 66	At Age 67
	5	6	7	8	9	10	15	20	30			
35	11%	14%	17%	20%	23%	27%	41%	59%	100%	100%	100%	100%

## RENEWAL PROVISION (cont.)

After your Renewal Age, we may decline to renew this Policy on the next renewal date that occurs, but this renewal date must be on or follow the anniversary of the Date of Issue. Our refusal to renew your Policy will not prejudice any claim that starts while your Policy is in force.

If we elect to allow renewal of your policy after the renewal date that follows your Renewal Age, you may renew this Policy under the following conditions:

1. Your premium for this Policy will increase to reflect your attained age until age 75 at which time the policy will terminate.
2. You must provide evidence of continued full time employment of at least 30 hours per week prior to renewal after your Renewal Age and annually thereafter. If your employment should terminate for reasons other than total disability, this Policy will terminate. Any premium paid for a period after termination of employment will be refunded to you.
3. Your Total Disability Monthly Benefit upon renewal after your Renewal Age will be up to 24 months or up to the Maximum Total Disability Benefit Period, whichever is less.

All renewal premiums are due and payable in advance or within the Policy's grace period. Each renewal will keep your Policy in force for the term for which premium has been paid except in the event of termination of employment after your Renewal Age. Each term will start and end at 12 o'clock noon at your address.

We reserve the right to increase premium rates on all or classes of like policies. A premium change prior to your Renewal Age will be based on your original classification and age at issue. A premium change after your Renewal Age will be based on your original classification and attained age. The increase will take effect on the first renewal date that follows the date of the change in the table of rates if it is on, or falls after, a Policy anniversary. We will mail you a written notice of the increase and send it to your last address shown on our records. This notice will be sent at least 30 days prior to the effective date of the increase. We may not change your rating classification or add restrictive riders to your Policy.

## DEFINITIONS

When used in this Policy:

**We, Us and Our** refers to Illinois Mutual Life Insurance Company.

**You and Your** refers to the Insured, as shown in the Schedule.

**Class** means a group of persons insured individually under this policy form who have a common bond such as, but not limited to: age, sex, occupation, tobacco use or state of residence.

**Injury** means accidental bodily injury independent of all other causes that you sustain while this Policy is in force.

**Sickness** means an illness, disease, or physical condition of yours which first manifests itself while this Policy is in force.

**Physician** means a doctor or practitioner, other than you or a member of your immediate family, who is duly licensed by the proper authority and who is practicing within the scope of his license.

**Regular Care of a Physician** means treatment, consultations and diagnostic services provided by a physician whose specialty is suitable for the condition causing your disability. Such care must be received in-person at a frequency that is appropriate for your Injury or Sickness according to accepted medical standards. We may waive this regular care requirement upon receipt of reasonable proof that such care is no longer appropriate for the Injury or Sickness causing your disability.

## DEFINITIONS (cont.)

**Alcoholism or Drug Abuse** means the diagnosis and treatment by a physician for the excess use of alcohol or drugs, whether prescription or nonprescription, or whether legal or illegal.

**Hospital** means a legally operated institution having accommodations for the care and treatment of sick or injured resident patients. It must be:

- (a) licensed as a hospital under the Hospital Licensing Laws of any state;
- (b) accredited as a hospital by the Joint Commission on Accreditation of the Healthcare Organizations;
- (c) supervised by a staff of physicians on the premises; and
- (d) able to provide on the premises 24 hour nursing services by registered nurses.

This definition shall not include any institution including a hospital or any part of a hospital:

- (a) operated as a rest home, convalescent home, or home for the aged;
- (b) used primarily for the care of convalescent or ambulatory patients; or
- (c) used primarily for rehabilitation care for alcoholism or drug abuse.

**Mental or Nervous Disorder** means a neurosis, psychoneurosis, psychopathy, psychosis or other mental, behavioral or emotional disease, disturbance, or disorder of any kind regardless of the cause or origin.

**Elimination Period** means the number of continuous days you must be totally or partially disabled before benefits begin to accrue and become payable. No benefits are payable for the Elimination Period unless so stated in the Policy.

**Your Occupation** means the occupation in which you are engaged at the time of your disability. Prior to your Renewal Age, if you are temporarily unemployed 6 months or less at the time of your disability, your occupation will be that occupation in which you were engaged prior to becoming unemployed. Prior to your Renewal Age, if you have been unemployed for more than 6 months or if you have retired while this Policy is in force and prior to becoming disabled, you will be considered to be disabled if, as a result of an injury or a sickness, you are unable to engage in the normal activities of an unemployed or a retired person of like age and sex.

**Total Disability** for any one period of disability starting while this policy is in force means:

- (a) During the first 24 months, your inability to perform the substantial and material duties of your occupation and you are not engaged in any occupation for wage or profit.
- (b) After 24 months, your inability to perform the substantial and material duties of any occupation for wage or profit in which you might be expected to be engaged, with due regard to your education, training, experience and you are not engaged in any occupation for wage or profit.

To be totally disabled, you must be under the Regular Care of a Physician. Only one total disability benefit will be payable at any one time even if you are totally disabled because of multiple causes. You cannot receive a Total Disability Monthly Benefit and a Partial Disability Monthly Benefit at the same time.

**Partial Disability** for any one period of disability starting while this Policy is in force means:

- (a) your inability to perform one or more of the substantial and material duties of your occupation;  
or
- (b) the necessary loss of one-half or more of the time spent by you in the usual daily performance of the duties of your occupation.

To be partially disabled, you must be under the Regular Care of a Physician. Only one partial disability benefit will be paid at any one time even if you are partially disabled because of multiple causes. You cannot receive a Partial Disability Monthly Benefit and a Total Disability Monthly Benefit at the same time.

## **BENEFIT PROVISIONS**

### **Total Disability Monthly Benefit**

If injury or sickness in and of itself causes your total disability, we will pay you the Total Disability Monthly Benefit shown in the Schedule. This Benefit shall be paid to you after the Elimination Period shown in the Schedule has been satisfied. This Benefit shall be paid to you for as long as you are totally disabled up to the Maximum Total Disability Benefit Period shown in the Schedule for any one period of total disability.

If we renew this Policy after your Renewal Age birthday and you become totally disabled on or after the first renewal date following your Renewal Age birthday, we will pay you this Benefit. However, the Benefit will be payable for up to 24 months or for up to the Maximum Total Disability Benefit Period, whichever is less.

### **Partial Disability Monthly Benefit**

If injury or sickness in and of itself causes your partial disability, we will pay you the Partial Disability Monthly Benefit shown in the Schedule. This Benefit will be paid to you after the Elimination Period shown in the Schedule has been satisfied or with the first day of partial disability immediately following total disability for which the Total Disability Monthly Benefit was payable. We will pay this Benefit to you during the continuance of your partial disability. However, this Benefit will not be paid for more than 6 months for any one period of partial disability.

### **Recurrent Disability**

A recurrence of your disability from the same or related causes will be considered a continuation of the prior period unless you have been engaged in any gainful occupation for more than 6 continuous months. You must be reasonably fitted and have been performing all of the substantial and material duties of that occupation.

If your disability is treated as a recurrent disability of the prior period, it will not be subject to a new Elimination Period or a new Maximum Total or Partial Disability Benefit Period.

### **Presumed Total Disability**

You will be deemed to be totally disabled if, while this Policy is in force, injury or sickness shall result in the total and irrecoverable loss of:

- (1) sight in both eyes; or
- (2) hearing of both ears; or
- (3) speech; or
- (4) use of both hands; or
- (5) use of both feet; or
- (6) use of a hand and a foot.

As long as such loss continues during your life you will be considered totally disabled up to the Maximum Total Disability Benefit Period. Such total disability will be presumed regardless of your ability to work and regardless of your being under the Regular Care of a Physician. Your presumed total disability will start on the day of such loss. The Elimination Period will apply.

### **Total Loss of Sight and Double Dismemberment Monthly Benefit**

If, while this Policy is in force, injury or sickness shall result in your total and irrecoverable loss of:

- (1) sight in both eyes; or
- (2) both hands by complete severance through or above the wrist; or
- (3) both feet by complete severance through or above the ankle joints; or
- (4) a hand and a foot by complete severance through or above the wrist and the ankle joint.

## **BENEFIT PROVISIONS (cont.)**

We will pay you the Total Loss of Sight and Double Dismemberment Monthly Benefit shown in the Schedule. This Benefit starts with the day of such loss. We will pay this Benefit to you as long as such loss continues during your life, up to 24 months for any such loss or the Maximum Total Disability Benefit Period, whichever is less. This Benefit will be paid in addition to any other benefits in the Policy.

### **Retraining and Home Modification Benefit**

If benefits have been paid to you under this Policy for 6 months of continuous total disability and if your total disability continues past the 6th month, we will pay you for:

- (1) your actual costs of tuition, books and equipment that are required for a formal retraining program. Such a program must be at a licensed college, vocational or business school.
- (2) your actual costs to modify your home to accommodate your disabling condition.

You must be totally disabled and be receiving total disability benefits under this Policy when you start a retraining program or make modifications to your home. The total amount we will pay for such costs shall not exceed 6 times the Total Disability Monthly Benefit. This Benefit will not be paid unless the Maximum Total Disability Benefit Period is 12 months or more.

### **Organ Donor Benefit**

After this Policy has been in force 6 months or more, if you become totally disabled as a result of giving one of your organs for use as a transplant, including bone marrow donations, benefits will be payable as for any other total disability. The Elimination Period will not apply to the payment of this Benefit.

### **Survivor Benefit**

If you die during a current period of total disability and have been receiving a total disability monthly benefit for 6 continuous months, we will pay 4 times the Total Disability Monthly Benefit shown in the Schedule. The Benefit will be paid to your spouse, if living, otherwise to your estate.

## **WAIVER OF PREMIUM PROVISION**

If injury or sickness causes your total disability for 90 continuous days, we will waive the payment of any premiums which become due. We will refund any premiums which you paid during such 90-day period and which became due after your total disability started. This Policy will stay in force at the end of a period of total disability until the next premium due date. We will then notify you when the next premium payment is due. You have the right to resume payment of premiums for this Policy at that time.

## **SUSPENSION OF POLICY DURING UNEMPLOYMENT**

After this Policy has been in force for at least one year, you may temporarily suspend this Policy if you become unemployed and have received 8 weeks of government unemployment benefits. The suspension will begin when we receive your written request to suspend this Policy and you certify that you are unemployed and that you have received 8 weeks of government unemployment benefits.

This Policy will not be in force while it is suspended and we will not accept premiums for the period of suspension. No benefits or options under this Policy or any attached riders may be exercised during the period of suspension. We will refund the pro rata portion of any premiums paid for a period beyond the date that the suspension begins. Premiums must be paid to the date of suspension. After the end of a period of suspension, this Policy may not be suspended again until 24 months have elapsed from the end of the period of suspension.

## **SUSPENSION OF POLICY DURING UNEMPLOYMENT (cont.)**

The suspension will end on the earlier of:

- (1) 6 months after the date of suspension, at which time you will be notified that the Policy will be placed back in force and premiums are now due.
- (2) the date we receive your written request to end the suspension, subject to evidence satisfactory to us that you are gainfully employed.

When your Policy is no longer suspended, you will have the same rights under your Policy as you had prior to suspension, however the Policy will not cover any loss due to an injury that occurs or sickness that first manifests itself while the Policy was suspended.

### **OWNERSHIP PROVISION**

You are the owner of this Policy unless a different owner is shown in the application. All privileges and rights under and control of this Policy are vested solely in the owner. The owner of this Policy may exercise all rights of ownership and take any other action with which we agree, including a change of ownership, without the consent of anyone else, unless such consent is required.

### **BENEFICIARY PROVISION**

The beneficiary shall be as shown in the application for this Policy. The owner may change a beneficiary at any time by sending a written request to us unless an irrevocable beneficiary has been named.

A change of beneficiary will not take effect until it is recorded by us. When the change is so recorded, it will take effect as of the date that the written request was signed, whether or not you are living when the change is recorded. We will not be liable for any proceeds paid prior to such recording.

### **PRE-EXISTING CONDITION LIMITATION**

During the first 2 years after the Date of Issue, this Policy will not pay benefits:

- (a) for any condition diagnosed or treated by a physician within 2 years prior to the Date of Issue;  
or
- (b) for any condition which caused symptoms within 2 years prior to the Date of Issue that would have caused an ordinarily prudent person to seek medical diagnosis, care or treatment.

However, if you fully disclosed such condition in the application for this Policy, benefits will be payable unless a Rider excludes such condition by name.

### **LIMITED BENEFITS FOR MENTAL OR NERVOUS DISORDERS, ALCOHOLISM OR DRUG ABUSE**

The total amount payable under this Policy for Total Disability caused or contributed to by a Mental or Nervous Disorder or Alcoholism or Drug Abuse shall not exceed a cumulative lifetime maximum of 24 months. This limitation will not apply to any period during which you are a resident patient in a Hospital due to medically necessary treatment for a Mental or Nervous Disorder or Alcoholism or Drug Abuse. This limitation will not extend the Maximum Total Disability Benefit Period shown in the Schedule.

## **LIMITED BENEFITS FOR FOREIGN TRAVEL**

If you become Totally Disabled due to an injury or sickness sustained or continued while you are outside of the United States, Canada or Mexico your Maximum Total Disability Benefit Period will be limited to 90 days.

After the 90 day period, benefits will not be paid until you return to the United States, Canada or Mexico. If you are still Totally Disabled as defined in this Policy when you return from outside the United States, Canada or Mexico, we will determine your remaining benefit period by subtracting the time period for which we have already paid you benefits from the Maximum Total Disability Benefit Period shown in the Schedule.

## **EXCEPTIONS AND REDUCTIONS**

This Policy does not provide benefits for disability resulting:

- (a) from normal pregnancy or childbirth;
- (b) from intentionally self-inflicted injury or sickness;
- (c) from your commission or attempted commission of a felony;
- (d) from war, declared or not;
- (e) from military service of any country or authority, except during active duty for training of less than 60 days. If we are notified of military service which is not covered, we will refund the pro rata unearned premiums for such period; or
- (f) Disability benefits will not be paid for any period during which you are incarcerated in any penal or correctional institution.

## GENERAL PROVISIONS

**1. Entire Contract; Changes:** This Policy, the application and the attached papers, if any, are the entire contract. No change in this Policy will be valid until such change is approved by one of our Officers. Such change must be endorsed on or attached to this Policy. No agent may change this Policy or waive any of its provisions.

**2. Time Limit on Certain Defenses:** (a) After this Policy has been in force for 2 years, no statements, except fraudulent ones, made by you in the application for such Policy shall be used to void the Policy. They shall not be used to deny a claim for disability that starts after the Policy has been in force for 2 years.

(b) No claim for disability that starts after 2 years from the Date of Issue shall be reduced or denied because a disease or physical condition, which has not been excluded by name or specific description before the disability began, had existed prior to the Date of Issue.

**3. Grace Period:** This Policy has a 31 day grace period during which each premium due after the first premium may be paid. During this grace period this Policy will stay in force.

**4. Reinstatement:** If any renewal premium is not paid within the Grace Period, this Policy will lapse. Later acceptance of the premium by us or by our agent authorized to accept premiums, without requiring an application for reinstatement, will reinstate this Policy.

If we or our agent require an application, you will be given a conditional receipt for the premium. If the application is later approved by us, this Policy will be reinstated as of the date of our approval. If not approved by us, this Policy will be reinstated on the 45th day after the date of the conditional receipt unless we have already given you written notice of its disapproval.

After reinstatement, this Policy will cover only a disability that results from an injury sustained after the date of reinstatement or a sickness that begins more than 10 days after such date. In all other respects your rights and our rights will stay the same, subject to any provisions that are endorsed on or attached to this Policy at the time of reinstatement.

**5. Notice of Claim:** Written notice of a claim must be given to us within 20 days after a loss starts or as soon as reasonably possible. Such notice may be given to our Home Office or to any of our authorized agents. Such notice should include your name.

**6. Claim Forms:** Upon receipt of notice of claim, we will send you the forms for filing proof of loss. If these forms are not furnished within 15 days, you will meet the proof of loss requirements by giving us a written statement of the nature and extent of the claim within the time stated below for Proofs of Loss.

**7. Proofs of Loss:** Written proof of loss which is satisfactory to us must be furnished within 90 days after the date of the loss. If the loss is one for which the Policy requires continuing eligibility for periodic benefit payments, subsequent written proofs of loss must be furnished at such intervals as we may reasonably require.

If it was not reasonably possible for you to give such proof within the time required, we shall not reduce your claim for such reason if the proof is filed as soon as reasonably possible. Such proof must be given no later than one year from the time specified above unless lack of legal capacity prevents it.

**8. Time of Payment of Claims:** After receiving written proof of loss, we will pay at the end of each 30 days all benefits for your continuing disability for which we are liable. Any balance unpaid at the end of your disability will be paid as soon as we receive written proof. Benefits for any other loss covered by this Policy will be paid as soon as we receive proper written proof.

**9. Payment of Claims:** Benefits will be paid to you. Any benefits that are unpaid at your death will be paid either to the beneficiary or to your estate if no beneficiary is named. If this Policy is not owned by you, benefits will be paid to the Owner.

If benefits are payable to your estate or to you or to a beneficiary who cannot execute a valid release, we may pay benefits up to \$1,000 to someone related to you or a beneficiary by blood or marriage whom we deem to be equitably entitled to such benefits. We will be discharged to the extent of any such payments made by us in good faith.

## GENERAL PROVISIONS (cont.)

**10. Physical Examination:** We shall have the right at our expense to have you examined as often as is reasonably necessary while a claim is pending.

**11. Legal Actions:** No legal action may be taken to recover on this Policy within 60 days after written proof of loss has been given as required by this Policy. No legal action may be taken after 3 years from the time written proof of loss is required to be given.

**12. Misstatement of Age:** If your age has been misstated, the benefits of this Policy will be such as the premium paid would have purchased at the correct age. If your age has been misstated and, according to your correct age, this Policy would not have taken effect or would have ceased before the acceptance of such premium(s), we will be liable only for the refund upon your request, of the premiums paid for the period not covered.

**13. Unpaid Premium:** When a claim is paid, any premium then due and unpaid may be deducted by us from the claim payment.

**14. Refund of Premium Upon Death of Insured:** In the event of the death of the Insured, the Company will refund unearned premiums for any period beyond the end of the Policy month in which the Insured's death occurred. Unearned premium shall be paid in a lump sum on a date no later than 30 days after the proof of the Insured's death has been furnished to the Company.

**15. Conformity With State Statutes:** Any provision of this Policy which, on its effective date, is in conflict on that date with the statutes of the state in which you reside is hereby amended to conform to the minimum requirements of such statutes.

**16. Notice of Assignment:** No assignment of this Policy is valid until we receive written notice.

**17. Charter or By-Laws:** No provision of our charter or by-laws, unless included herein, will void this Policy nor be used in any legal action.

**18. Annual Meeting:** Our annual meeting will be held at our Home Office at 10:00 A.M. C.D.T. on the third Tuesday of July of each year. If that day is a legal holiday, it will be held on the next Wednesday.

**19. Choice of Physician:** You have a free choice of physician.

**20. Extension of Time Limits:** If any time limit in this Policy for taking legal action is less than that allowed by the law of the state in which you reside on the Date of Issue, such time limit is extended to the minimum period allowed by such law.

**21. Authorization:** We may require you to give proper authorization to obtain needed information to determine what benefits, if any, are payable under this Policy.

This Policy is signed by our President and Secretary, in Peoria, Illinois on the Date of Issue shown in the Schedule.



Secretary



President

## DISABILITY INCOME POLICY DI105 (AR)

### Illinois Mutual Life Insurance Company

Home Office 300 S.W. Adams Street Peoria, IL 61634 Phone 800.437.7355



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

## NON-CANCELABLE POLICY RIDER

This Rider is made a part of the Policy to which it is attached. This Rider is issued in consideration of an added premium that is included in the Policy's total premium and of the application for this Rider and the Policy. This Rider amends the Policy to add the following provision to modify the RENEWAL PROVISION:

This Policy is Non-Cancelable and Guaranteed Renewable. As long as the premium is paid by the end of the grace period, until the renewal date that follows your Renewal Age birthday shown in the Schedule, we can not change the premium for this Policy. This will not apply to benefit changes or the addition or termination of Riders after the Date of Issue. Any provision in the Policy which would provide for an increase in premium by class prior to your Renewal Age has no effect while this Rider remains in force.

### RIDER PREMIUM

The premium for this Rider is shown in the Schedule.

### RIDER EFFECTIVE DATE

The effective date of this Rider is the same as the Policy Date of Issue unless a different effective date has been given to this rider as stated in the Policy Schedule.

### TIME LIMIT ON CERTAIN DEFENSES

The Policy's Time Limit on Certain Defenses provision will apply to this Rider as of the Rider Effective Date.

### TERMINATION

This Rider terminates on the earliest of:

- (1) The due date of any Policy or Rider premium not paid before the Grace Period ends;
- (2) The date your Policy terminates for any reason;
- (3) The date you request termination; or
- (4) Your Renewal Age shown in the Schedule.

This Rider is signed by our President and Secretary in Peoria, Illinois. This Rider is dated and takes effect on the date shown in the Schedule.



Secretary



President



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

## **AUTOMATIC INCREASE BENEFIT RIDER**

This Rider is made a part of the Policy to which it is attached. This Rider is designed to provide for an automatic increase in the Total Disability Monthly Benefit shown on the Schedule page of the Policy. This increase will be made without evidence of insurability.

### **BENEFIT INCREASE**

Your Total Disability Monthly Benefit will increase automatically on the first premium due date on or after each of the first five policy anniversaries. The amount of the increase will be the Automatic Increase Benefit Rider percentage shown in the Schedule page of the policy times the Total Disability Monthly Benefit at policy issue. Increases will not be offered on any automatic increase date on which you are disabled or your amount of total coverage would exceed our issue and participation limits. You may decline to accept a benefit increase, but if you decline, you forfeit your right to further increases.

### **WHEN BENEFIT INCREASE WILL APPLY**

The automatic benefit increase under this Rider will apply only to a period of disability which starts after the effective date of the increase.

### **PREMIUMS**

There are no premiums charged for this Rider, however when an automatic benefit increase takes place, the Policy premiums will increase in accordance with the increase in benefits. The additional benefit premium will be based upon your classification at policy issue and your attained age at the time of the increase.

### **TERMINATION**

This Rider terminates on the earliest of:

- (1) the date you decline to accept an automatic benefit increase;
- (2) the date you reduce your Total Disability Monthly Benefit;
- (3) the date that you request termination of this Rider;
- (4) the date after the final automatic benefit increase is made under this Rider;
- (5) your 56th birthday; or
- (6) the date your Policy terminates for any reason.

This Rider is signed by our President and Secretary in Peoria, Illinois. This Rider is dated and takes effect on the date as shown in the Schedule.

  
Secretary

  
President



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

## RETROACTIVE INJURY BENEFIT RIDER

This Rider is made a part of the Policy to which it is attached. This Rider is issued in consideration of an added premium that is included in the Policy's total premium and the application for this Rider and the Policy.

This Rider adds the following Benefit to the Policy:

### RETROACTIVE INJURY BENEFIT

If injury in and of itself causes your total disability within 30 days of such injury and the Elimination Period has been satisfied, we will pay the Total Disability Monthly Benefit shown in the Schedule page of the Policy starting from the first day of total disability. You must have been continuously totally disabled from your injury for the entire Elimination Period shown in the Schedule page of the Policy.

### RIDER PREMIUM

The premium for this Rider is shown on the Schedule page of the Policy. The rider premium will be included in the total premium charged for the Policy and any optional policy riders.

### RIDER EFFECTIVE DATE

The effective date of this Rider is the same as the Policy Date of Issue unless a different effective date has been given to this rider as stated in the Policy Schedule

### TIME LIMIT ON CERTAIN DEFENSES

The Policy's Time Limit on Certain Defenses provision will apply to this Rider as of the Rider Effective Date.

### TERMINATION

This Rider will terminate on the earliest of:

- (1) the due date of any Policy or Rider premium not paid before the Grace Period ends;
- (2) the date your Policy terminates for any reason;
- (3) the date you request termination; or
- (4) your Renewal Age shown in the Schedule.

This Rider is signed by our President and Secretary in Peoria, Illinois. This Rider is dated and takes effect on the date as shown in the Schedule.



Secretary



President



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

## TWO YEAR PURE OWN OCCUPATION RIDER

This Rider is made a part of the Policy to which it is attached. This Rider is issued in consideration of an added premium that is included in the Policy's total premium and the application for this Rider and the Policy.

This Rider amends the Policy by deleting the **DEFINITION of Total Disability** and replacing it with the following provision:

**Total Disability** for any one period of disability starting while this policy is in force means:

- (a) During the first 24 months, your inability to perform the substantial and material duties of your occupation.
- (b) After 24 months, your inability to perform the substantial and material duties of any occupation for wage or profit in which you might be expected to engaged, with due regard to your education, training, experience and you are not engaged in any occupation for wage or profit.

To be totally disabled, you must be under the Regular Care of a Physician. Only one total disability benefit will be payable at any one time even if you are totally disabled because of multiple causes. You cannot receive a Total Disability Monthly Benefit and a Partial Disability Monthly Benefit at the same time.

### RIDER PREMIUM

The premium for this Rider is shown on the Schedule page of the Policy. The rider premium will be included in the total premium charged for the Policy and any optional policy riders.

### RIDER EFFECTIVE DATE

The effective date of this Rider is the same as the Policy Date of Issue unless a different effective date has been given to this rider as stated in the Policy Schedule

### TIME LIMIT ON CERTAIN DEFENSES

The Policy's Time Limit on Certain Defenses provision will apply to this Rider as of the Rider Effective Date.

### TERMINATION

This Rider will terminate on the earliest of:

- (1) the due date of any Policy or Rider premium not paid before the Grace Period ends;
- (2) the date your policy terminates for any reason;
- (3) the date you request termination; or
- (4) your Renewal Age shown in the Schedule.

This Rider is signed by our President and Secretary in Peoria, Illinois. This Rider is dated and takes effect on the date as shown in the Schedule.

  
Secretary

  
President

**FIVE YEAR PURE OWN OCCUPATION RIDER**

This Rider is made a part of the Policy to which it is attached. This Rider is issued in consideration of an added premium that is included in the Policy's total premium and the application for this Rider and the Policy.

This Rider amends the Policy by deleting the **DEFINITION** of **Total Disability** and replacing it with the following provision:

**Total Disability** for any one period of disability starting while this policy is in force means:

- (a) During the first 60 months, your inability to perform the substantial and material duties of your occupation.
- (b) After 60 months, your inability to perform the substantial and material duties of any occupation for wage or profit in which you might be expected to engaged, with due regard to your education, training, experience and you are not engaged in any occupation for wage or profit.

To be totally disabled, you must be under the Regular Care of a Physician. Only one total disability benefit will be payable at any one time even if you are totally disabled because of multiple causes. You cannot receive a Total Disability Monthly Benefit and a Partial Disability Monthly Benefit at the same time

**RIDER PREMIUM**

The premium for this Rider is shown on the Schedule page of the Policy. The rider premium will be included in the total premium charged for the Policy and any optional policy riders.

**RIDER EFFECTIVE DATE**

The effective date of this Rider is the same as the Policy Date of Issue unless a different effective date has been given to this rider as stated in the Policy Schedule

**TIME LIMIT ON CERTAIN DEFENSES**

The Policy's Time Limit on Certain Defenses provision will apply to this Rider as of the Rider Effective Date.

**TERMINATION**

This Rider will terminate on the earliest of:

- (1) the due date of any Policy or Rider premium not paid before the Grace Period ends;
- (2) the date your policy terminates for any reason;
- (3) the date you request termination; or
- (4) your Renewal Age as shown in the Schedule.

This Rider is signed by our President and Secretary in Peoria, Illinois. This Rider is dated and takes effect on the date as shown in the Schedule.

  
Secretary

  
President

**FIVE YEAR OWN OCCUPATION  
EXTENSION RIDER**

This Rider is made a part of the Policy to which it is attached. This Rider is issued in consideration of an added premium that is included in the Policy's total premium and the application for this Rider and the Policy.

This Rider amends the Policy by deleting the **DEFINITION of Total Disability** and replacing it with the following provision:

**Total Disability** for any one period of disability starting while this policy is in force means:

- (a) During the first 60 months, your inability to perform the substantial and material duties of your occupation and you are not engaged in any occupation for wage or profit;
- (b) After 60 months, your inability to perform the substantial and material duties of any occupation for wage or profit in which you might be expected to engaged, with due regard to your education, training, experience and you are not engaged in any occupation for wage of profit.

To be totally disabled, you must be under the Regular Care of a Physician. Only one total disability benefit will be payable at any one time even if you are totally disabled because of multiple causes. You cannot receive a Total Disability Monthly Benefit and a Partial Disability Monthly Benefit at the same time.

If the Two Year Pure Own Occupation Rider has been purchased in addition to this Rider, the definition of Total Disability during the two year period will be governed by the terms of that Rider while it remains in force.

**RIDER PREMIUM**

The premium for this Rider is shown on the Schedule page of the Policy. The rider premium will be included in the total premium charged for the Policy and any optional policy riders.

**RIDER EFFECTIVE DATE**

The effective date of this Rider is the same as the Policy Date of Issue unless a different effective date has been given to this rider as stated in the Policy Schedule

**TIME LIMIT ON CERTAIN DEFENSES**

The Policy's Time Limit on Certain Defenses provision will apply to this Rider as of the Rider Effective Date.

## TERMINATION

This Rider will terminate on the earliest of:

- (1) the due date of any Policy or Rider premium not paid before the Grace Period ends;
- (2) the date your policy terminates for any reason;
- (3) the date you request termination; or
- (4) your Renewal Date shown in the Schedule.

This Rider is signed by our President and Secretary in Peoria, Illinois. This Rider is dated and takes effect on the date as shown in the Schedule.



Secretary



President

**OWN OCCUPATION EXTENSION  
TO YOUR RENEWAL AGE RIDER**

This Rider is made a part of the Policy to which it is attached. This Rider is issued in consideration of an added premium that is included in the Policy's total premium and the application for this Rider and the Policy.

This Rider amends the Policy by deleting the **DEFINITION** of **Total Disability** and replacing it with the following provision:

**Total Disability** for any one period of disability starting while this policy is in force means:

To your Renewal Age shown in the schedule, your inability to perform the substantial and material duties of your occupation and you are not engaged in any occupation for wage or profit.

To be totally disabled, you must be under the Regular Care of a Physician. Only one total disability benefit will be payable at any one time even if you are totally disabled because of multiple causes. You cannot receive a Total Disability Monthly Benefit and a Partial Disability Monthly Benefit at the same time.

If the Two Year or Five Year Pure Own Occupation Rider has been purchased in addition to this Rider, the definition of Total Disability during the two or five year period as applicable will be governed by the terms of those Riders while they remain in force.

**RIDER PREMIUM**

The premium for this Rider is shown on the Schedule page of the Policy. The rider premium will be included in the total premium charged for the Policy and any optional policy riders.

**RIDER EFFECTIVE DATE**

The effective date of this Rider is the same as the Policy Date of Issue unless a different effective date has been given to this rider as stated in the Policy Schedule

**TIME LIMIT ON CERTAIN DEFENSES**

The Policy's Time Limit on Certain Defenses provision will apply to this Rider as of the Rider Effective Date.

**TERMINATION**

This Rider will terminate on the earliest of:

- (1) the due date of any Policy or Rider premium not paid before the Grace Period ends;
- (2) the date your policy terminates for any reason;
- (3) the date you request termination; or
- (4) Your Renewal Age shown in the Schedule.

This Rider is signed by our President and Secretary in Peoria, Illinois. This Rider is dated and takes effect on the date as shown in the Schedule.

  
Secretary

  
President



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

## ACTIVITIES OF DAILY LIVING RIDER

This Rider is made a part of the Policy to which it is attached. This Rider is issued in consideration of an added premium that is included in the Policy's total premium and of the applications for this Rider and the Policy. This Rider also amends said Policy by adding the following:

### DEFINITIONS

When used in this Rider:

**Activities of Daily Living Benefit** means the amount shown on the Schedule.

**Activities of Daily Living Maximum Benefit Period** means the longest period of time we will make payments to you under the Activities of Daily Living Benefit for any one period of disability. The Activities of Daily Living Maximum Benefit Period is shown in the Schedule.

**Limited Activities** means that, as a result of injury or sickness:

- (1) you are unable to perform two or more Activities of Daily Living without stand-by assistance;
- or**
- (2) you are Cognitively Impaired.

You must also be under the regular care of a Physician.

**Activities of Daily Living Elimination Period** means the number of days stated in the Schedule preceding the date benefits become payable, during which you have Limited Activities. The Elimination Period begins on the first day that you have Limited Activities.

**Activities of Daily Living (ADLs)** are:

- (1) **Bathing** means the ability to wash yourself, either in the tub or shower, or by sponge bath, including the task of getting into or out of the tub or shower.
- (2) **Continence** means the ability to maintain control of bowel and bladder function; or, when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene (including caring for catheter or colostomy bag).
- (3) **Dressing** means putting on and taking off all items of clothing and any necessary braces, fasteners or artificial limbs.
- (4) **Eating** means feeding yourself by getting food into your body from a receptacle (such as a plate, cup or table) or by a feeding tube or intravenously.
- (5) **Toileting** means getting to and from the toilet, getting on and off the toilet and performing associated personal hygiene.
- (6) **Transferring** means moving into or out of a bed, chair or wheelchair.

**Cognitively Impaired** means that you have suffered a deterioration or loss in your intellectual capacity which requires another person's assistance or verbal cueing to protect yourself or others. This must be measured by clinical evidence and standardized tests. Such loss in intellectual capacity can result from injury, sickness, Alzheimer's Disease or similar forms of senility or irreversible dementia.

### **ACTIVITIES OF DAILY LIVING BENEFIT**

We will pay the Activities of Daily Living Benefit, as shown in the Schedule, in any month after you have satisfied the Activities of Daily Living Elimination Period that:

- (1) you have Limited Activities; and
- (2) your limitation is the result of the same injury or sickness which caused you to satisfy the Activities of Daily Living Elimination Period.

The Activities of Daily Living Benefit will not be paid beyond the Activities of Daily Living Maximum Benefit Period.

### **RECURRENT DISABILITY**

A period of Limited Activities will be considered a continuation of a prior period of Limited Activities if:

- (1) it is from the same or related causes; and
- (2) it occurs within 6 months of the end of the prior period of Limited Activities.

If the new period of Limited Activities is considered a continuation of a prior period of Limited Activities, you will not need to satisfy a new Activities of Daily Living Elimination Period.

If the period of Limited Activities is from a different or unrelated causes, or if it occurs more than 6 months after the end of the prior period of Limited Activities, it will be considered a new period of Limited Activities. It will be subject to its own Activities of Daily Living Elimination Period and Activities of Daily Living Maximum Benefit Period.

### **RIDER PREMIUM**

The premium for this Rider is shown on the Schedule page of the Policy. The rider premium will be included in the total premium charged for the Policy and any optional policy riders.

### **RIDER EFFECTIVE DATE**

The effective date of this Rider is the same as the Policy Date of Issue unless a different effective date has been given to this rider as stated in the Policy Schedule.

### **TIME LIMIT ON CERTAIN DEFENSES**

The Policy's Time Limit on Certain Defenses provision will apply to this Rider as of the Rider Effective Date.

### **TERMINATION**

This Rider will terminate on the earliest of:

- (1) the due date of any Policy or Rider premium not paid before the Grace Period ends;
- (2) the date your Policy terminates for any reason;
- (3) the date you request termination; or
- (4) the date of the first Policy renewal date that follows your Renewal Age birthday.

This Rider is signed by our President and Secretary in Peoria, Illinois. This Rider is dated and takes effect on the date as shown in the Schedule.

  
Secretary

  
President



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

## **COST OF LIVING ADJUSTMENT RIDER**

This Rider is made a part of the Policy to which it is attached. This Rider is issued in consideration of an added premium that is included in the Policy's premium and of the applications for this Rider and the Policy. This Rider amends the Policy by adding the following:

### **DEFINITIONS**

When used in this Rider:

**CPI-U** means the Consumer Price Index for All Urban Consumers. It is published by the Bureau of Labor Statistics of the United States Department of Labor. If the CPI-U is stopped or if it is greatly changed, we may use some other index that is issued nationwide. An index like in scope and purpose to the CPI-U will be used. The term "CPI-U" shall then mean that index.

**Review Date** means each anniversary date of the start of a period of total disability.

**Index Month** means the calendar month that is 3 months prior to the Review Date. But, the first Index Month shall mean the calendar month that is 3 months prior to the start of a period of total disability. Each change in the CPI-U will be gauged from the first Index Month.

**Adjusted Total Disability Monthly Benefit** means the Total Disability Monthly Benefit plus the Cost of Living Adjustment.

### **COST OF LIVING ADJUSTMENT**

The Cost of Living Adjustment will be computed on each Review Date. In order to do this, we will compare the CPI-U for the most recent Index Month to the one for the first Index Month.

Computations of the Cost of Living Adjustment on a Review Date will end on the earliest of:

- (1) the date that a period of total disability shall end;
- (2) the date that the Maximum Total Disability Benefit has been reached; or
- (3) the date of your Renewal Age birthday.

If the computations end because of (1) or (2) above, then the Total Disability Monthly Benefit which is payable at the start of a later period of total disability will not include the Cost of Living Adjustment. A new first Index Month and Review Date will apply to such a later period of total disability.

If the computations end because of (3) above and if you should qualify for a Total Disability Monthly Benefit after your Renewal Age birthday for a period of total disability that starts prior to your Renewal Age birthday, we will pay you the same Adjusted Total Disability Monthly Benefit which was payable just prior to your Renewal Age birthday. No computations will be made after your Renewal Age birthday.

If injury or sickness shall result in a period of total disability that lasts at least one year, then your Total Disability Monthly Benefit will be adjusted as follows:

- (1) For any Total Disability Monthly Benefit which accrues on or after each Review Date, we will pay you instead the Adjusted Total Disability Monthly Benefit.
- (2) On each Review Date, the Adjusted Total Disability Monthly Benefit will be computed by taking the Total Disability Monthly Benefit and multiplying it by a factor that is equal to the CPI-U for the most recent Index Month. That product will then be divided by the CPI-U for the first Index Month. But, the Adjusted Total Disability Monthly Benefit will not:
  - (a) be paid if you are working for pay;
  - (b) be more than the Total Disability Monthly Benefit increased at 6% compounded annually from the first to the most recent Index Month;
  - (c) be more than 2 times the Total Disability Monthly Benefit; or
  - (d) be less than the amount of the Total Disability Monthly Benefit.
- (3) If you are paid a Total Disability Monthly Benefit under the Presumed Total Disability section of the Policy, an Adjusted Total Disability Monthly Benefit will only be paid if you are not working for pay.

#### **RIDER PREMIUM**

The premium for this Rider is shown on the Schedule page of the Policy. The rider premium will be included in the total premium charged for the Policy and any optional policy riders.

#### **RIDER EFFECTIVE DATE**

The effective date of this Rider is the same as the Policy Date of Issue unless a different effective date has been given to this rider as stated in the Policy Schedule.

#### **TIME LIMIT ON CERTAIN DEFENSES**

The Policy's Time Limit on Certain Defenses provision will apply to this Rider as of the Rider Effective Date.

#### **TERMINATION**

This Rider will terminate on the earliest of:

- (1) the due date of any Policy or Rider premium not paid before the Grace Period ends;
- (2) the date your Policy terminates for any reason;
- (3) the date you request termination; or
- (4) the date of the first Policy renewal date that follows your Renewal Age birthday.

This Rider is signed by our President and Secretary in Peoria, Illinois. This Rider is dated and takes effect on the date as shown in the Schedule.

  
Secretary

  
President



ILLINOIS MUTUAL®  
Life Insurance Company

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

## RESIDUAL DISABILITY BENEFIT RIDER

This Rider is made a part of the Policy to which it is attached. This Rider is issued in consideration of an added premium that is included in the Policy's total premium and of the applications for this Rider and the Policy. If you qualify for both a Residual Disability Monthly Benefit and a Partial Disability Monthly Benefit, you will receive the greater benefit of the two, but not both. This Rider also amends said Policy by adding the following:

### DEFINITIONS

When used in this Rider:

**Monthly Income** means your monthly income from your occupation from salary, wages, bonuses, commissions, fees or other pay for personal services. Normal and customary business expenses are to be deducted. Income taxes are not to be deducted. Monthly Income must be earned for services performed by you. It does not include dividends, rent, royalties, annuities or other forms of unearned income.

**Prior Monthly Income** means the greater of:

- (1) your average Monthly Income during the 12 months just prior to the start of the period of disability for which claim is made; or
- (2) your average Monthly Income during the calendar year just prior to the start of that period of disability.

**Current Monthly Income** means your Monthly Income for each month of your residual disability.

**Loss of Monthly Income** means the difference between Prior Monthly Income and Current Monthly Income. Loss of Monthly Income must be caused by the residual disability for which claim is made. The difference must equal at least 20% of Prior Monthly Income to be considered Loss of Monthly Income. If Loss of Monthly Income is more than 80% of Prior Monthly Income, we will consider it to be 100%.

**Residual Disability** means that due to injury or sickness in and of itself:

- (1) if you are working in your occupation and you are unable to do one or more of the substantial and material duties of your occupation at the time of your disability or you are unable to do said duties for as long as they usually require;
- (2) your Loss of Monthly Income is at least 20% of your Prior Monthly Income; and
- (3) you are under the regular care of a physician.

**Residual Disability Monthly Benefit** means the benefit payable under this provision. It is determined monthly by this formula:

$$\frac{\text{Loss of Monthly Income}}{\text{Prior Monthly Income}} \times \text{Total Disability Monthly Benefit} = \text{Residual Disability Monthly Benefit}$$

## **BENEFITS**

We will pay the Residual Disability Monthly Benefit during your residual disability as follows:

- (1) The Residual Disability Monthly Benefit starts after the Elimination Period is satisfied as shown in the Schedule. The Elimination Period can be satisfied by any continuous period of total and/or residual disability.
- (2) Benefits are not payable for any period when a Total Disability Monthly Benefit is payable.
- (3) Benefits are payable until the earliest of the following:
  - (a) the date your residual disability ends;
  - (b) the date the Maximum Total Disability Benefit Period, as shown in the Schedule, has been reached; or
  - (c) the date of your Renewal Age birthday.

But, if you are age 55 or older when a period of residual disability starts and it is not preceded by at least 180 days of total disability due to the same or related cause, the Residual Disability Monthly Benefit is payable for no longer than 24 months or to Renewal Age, if earlier.

- (4) for each of the first 6 months of residual disability your benefit will be the greater of:
  - (a) 50% of the Total Disability Monthly Benefit; or
  - (b) the Residual Disability Monthly Benefit.

Nothing in this provision changes the definition of Total Disability in the Policy.

## **EVIDENCE OF MONTHLY INCOME**

We may require any evidence which is needed to determine your Current Monthly Income and Prior Monthly Income prior to and during a period of residual disability. From time to time, we may require certified audits to verify such evidence.

## **RECURRENT DISABILITY**

A recurrence of your residual disability from the same or related causes will be considered a continuation of the prior period unless you have been engaged in your occupation for more than 6 continuous months.

## **WAIVER OF PREMIUM**

For periods of total and/or residual disability starting before Renewal Age, the Waiver of Premium Provision in the Policy is replaced by the following:

### **WAIVER OF PREMIUM PROVISION – TOTAL DISABILITY AND RESIDUAL DISABILITY**

If injury or sickness causes your total and/or residual disability for 90 continuous days, we will waive the payment of any premiums which become due during your continuous period of disability. We shall refund any premiums which you paid during such 90-day period and which became due after your disability started. At the end of a period of total and/or residual disability during which premiums were waived, this Policy will stay in force until the next premium due date. At the end of a period of total and/or residual disability during which premiums were waived, we will notify you when the next premium payment from you is due. You will then have the right to resume payment of premiums for this Policy.

### **RIDER PREMIUM**

The premium for this Rider is shown on the Schedule page of the Policy. The rider premium will be included in the total premium charged for the Policy and any optional policy riders.

### **RIDER EFFECTIVE DATE**

The effective date of this Rider is the same as the Policy Date of Issue unless a different effective date has been given to this rider as stated in the Policy Schedule.

### **TIME LIMIT ON CERTAIN DEFENSES**

The Policy's Time Limit on Certain Defenses provision will apply to this Rider as of the Rider Effective Date.

### **TERMINATION**

This Rider will terminate on the earliest of:

- (1) the due date of any Policy or Rider premium not paid before the Grace Period ends;
- (2) the date your Policy terminates for any reason;
- (3) the date you request termination; or
- (4) the date of the first Policy renewal date that follows your Renewal Age birthday.

This Rider is signed by our President and Secretary in Peoria, Illinois. This Rider is dated and takes effect on the date as shown in the Schedule.

  
Secretary

  
President

**RESIDUAL DISABILITY BENEFIT  
WITH COST OF LIVING ADJUSTMENT RIDER**

This Rider is made a part of the Policy to which it is attached. This Rider is issued in consideration of an added premium that is included in the Policy's total premium and of the applications for this Rider and the Policy. If you qualify for both a Residual Disability Monthly Benefit and a Partial Disability Monthly Benefit, you will receive the greater benefit of the two, but not both. This Rider also amends said Policy by adding the following:

**DEFINITIONS**

When used in this Rider:

**Monthly Income** means your monthly income from your occupation from salary, wages, bonuses, commissions, fees or other pay for personal services. Normal and customary business expenses are to be deducted. Income taxes are not to be deducted. Monthly Income must be earned for services performed by you. It does not include dividends, rent, royalties, annuities or other forms of unearned income.

**Prior Monthly Income** means the greater of:

- (1) your average Monthly Income during the 12 months just prior to the start of the period of disability for which claim is made; or
- (2) your average Monthly Income during the calendar year just prior to the start of that period of disability.

**Current Monthly Income** means your Monthly Income for each month of your residual disability.

**Loss of Monthly Income** means the difference between Prior Monthly Income and Current Monthly Income. Loss of Monthly Income must be caused by the residual disability for which claim is made. The difference must equal at least 20% of Prior Monthly Income to be considered Loss of Monthly Income. If Loss of Monthly Income is more than 80% of Prior Monthly Income, we will consider it to be 100%.

**Residual Disability** means that due to injury or sickness in and of itself:

- (1) if you are working in your occupation and you are unable to do one or more of the substantial and material duties of your occupation at the time of your disability or you are unable to do said duties for as long as they usually require;
- (2) your Loss of Monthly Income is at least 20% of your Prior Monthly Income; and
- (3) you are under the regular care of a physician.

**Residual Disability Monthly Benefit** means the benefit payable under this provision. It is determined monthly by this formula:

$$\frac{\text{Loss of Monthly Income}}{\text{Prior Monthly Income}} \times \text{Total Disability Monthly Benefit} = \text{Residual Disability Monthly Benefit}$$

## DEFINITIONS (cont.)

**CPI-U** means the Consumer Price Index for All Urban Consumers. It is published by the Bureau of Labor Statistics of the United States Department of Labor. If the CPI-U is stopped or if it is greatly changed, we may use some other index that is issued nationwide. An index like in scope and purpose to the CPI-U will be used. The term "CPI-U" shall then mean that index.

**Review Date** means each anniversary date of the start of a period of total or residual disability.

**Index Month** means the calendar month that is 3 months prior to the Review Date. But, the first Index Month shall mean the calendar month that is 3 months prior to the start of a period of residual disability. Each change in the CPI-U will be gauged from the first Index Month.

**Adjusted Residual Disability Monthly Benefit** means the Residual Disability Monthly Benefit plus the Cost of Living Adjustment.

## RESIDUAL DISABILITY BENEFITS

We will pay the Residual Disability Monthly Benefit during your residual disability as follows:

- (1) The Residual Disability Monthly Benefit starts after the Elimination Period is satisfied as shown in the Schedule. The Elimination Period can be satisfied by any continuous period of total and/or residual disability.
- (2) Benefits are not payable for any period when a Total Disability Monthly Benefit is payable.
- (3) Benefits are payable until the earliest of the following:
  - (a) the date your residual disability ends;
  - (b) the date the Maximum Total Disability Benefit Period, as shown in the Schedule, has been reached; or
  - (c) the date of your Renewal Age birthday.

But, if you are age 55 or older when a period of residual disability starts and it is not preceded by at least 180 days of total disability due to the same or related cause, the Residual Disability Monthly Benefit is payable for no longer than 24 months or to your Renewal Age, if earlier.

- (4) for each of the first 6 months of residual disability your benefit will be the greater of:
  - (a) 50% of the Total Disability Monthly Benefit; or
  - (b) the Residual Disability Monthly Benefit.

Nothing in this provision changes the definition of Total Disability in the Policy.

### **COST OF LIVING ADJUSTMENT BENEFIT**

The Cost of Living Adjustment will be computed on each Review Date. In order to do this, we will compare the CPI-U for the most recent Index Month to the one for the first Index Month.

Computations of the Cost of Living Adjustment on a Review Date will end on the earliest of:

- (1) the date your residual disability ends;
- (2) the date the Maximum Total Disability Benefit Period is reached; or
- (3) the date of your Renewal Age birthday.

If the computations end, then the Residual Disability Monthly Benefit which is payable at the start of a later period of residual disability will not include the Cost of Living Adjustment unless the later period of residual disability is a recurrent disability, as defined below. If the later period of residual disability is a recurrent disability, as defined below, we will continue to make computations as though the prior period did not end.

If injury or sickness shall result in a period of continuous total and/or residual disability that lasts at least one year, then your Residual Disability Monthly Benefit will be adjusted as follows:

- (1) for any Residual Disability Monthly Benefit which accrues on or after each Review Date, we will pay you instead the Adjusted Residual Disability Monthly Benefit.
- (2) On each Review Date, the Adjusted Residual Disability Monthly Benefit will be computed by multiplying the Residual Disability Monthly Benefit by the CPI-U for the most recent Index Month. That product will then be divided by the CPI-U for the first Index Month. But, the Adjusted Residual Disability Monthly Benefit will not:
  - (a) be more than the Residual Disability Monthly Benefit increased at 6% compounded annually from the first to the most recent Index Month;
  - (b) be more than 2 times the Residual Disability Monthly Benefit; or
  - (c) be less than the amount of the Residual Disability Monthly Benefit.

### **EVIDENCE OF MONTHLY INCOME**

We may require any evidence which is needed to determine your Current Monthly Income and Prior Monthly Income prior to and during a period of residual disability. From time to time, we may require audits to verify such evidence.

### **RECURRENT DISABILITY**

A recurrence of your residual disability from the same or related causes will be considered a continuation of the prior period unless you have been engaged in your occupation for more than 6 continuous months.

## WAIVER OF PREMIUM

For periods of total and/or residual disability starting before your Renewal Age, the Waiver of Premium Provision in the Policy is replaced by the following:

### WAIVER OF PREMIUM PROVISION – TOTAL DISABILITY AND RESIDUAL DISABILITY

If injury or sickness causes your total and/or residual disability for 90 continuous days, we will waive the payment of any premiums which become due during your continuous period of disability. We shall refund any premiums which you paid during such 90-day period and which became due after your disability started. At the end of a period of total and/or residual disability during which premiums were waived, this Policy will stay in full force until the next premium due date. At the end of a period of total and/or residual disability during which premiums were waived, we will notify you when the next premium payment from you is due. You will then have the right to resume payment of premiums for this Policy.

### RIDER PREMIUM

The premium for this Rider is shown on the Schedule page of the Policy. The rider premium will be included in the total premium charged for the Policy and any optional policy riders.

### RIDER EFFECTIVE DATE

The effective date of this Rider is the same as the Policy Date of Issue unless a different effective date has been given to this rider as stated in the Policy Schedule.

### TIME LIMIT ON CERTAIN DEFENSES

The Policy's Time Limit on Certain Defenses provision will apply to this Rider as of the Rider Effective Date.

### TERMINATION

This Rider will terminate on the earliest of:

- (1) the due date of any Policy or Rider premium not paid before the Grace Period ends;
- (2) the date your Policy terminates for any reason;
- (3) the date you request termination; or
- (4) the date of the first Policy renewal date that follows your Renewal Age birthday.

This Rider is signed by our President and Secretary in Peoria, Illinois. This Rider is dated and takes effect on the date shown in the Schedule.

  
Secretary

  
President

**INTEGRATED MONTHLY BENEFIT  
RIDER**

This Rider is made a part of the Policy to which it is attached. This Rider is issued in consideration of an added premium that is included in the Policy's total premium and of the applications for this Rider and the Policy. This Rider amends the Policy by adding the following:

**DEFINITIONS**

When used in this Rider:

**Maximum Integrated Monthly Benefit** means the amount of the Maximum Integrated Monthly Benefit shown in the Schedule.

**Social Insurance Benefit** means your eligibility to receive payments from the following programs:

- (1) The Federal Social Security Act, which includes primary or family disability benefits for which you may become eligible. Any payment under Social Security Retirement provisions will be considered as disability benefits.
- (2) Any Worker's Compensation Act or Law or Occupational Disease Law benefit for which you may become eligible in any state or territory of the United States or similar act or law of any other country.
- (3) The Railroad Retirement Act, which includes primary or family disability benefits. Any payment resulting from the Retirement option will be considered as disability benefits.
- (4) Any Federal, State, County, Municipal or other government subdivision retirement and disability fund for which you may be eligible. Any payment resulting from retirement will be considered as disability benefits.

**Integrated Monthly Benefit** means the amount that will be added to your Total Disability Monthly Benefit. The amount of the Integrated Monthly Benefit depends upon the amount of a Social Insurance Benefit to which you are entitled.

- (1) If you receive no Social Insurance Benefit, the Integrated Monthly Benefit is the Maximum Integrated Monthly Benefit.
- (2) If you receive a Social Insurance Benefit, the Integrated Monthly Benefit is the Maximum Integrated Monthly Benefit minus the Social Insurance Benefit you receive.
- (3) If you receive a Social Insurance Benefit that is equal to or greater than the Maximum Integrated Monthly Benefit, the Integrated Monthly Benefit is zero.
- (4) If you receive a lump sum payment under a Social Insurance Benefit, it will be treated as if it was received over several months. The lump sum will be divided by the Maximum Integrated Monthly Benefit. The result will be the number of months that the Integrated Monthly Benefit will not be paid. Any remainder reduces the next payable Integrated Monthly Benefit. We will not seek a refund of benefits paid before the lump sum was received.

## **DEFINITIONS (cont.)**

Any legislated automatic increases in your Social Insurance Benefit during a period of total disability will not be included in the calculation of the Integrated Monthly Benefit.

## **BENEFITS**

We will pay the Integrated Monthly Benefit if injury or sickness in and of itself shall cause your total disability. The Integrated Monthly Benefit will start to accrue on the day of total disability after the Elimination Period shown in the Schedule has been satisfied. It will be added to and paid with the Total Disability Monthly Benefit. The Integrated Monthly Benefit will continue to be paid for as long as total disability continues but not beyond the Maximum Total Disability Benefit Period shown in the Schedule.

## **PROOF OF SOCIAL INSURANCE BENEFIT**

Before any payments under this Rider can be made, we must receive satisfactory evidence as to your eligibility to receive payments under a Social Insurance Benefit. For each Social Insurance Benefit this may, at the option of the Company, include:

- (1) Proof that an application has been made for payments under a Social Insurance Benefit.
- (2) Written authorization for us to receive information as to the status of that application.
- (3) Proof that the application has been approved or disapproved.
- (4) If disapproved, proof that the appeals process has been followed and approval or disapproval received.
- (5) If the application or appeal has been approved, proof of the amounts payable under the Social Insurance Benefit.

We have the right to pursue any further appeals process that may be available to you. Any appeal by us will be at no cost to you.

We also have the right, at any time, to require proof that you continue to be totally disabled and that you are, or are not, receiving a Social Insurance Benefit.

## **RIDER PREMIUM**

The premium for this Rider is shown on the Schedule page of the Policy. The rider premium will be included in the total premium charged for the Policy and any optional policy riders.

## **RIDER EFFECTIVE DATE**

The effective date of this Rider is the same as the Policy Date of Issue unless a different effective date has been given to this rider as stated in the Policy Schedule.

## **TIME LIMIT ON CERTAIN DEFENSES**

The Policy's Time Limit on Certain Defenses provision will apply to this Rider as of the Rider Effective Date.

## TERMINATION

This Rider terminates on the earliest of:

- (1) the due date of any Policy or Rider premium not paid before the Grace Period ends;
- (2) the date your Policy terminates for any reason;
- (3) the date you request termination;
- (4) the date disability benefits under the Federal Social Security Act are eliminated; or
- (5) the date of the first Policy renewal following your Renewal Age birthday.

This Rider is signed by our President and Secretary in Peoria, Illinois. This Rider is dated and takes effect on the date as shown in the Schedule.



Secretary



President



**FULL BENEFITS FOR MENTAL OR NERVOUS DISORDERS, ALCOHOLISM OR DRUG ABUSE RIDER**

This Rider is made a part of the Policy to which it is attached. This Rider is issued in consideration of an added premium that is included in the Policy's total premium and of the application for this Rider and the Policy.

This Rider amends the Policy by deleting the Policy provision entitled "LIMITED BENEFITS FOR MENTAL OR NERVOUS DISORDERS, ALCOHOLISM OR DRUG ABUSE". While this Rider remains in force, Total Disability caused or contributed to by Mental or Nervous Disorder or Alcoholism or Drug Abuse will be treated as any other Sickness under the Policy.

**RIDER PREMIUM**

The premium for this Rider is shown in the Schedule.

**RIDER EFFECTIVE DATE**

The effective date of this Rider is the same as the Policy Date of Issue unless a different effective date has been given to this rider as stated in the Policy Schedule.

**TIME LIMIT ON CERTAIN DEFENSES**

The Policy's Time Limit on Certain Defenses provision will apply to this Rider as of the Rider Effective Date.

**TERMINATION**

This Rider terminates on the earliest of:

- (1) The due date of any Policy or Rider premium not paid before the Grace Period ends;
- (2) The date your Policy terminates for any reason;
- (3) The date you request termination; or
- (4) Your Renewal Age shown in the Schedule.

This Rider is signed by our President and Secretary in Peoria, Illinois. This Rider is dated and takes effect on the date shown in the Schedule.



Secretary



President



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

## RETURN OF PREMIUM RIDER

This Rider is made a part of the Policy to which it is attached. This Rider is issued in consideration of an added premium included in the Policy's total premium and of the applications for this Rider and the Policy. This Rider amends the Policy by adding the following:

The Return of Premium Amount, if any, of this Policy is the amount, if any, by which (a) the total of all premiums paid for this Policy multiplied by the appropriate percentage in the Table of Return of Premium Percentages shown in the Policy Schedule exceeds (b) the total of all benefits paid under this Policy.

The Return of Premium Amount, if any, will be paid: (a) upon Owner's written request at any time; (b) upon lapse of this Policy; (c) upon receipt of proof of your death; or (d) on the termination of this Policy. The Company may require the surrender of this Policy as a condition to the payment of its Return of Premium Amount.

If the Policy is renewed after your Renewal Age then the Return of Premium Amount at that time will be held at interest until Policy termination at which time the Return of Premium Amount plus interest will be paid less any claims paid after the Renewal Age renewal. The interest rate credited will be that paid by the Company for funds held on deposit. After the Renewal Age renewal no premiums will be charged for this Rider and no premiums paid for the Policy will be applied to a determination of the Return of Premium Amount.

Any premium waived under the Waiver of Premium Provision of this Policy will be considered a paid premium when determining the total premiums paid for this Policy and also as a benefit paid when determining the total benefits paid under this Policy.

Upon payment of the Return of Premium Amount, this Policy will terminate as of the date to which the Return of Premium Amount is computed. Thereafter, it may not be reinstated. Any benefits which accrue under this Policy after the Return of Premium Amount has been paid will be payable only to the extent that such benefits exceed the amount of the Return of Premium Amount paid.

This Rider does not waive, extend or change said Policy except as stated herein.

IN WITNESS WHEREOF, this Rider is signed by our President and Secretary in Peoria, Illinois. This Rider is dated and effective on the Date of Issue of said Policy.

  
Secretary

  
President



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

## GUARANTEED INSURABILITY OPTION RIDER

This Rider is made a part of the Policy to which it is attached. This Rider is issued in consideration of an added premium that is included in the Policy's total premium and of the applications for this Rider and the Policy. This Rider amends the Policy by adding the following:

You will have the right, before your 55th birthday, without giving evidence of insurability as to your health, to purchase additional Total Disability Monthly Benefits, subject to the following:

- (1) The first purchase must be made at least 24 months after the Date of Issue of this Policy. No more than 5 purchases may be made. Each purchase must be 24 consecutive months or more apart. In the event that you have a life change which is defined as a marriage, death of a spouse, divorce or birth or adoption of a child, you may accelerate a purchase but the next purchase will follow based upon the normal 24 month sequence. A request to accelerate a purchase due to a life change must be made within three months of the life change. Purchases made due to a life change will not increase the 5 total purchases that may be made. We will require reasonable proof of life changes to accelerate a purchase date.
- (2) Each purchase will be subject to:
  - (a) our writing and participation limits;
  - (b) our underwriting requirements with respect to your earnings, sex, age and occupation at the time of such purchase; and
  - (c) any impairment rating or exclusion of coverage that had been applied to this Policy and is still in effect at the time of such purchase.
- (3) Each purchase may be for an amount of Total Disability Monthly Benefit up to the Maximum Per Purchase shown in the Schedule. The minimum purchase is \$100. You must apply for each purchase and pay the first premium.
- (4) A new policy will be issued when your application is approved. The new policy will be on a current form we use that is most similar to this Policy. Each new policy will be issued with an elimination period that is the same or longer than this Policy. Each new policy will have the same or shorter maximum benefit period than this Policy.
- (5) Each new policy will provide benefits only with respect to total or partial disabilities that start after the effective date of the new policy.
- (6) We reserve the right to approve the addition of any optional benefits or riders to each new policy.

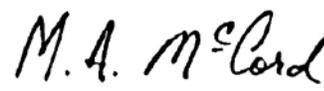
## TERMINATION

This Rider will terminate on the earliest of:

- (1) the due date of any Policy or Rider premium not paid before the Grace Period ends;
- (2) the date your Policy terminates for any reason;
- (3) the date you request termination; or
- (4) the date of the first Policy renewal date that follows your 55th birthday.

This Rider is signed by our President and Secretary in Peoria, Illinois. This Rider is dated and takes effect on the date as shown in the Schedule.

  
Secretary

  
President

# Application for Disability Insurance Option to Purchase

I have chosen to exercise my option to purchase additional disability insurance as provided by the Rider attached to and made a part of Policy No. \_\_\_\_\_ .

**1. Proposed Insured**

- 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. Date of Birth \_\_\_\_\_
- f. Is a life change prompting exercise of option?  Yes  No  
 If yes, select one of the following:  Marriage  Birth or Adoption of Child  Divorce  Death of Spouse
- g. In the past 12 months, have you used any form of tobacco or nicotine-based product?  Yes  No

**2. Individual Disability Plan Information**

**Base Monthly Benefit Amount \$** \_\_\_\_\_ (Amount cannot exceed the Maximum Per Purchase stated in the Schedule of your base policy.)

**Elimination Period:** (Must be the same or longer than the elimination period of your base policy.)

- 30 Day  60 Day  90 Day  180 Day  1 Year  2 Year

**Benefit Period:** (Must be the same or shorter than the benefit period of your base policy.)

- 6 Month  1 Year  2 Year  5 Year  10 Year  To Age 67

**Optional Benefit Riders**

- Return of Premium Beneficiary \_\_\_\_\_ Relationship \_\_\_\_\_
- Other \_\_\_\_\_

**3. Business Expense Plan Information**

**Base Monthly Benefit Amount \$** \_\_\_\_\_ (Amount cannot exceed the Maximum Per Purchase stated in the Schedule of your base policy.)

**Elimination Period:** (Must be the same or longer than the elimination period of your base policy.)

- 30 Day  60 Day  90 Day

**Benefit Period:** (Must be the same or shorter than the benefit period of your base policy.)

- 12 Months  18 Months  24 Months

**Optional Benefit Riders**

- Surrender Value (SVR) SVR Beneficiary \_\_\_\_\_ Relationship \_\_\_\_\_
- Other \_\_\_\_\_

**Business Expense Details**

Indicate your share of current, ongoing, average monthly fixed business expenses. Include Mortgage and Other Business Interest (but not principal), Rent or Lease, Property and Casualty Insurance, Property and Payroll Taxes, Depreciation, Office Maintenance, Utilities, Periodicals, Magazines and Professional Dues, Professional Services Fees, and Employees' Salaries. Exclude salary, fees or other remuneration received by you, by a partner(s) or by any other member of your profession employed or working with you.

**Total Average Monthly Expenses \$** \_\_\_\_\_

**4. Employment and Income Information**

- 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. Indicate earned income from primary occupation as reported for federal income tax purposes. If self-employed or owner/employee (more than 20% ownership), also indicate share of after-tax net profit (loss) after business expenses.  
(1) Current Monthly Income \$ \_\_\_\_\_ (2) Income Last Year \$ \_\_\_\_\_

**5. Other Disability Insurance**

Do you have, are you applying for, or will you become eligible for, any disability insurance plan or benefit?  Yes  No

If yes, list below all: (1) Individual Disability, (2) Group Disability, (3) Sick Leave or Salary Continuation, (4) Disability Retirement/Pension, (5) Business Overhead Expense, or (6) Any other coverage which provides disability benefits.

Company or Source	Pending (P) In Force (I) Eligible (E) Replacing (R)	Type (1 - 6)	Monthly Amt. or Percent of Income	Maximum Benefit Cap	Elim. Period	Benefit Period	Coordinates w/ Soc. Security?	Employer Paid?
_____	_____	_____	_____	_____	_____	_____	<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

**6. Owner (If other than the Proposed Insured)**

- a. Name \_\_\_\_\_ b. Social Security or Tax ID Number \_\_\_\_\_
- c. Address \_\_\_\_\_  
STREET CITY STATE ZIP CODE

**Home Office Endorsement Only.** Question No. \_\_\_\_\_ 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.

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.)

**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: (Required when Agent completes Application):** I,  do  do not, have knowledge that the insurance applied for will replace any existing disability insurance.

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

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

Agent's E-mail \_\_\_\_\_

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.

# Application for Disability Insurance

## PART A

### 1. Proposed Insured

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. Are you a U.S. Citizen?  Yes  No  
 (1) If no, have you resided in the U.S. for the past 5 years?  Yes  No  
 (1a.) If yes, have you been granted permanent resident (green card) status?  Yes  No

i. In the past 12 months, have you used any form of tobacco or nicotine-based product?  Yes  No

j. Occupation and duties:  
 \_\_\_\_\_

### 2. Individual Disability Plan Information

**Base Monthly Benefit Amount \$** \_\_\_\_\_

**Elimination Period:**  30 Day  60 Day  90 Day  180 Day  1 Year

**Benefit Period:**  6 Month  1 Year  2 Year  5 Year  10 Year  To Age 67

**Optional Benefit Riders**

Activities of Daily Living (ADL) Monthly Amount \$ \_\_\_\_\_  2 Year  5 Year  To Age 67

Cost of Living Adjustment (COLA)

Critical Illness Benefit Amount \$ \_\_\_\_\_

Extended Own Occupation Period  5 Year  To Age 67

Guaranteed Insurability Option (GIO)  \$100  \$200  \$300  \$400  \$500  \$600

Integrated Monthly Benefit Amount \$ \_\_\_\_\_

Mental/Nervous Benefit

Non-Can

Pure Own Occupation Period  2 Year  5 Year

Residual Disability Benefit

Retroactive Injury Benefit

Return of Premium Beneficiary \_\_\_\_\_ Relationship \_\_\_\_\_

### 3. Business Expense Plan Information

**Base Monthly Benefit Amount \$** \_\_\_\_\_

**Elimination Period:**  30 Day  60 Day  90 Day

**Benefit Period:**  12 Months  18 Months  24 Months

**Optional Benefit Riders**

Guaranteed Insurability Option (GIO)  \$100  \$200  \$300  \$400  \$500  \$600

Mental/Nervous Benefit

Pure 2 Year Own Occupation Period

Retroactive Injury Benefit

Return of Premium Beneficiary \_\_\_\_\_ Relationship \_\_\_\_\_

### Business Expense Details

Indicate your share of current, ongoing, average monthly fixed business expenses. Include Mortgage and Other Business Interest (but not principal), Rent or Lease, Property and Casualty Insurance, Property and Payroll Taxes, Depreciation, Office Maintenance, Utilities, Periodicals, Magazines and Professional Dues, Professional Services Fees, and Employees' Salaries. Exclude salary, fees or other remuneration received by you, by a partner(s) or by any other member of your profession employed or working with you.

**Total Average Monthly Expenses \$** \_\_\_\_\_





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

POLICY FORM DI105

DISABILITY INCOME PROTECTION COVERAGE  
REQUIRED OUTLINE OF COVERAGE

(1) **READ YOUR POLICY CAREFULLY.** This Outline of Coverage gives a very brief description of the features of your Policy. This is not the insurance contract. Only the actual Policy provisions will control. The Policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is important that you **READ YOUR POLICY CAREFULLY!**

(2) **DISABILITY INCOME PROTECTION COVERAGE** is designed to provide you with coverage for disabilities resulting from a covered injury or sickness. Coverage is provided by the benefits described in Paragraph (3). The benefits described in Paragraph (3) may be limited by Paragraph (4). Coverage is not provided for basic hospital, basic medical-surgical or major medical expenses.

(3) **BENEFITS –**

A. Total Disability Monthly Benefit..... \$ \_\_\_\_\_/mo.  Included

If an injury or a sickness causes you to be totally disabled, we will pay this Benefit to you. Payment to you shall start after the \_\_\_\_\_ day Elimination Period has been satisfied. We will pay you up to \_\_\_\_\_. But, if this Policy is renewed on or after the renewal date next after your 67th birthday and you become totally disabled after that date, this Benefit will only be paid for a total of 24 months.

B. Partial Disability Monthly Benefit..... \$ \_\_\_\_\_/mo.  Included

This Benefit will be paid to you if injury or sickness causes your partial disability. It will be paid for up to 6 months. Payment to you shall start after the \_\_\_\_\_ day Elimination Period has been satisfied.

C. Presumed Total Disability .....  Included

If an injury or a sickness causes the total and irrecoverable loss of sight in both eyes, hearing of both ears, or speech, or in the total and irrecoverable loss of the use of both hands, both feet or a hand and a foot, you will be presumed to be totally disabled. Such disability shall start with the date of your loss. It shall continue up to the longest length of time that benefits can be paid. Such disability shall continue whether or not you are under the care of a physician. It shall continue whether or not you are able to work.

D. Total Loss of Sight and Double Dismemberment Monthly Benefit..... \$ \_\_\_\_\_  Included

If an injury or a sickness shall cause the loss, by actual severance, of both hands, or both feet, or a hand and a foot, or irrecoverable loss of sight of both eyes, this Benefit will be paid. Payment shall be equal to Benefit A, above. Payment of this Benefit shall start with the day of such loss. It shall be paid up to your maximum benefit period or 24 months, whichever is less. It shall be paid in addition to any other benefits.

E. Retraining and Home Modification Benefit.....\$\_\_\_\_\_  Included

If benefits have been paid to you for at least 6 months in a row for total disability and you continue to be totally disabled, up to the amount of this Benefit will be payable. This Benefit provides for the actual expense of tuition, books and equipment at a licensed college, vocational or business school for a formal retraining program. It also provides for the actual costs to modify your home to accommodate your disabling condition. The amount of this Benefit is up to 6 times Benefit A above.

**Not Included if Maximum Benefit Period is less than 12 months.**

F. Organ Donor Benefit .....  Included

If you become totally disabled as a result of giving one of your organs Benefit A will be paid to you. Your Policy must have been in force at least 6 months for Benefit A to be payable for this reason. No Elimination Period will apply to this Benefit.

G. Survivor Benefit.....  Included

If you die during a current period of total disability and have been receiving Benefit A for 6 continuous months, we will pay 4 times the amount of Benefit A to your spouse, if living, otherwise to your estate.

**Not Included if Maximum Benefit Period is 6 months.**

H. Waiver of Premium.....  Included

When you have been totally disabled for 3 consecutive months, we will waive the premiums that follow. We will continue to waive them for as long as your total disability continues. All premiums paid in the first 3 months of your total disability will be returned to you.

I. Automatic Increase Benefit Rider, Form 9252 .....  Included

Your Total Disability Monthly Benefit will increase automatically on the first premium due date on or after each of the first five policy anniversaries. The amount of the increase will be 3% times the Total Disability Monthly Benefits at policy issue. Increases will not be offered on any policy anniversary on which you are disabled or your amount of total coverage would exceed our issue and participation limits. You may decline to accept an increase, but if you decline, you forfeit your right to further increases. There are no premiums charged for this Rider, however when an automatic benefit increase takes place, the Policy premium will increase in accordance with the increase in benefits. The additional benefit premium will be based upon your classification at policy issue and your attained age at the time of the increase.

**Not Included if the monthly benefit is less than \$1,000 or the insured is over age 50.**

J. Optional Non-Cancelable Policy Rider, Form 9251 .....  Included

This Rider provides that as long as the premium is paid by the end of the grace period until the renewal date that follows your 67th birthday, we can not change the premium for this Policy. This would not apply to benefit changes or the addition or termination of Riders after the Date of Issue.

Not Included  
Premium: \$\_\_\_\_\_ Per \_\_\_\_\_

K. Optional Retroactive Injury Rider, Form 9253.....  Included

If injury causes your total disability within 30 days of your injury, Benefit A will be paid from the 1st day of total disability. You must have been continuously totally disabled from your injury for the entire Elimination Period before benefits will be payable.

Not Included  
Premium: \$\_\_\_\_\_ Per \_\_\_\_\_

L. Optional Five Year Own Occupation Extension Rider, Form 9257 .....  
This Rider changes the definition of Total Disability for your own occupation from 24 months to 60 months.  
 Included  
 Not Included  
Premium: \$\_\_\_\_\_ Per  
\_\_\_\_\_

M. Optional Own Occupation Extension To Your Renewal Age Rider, Form 9258.....  
This Rider changes the definition of Total Disability for your own occupation from 24 months to your age 67.  
 Included  
 Not Included  
Premium: \$\_\_\_\_\_ Per  
\_\_\_\_\_

N. Optional Two Year Pure Own Occupation Rider, Form 9255 .....  
This Rider changes the definition of Total Disability during the first 24 months to your inability to perform the substantial and material duties of your occupation only.  
 Included  
 Not Included  
Premium: \$\_\_\_\_\_ Per  
\_\_\_\_\_

O. Optional Five Year Pure Own Occupation Rider, Form 9256 .....  
This Rider changes the definition of Total Disability during the first 60 months to your inability to perform the substantial and material duties of your occupation only.  
 Included  
 Not Included  
Premium: \$\_\_\_\_\_ Per  
\_\_\_\_\_

P. Optional Return of Premium Rider, Form 9266.....  
This Rider provides a return of premium payment. This payment, if any, is the amount by which (a) the total of all premiums paid times the proper percentage is greater than (b) the total of all the benefits paid. The proper percentage is determined by how long the policy is in force. The return of premium payment, if any, is payable (1) upon your request in writing, (2) upon lapse, (3) upon your death, or (4) when you reach age 67. The surrender of the Policy is required in each case.  
 Included  
 Not Included  
Premium: \$\_\_\_\_\_ Per  
\_\_\_\_\_

Q. Optional Guaranteed Insurability Options Rider, Form 9267 .....  
This Rider affords you 5 options to buy more coverage prior to your 55th birthday. Your health status will not be considered. You may choose to exercise your options at any time after 24 months from the Date of Issue. But, each such purchase must be at least 24 months apart. In the event of a life change which is defined as a marriage, death of a spouse, divorce or birth or adoption of a child, you may accelerate a purchase but the next purchase will follow upon the normal 24 month sequence. Each purchase is subject to our issue and participation limits. Each purchase may be for no more than \$\_\_\_\_\_ per month.  
 Included  
 Not Included  
Premium: \$\_\_\_\_\_ Per  
\_\_\_\_\_

R. Optional Integrated Monthly Benefit Rider, Form 9264

..... up to \$\_\_\_\_\_ /mo.

This Rider provides a monthly benefit that is paid in addition to Benefit A after the Elimination Period has been satisfied. The amount of this Benefit will be reduced by any benefits you receive from:

- a. Federal Social Security Act (primary or family benefits) and Social Security retirement benefits.
- b. Worker's Compensation Act or Law or Occupational Disease Law.
- c. The Railroad Retirement Act (primary or family benefits) and retirement benefits.
- d. Federal, State, County, Municipal or other government subdivision retirement and disability fund.

This Benefit will continue to be paid for as long as your total disability continues, but not beyond the Maximum Total Disability Benefit Period.

Included  
 Not Included  
 Premium:  
 \$\_\_\_\_\_ Per  
 \_\_\_\_\_

S. Optional Activities of Daily Living Rider, Form 9259 ... \$\_\_\_\_\_ /mo.

This Benefit will be paid to you up to \_\_\_\_\_ if you are unable to perform 2 or more Activities of Daily Living (ADLs) without stand-by assistance or you are cognitively impaired. Activities of Daily Living are bathing, continence, dressing, eating, toileting, or transferring. You must first satisfy the ADL Elimination Period of \_\_\_\_\_ days.

Included  
 Not Included  
 Premium:  
 \$\_\_\_\_\_ Per  
 \_\_\_\_\_

T. Optional Cost of Living Adjustment Rider, Form 9260 .....

This Rider provides that an increase in Benefit A, above, will start on the second year of your continuous total disability. Benefit A, above, can be increased each year up to 6% compounded annually, based upon the Consumer Price Index for All Urban Consumers, until the benefit doubles, until you reach age 67 or until the end of the benefit period, whichever occurs first; but, your total disability must be continuous. The Adjusted Benefit provided by this Rider will not be paid if you are working for pay.

Included  
 Not Included  
 Premium:  
 \$\_\_\_\_\_ Per  
 \_\_\_\_\_

U. Optional Residual Disability Benefit Rider.....

This Rider provides a monthly benefit if you return to your regular job and suffer a loss of 20% or more of your prior monthly income. Your Benefit is based on your percent of income lost as a result of sickness or injury. We will pay this Benefit to you starting on the \_\_\_\_\_ day of continuous total and/or residual disability. This Rider is available with a Cost of Living Adjustment Benefit. But, it is available with this Rider only if you have also chosen Benefit T.

Included  
 Not Included  
 Premium:  
 \$\_\_\_\_\_ Per  
 \_\_\_\_\_  
 Form 9261 without COLA  
 Form 9263 with COLA

V. Optional Full Benefits for Mental or Nervous Disorders, Alcoholism or Drug Abuse Rider, Form 9265 .....

This Rider amends the Policy to eliminate the limitations for total disability caused or contributed to by mental or nervous disorder or alcoholism or drug abuse to a lifetime benefit maximum of 24 months so that these conditions will be treated as any other sickness.

Included  
 Not Included  
 Premium:  
 \$\_\_\_\_\_ Per  
 \_\_\_\_\_

**(4) EXCEPTIONS AND REDUCTIONS –**

- A. We will pay no benefits for disability that results (a) from normal pregnancy or childbirth; (b) from intentionally self-inflicted injury or sickness; (c) from your commission or attempted commission of a felony; (d) from war, declared or not; (e) from any military service, except during active duty for training of less than 60 days. The pro rata premium will be refunded for a period during which you are not covered for such military reason; or (f) We will not pay disability benefits while you are incarcerated in any penal or correctional institution.
  
- B. Total Disability benefits caused or contributed to by a mental or nervous disorder or alcohol or drug abuse will be limited to a cumulative lifetime maximum of 24 months. This limitation will not apply to any period during which you are confined to a Hospital for one of these conditions. If the Optional Full Benefits for Mental or Nervous Disorders, Alcoholism or Drug Abuse is purchased this limitation will not apply.
  
- C. If you become Totally Disabled due to an injury or sickness sustained or continued while you are outside of the United States, Canada or Mexico your Total Disability Benefit Period will be limited to 90 days. After the 90 day period, benefits will not be paid until you return to the United States, Canada or Mexico.
  
- D. In the first 2 years that this Policy is in force, we will not pay benefits:
  - 1. for a condition which was diagnosed or treated by a physician in the 2 years prior to the Date of Issue; or
  - 2. for a condition which caused symptoms in the 2 years prior to the Date of Issue if it would have caused an ordinarily prudent person to seek medical care.

However, if you fully disclosed such a condition in your application, we will pay benefits unless a Rider excludes such condition by name.

**(5) RENEWABILITY –** This Policy is guaranteed to be renewed until the renewal date that follows your 67th birthday. We have the right to increase the premiums by class unless you purchase the Optional Non-Cancelable Rider. After the renewal date that follows your 67th birthday, it is renewable annually at our option.

**(6) PREMIUM –**

Proposed  
Insured: \_\_\_\_\_ Total Premium: \$\_\_\_\_\_ Per \_\_\_\_\_.  
Total Premium: \$\_\_\_\_\_ Per Year.

The premiums that you pay may change by class unless you purchase the Optional Non-Cancelable Rider. Each Policy has a 31 day grace period.

\_\_\_\_\_  
Date

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

**RETAIN FOR YOUR RECORDS**

SERFF Tracking Number: LLNS-126599604 State: Arkansas  
 Filing Company: Illinois Mutual Life Insurance Company State Tracking Number: 45575  
 Company Tracking Number: DI105(AR)  
 TOI: H111 Individual Health - Disability Income Sub-TOI: H111.003 Long Term - Unrelated to marketing  
 with employer or association groups  
 Product Name: Disability Income  
 Project Name/Number: Disability Income/DI105

## Supporting Document Schedules

		<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b>	Flesch Certification	Approved-Closed	05/05/2010
<b>Comments:</b>			
<b>Attachment:</b>			
Readability.pdf			

		<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b>	Application	Approved-Closed	05/05/2010
<b>Comments:</b>	Applications are being submitted for review and are attached to the Forms Schedule tab of this filing.		

		<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b>	Outline of Coverage	Approved-Closed	05/05/2010
<b>Comments:</b>	Outlines of Coverage are attached to the Forms Schedule Tab of this filing and are being submitted for your review and approval.		

## READABILITY CERTIFICATION

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:

50.0%	Form DI105, Disability Income Policy
50.2%	Form BE105, Business Expense Policy
54.1%	Form 9251, Non-Cancelable Policy Rider
57.2%	Form 9252, Automatic Increase Benefit Rider
53.8%	Form 9253, Retroactive Injury Rider
50.7%	Form 9255, Two Year Pure Own Occupation Rider
52.9%	Form 9256, Five Year Pure Own Occupation Rider
50.0%	Form 9257, Five Year Own Occupation Extension Rider
51.3%	Form 9258, Own Occupation Extension To Your Renewal Age Rider
52.7%	Form 9259, Activities of Daily Living Rider
50.5%	Form 9260, Cost of Living Adjustment Rider
53.5%	Form 9261, Residual Disability Rider
53.6%	Form 9263, Residual Disability Rider with Cost of Living Adjustment Rider
54.5%	Form 9264, Integrated Monthly Benefit Rider
50.0%	Form 9265, Full Benefits for Mental or Nervous Disorders, Alcoholism or Drug Abuse Rider
52.4%	Form 9266, Return of Premium Rider
58.0%	Form 9267, Guaranteed Insurability Rider
56.0%	Form APP9267, Application for Guaranteed Insurability Rider
58.1%	Form APP105-D, Application for Disability Insurance
53.8%	Form APP105, Application for insurance
55.0%	Form OCDI105, Outline of Coverage for Disability Income Policy
53.3%	Form OCBE105, Outline of Coverage for Business Expense Policy

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: April 14, 2010