

SERFF Tracking Number: LLNS-126612929 State: Arkansas
Filing Company: Illinois Mutual Life Insurance Company State Tracking Number: 45581
Company Tracking Number: BE105(AR)
TOI: H111 Individual Health - Disability Income Sub-TOI: H111.001 Business Overhead Expense -
Unrelated to marketing with employer or
association groups
Product Name: BE105(AR)
Project Name/Number: BE105(AR)/BE105(AR)

Filing at a Glance

Company: Illinois Mutual Life Insurance Company

Product Name: BE105(AR) SERFF Tr Num: LLNS-126612929 State: Arkansas

TOI: H111 Individual Health - Disability Income SERFF Status: Closed-Approved- State Tr Num: 45581
Closed

Sub-TOI: H111.001 Business Overhead Co Tr Num: BE105(AR) State Status: Approved-Closed
Expense - Unrelated to marketing with
employer or association groups

Filing Type: Form

Author: Hollie Henderson

Date Submitted: 05/04/2010

Reviewer(s): Rosalind Minor

Disposition Date: 05/05/2010

Disposition Status: Approved-
Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: BE105(AR)

Project Number: BE105(AR)

Requested Filing Mode:

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Filing Status Changed: 05/05/2010

Status of Filing in Domicile: Pending

Date Approved in Domicile:

Domicile Status Comments:

Market Type: Individual

Group Market Size:

Group Market Type:

Explanation for Other Group Market Type:

State Status Changed: 05/05/2010

Created By: Hollie Henderson

Corresponding Filing Tracking Number:

Deemer Date:

Submitted By: Hollie Henderson

Filing Description:

Form BE105, Business Expense Policy

Form OCBE105, Outline of Coverage for Business Expense Policy

Enclosed are a new Business Expense Policy and Outline of Coverage submitted for your review and approval. These forms will be marketed through licensed agents.

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Form BE105 provides business expense total disability benefits as defined for 12 or 24 months. Partial business expense 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.

The following forms will be used with the BE105(AR) policy and have been submitted for your approval under SERFF Tracking# LLNS-126599604

Form APP105-D will be used to qualify applicants for BE105 policies. 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 BE105 policies.

The following Rider Forms may be issued with Form BE105:

Form 9253 Retroactive Injury Rider

Form 9266 Surrender Value Rider

Form 9265 Full Benefits for Mental or Nervous Disorders, Alcoholism or Drug Abuse

Form 3166 Guaranteed Insurability Rider

This form was previously approved by your Department on 3/27/2000.

OCBE105 Outline of Coverage for Policy Form BE105 is also being submitted for your review and 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

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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

Fee Required? Yes
 Fee Amount: \$100.00
 Retaliatory? Yes
 Fee Explanation: 2 forms * \$50 per form
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Illinois Mutual Life Insurance Company	\$100.00	05/04/2010	36209074

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Correspondence Summary

Dispositions

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

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Disposition

Disposition Date: 05/05/2010

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	No
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Form	Business Expense Policy	Approved-Closed	Yes
Form	Outline of Coverage for Business Expense Policy	Approved-Closed	Yes
Rate	BE105 Act memo	Approved-Closed	Yes

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Form Schedule

Lead Form Number: BE105(AR)

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 05/05/2010	BE105(AR)	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Business Expense Policy	Initial		50.200	BE105 (AR) (2).pdf
Approved-Closed 05/05/2010	OCBE105	Outline of Coverage	Outline of Coverage for Business Expense Policy	Initial		53.300	OCBE105.pdf



A Mutual Life Insurance Company

This Policy provides benefits, as shown in the Schedule, for monthly business expense that is incurred by you while you are totally or partially disabled as the result of 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 Birthday**

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. The Policy may not be renewed after the renewal date that follows your 75th birthday.

(continued on page 3)

BUSINESS EXPENSE POLICY

Illinois Mutual Life Insurance Company

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

**BUSINESS EXPENSE POLICY
Form BE105 (AR)**

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

READ YOUR CONTRACT CAREFULLY

This BUSINESS EXPENSE contract provides benefits for monthly expense incurred by the Insured while totally or partially disabled as the result of 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 annually at the option of the Company.

ALPHABETIC GUIDE TO YOUR CONTRACT

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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: 2 Non-Tobacco Renewal Age: 67</p>	<p>Policy Number: 8-1516761 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>Annual \$1,197.40 Quarterly \$ 317.31</p>
<p>Elimination Period Maximum Total Disability Business Expense Benefit Period Maximum Partial Disability Benefit Period</p>	<p>30 Days 24 Months 6 Months</p>
POLICY BENEFITS	
<p>Total Disability Monthly Business Expense Benefit Maximum Benefit Amount Payable - \$60,000.00</p>	<p>\$ 2,500.00</p>
<p>Partial Disability Monthly Business Expense Benefit</p>	<p>\$ 1,250.00</p>
<p>Waiver of Premium</p>	<p>INCLUDED</p>
RIDERS	
<p>Return of Premium See Table of Return of Premium Percentages on Schedule Page 2</p>	<p>Annual Premium \$342.12 Date of Issue 01/28/2010</p>
<p>Guaranteed Insurability Option Maximum Per Purchase \$400</p>	<p>\$ 12.29 01/28/2010</p>
<p>Retroactive Injury Benefit</p>	<p>\$75.00 01/28/2010</p>

POLICY SCHEDULE (cont.)

Insured: John Doe
 Age: 35
 Rate Classification: 2 Non-Tobacco
 Renewal Age: 67

Policy Number: 8-1516761
 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.

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.

DEFINITIONS (cont.)

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 your inability to perform all of 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 Business Expense Benefit and a Partial Disability Monthly Business Expense 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 Business Expense Benefit and a Total Disability Monthly Business Expense Benefit at the same time.

Monthly Business Expense means that overhead expense that is actually incurred by you in the operation of your business. This term includes rent, utilities, employees' salaries, property and payroll taxes, property and liability insurance and depreciation. The term does not include salaries, fees, drawing account or any other remuneration or the taxes thereon, for you or any member of your profession or occupation hired by or working with you. The term also does not include a member of your family who is not regularly employed at least 3 months prior to the start of your total or partial disability.

BENEFIT PROVISIONS

Total Disability Monthly Business Expense Benefit

If injury or sickness in and of itself causes your total disability, we shall pay you the Total Disability Monthly Business Expense 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 Monthly Business Expense Benefit Period shown in the Schedule for any one period of total disability.

However, this Benefit will only be paid up to the amount of monthly business expense you actually incur in a month. Then, if you remain totally disabled beyond the Maximum Total Disability Monthly Expense Benefit Period, we shall continue to pay this Benefit until you have been paid the Maximum Benefit Amount shown in the Schedule.

Partial Disability Monthly Business Expense Benefit

If injury or sickness in and of itself causes your partial disability, we will pay you up to the Partial Disability Monthly Business Expense Benefit shown in the Schedule. The 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 Business Expense Benefit was payable. We will pay this benefit to you during the continuance of your partial disability, but such Benefit shall not exceed one-half of your actual monthly business expenses. 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 Monthly Business Expense Benefit Period.

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.

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.

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.

CONVERSION PROVISION

Prior to your 60th birthday, you have the right to apply for a total disability policy, guaranteed renewable to your Renewal Age, that will replace this Policy. You do not have to submit any health information. However, you must be gainfully employed and not be totally or partially disabled on the date we receive your application for conversion. The converted policy will provide:

- (a) a maximum benefit period equal to or less than this Policy.
- (b) an elimination period equal to or more than this Policy.

The total disability monthly benefit of the converted policy will be the least of:

- (a) the Total Disability Monthly Business Expense Benefit;
- (b) the amount you are eligible for under our writing and participation limits; or
- (c) \$1,000.

The converted policy will be issued on a form we issue at that time. The premium will be based on your age as of the Date of Issue of this Policy. The premium for the converted policy will be based on the occupational classification of this Policy. Also, any impairment rating or exclusion of coverage still in effect on this Policy will also apply to the converted policy. The effective date of the converted policy will be the date we receive a written application and receive the first premium. This Policy will terminate on that date.

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.

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.

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.

EXCEPTIONS AND REDUCTIONS

This Policy does not provide benefits for disability resulting:

- (a) from normal pregnancy or childbirth;
- (b) from intentional 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.

GENERAL PROVISIONS (cont.)

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 for a periodic payment due for a continuing loss must be given to us within 90 days after the date of 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.

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.

GENERAL PROVISIONS (cont.)

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

BUSINESS EXPENSE POLICY BE105 (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

POLICY FORM BE105

DISABILITY INCOME PROTECTION
FOR BUSINESS EXPENSE 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 provisions of the Policy 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 FOR BUSINESS EXPENSE COVERAGE** is designed to provide you with coverage for your business expense while you are disabled by 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 Business Expense Benefit Up to \$_____/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 for up to _____ months. But, the amount that we pay to you shall not be greater than the monthly business expense that you actually incur for the period of such total disability. If your actual business expenses are less than this Benefit and you stay totally disabled past the maximum period, we will still pay you until an amount that is equal to the Benefit times the maximum period has been paid to you.

B. Partial Disability Monthly Business Expense Benefit Up to \$_____/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. But, the amount that is paid to you shall not be greater than one-half of the actual monthly business expense that you incur while you are partially disabled.

C. 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.

D. Waiver of Premium..... Included

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

E. Optional Retroactive Injury Rider, Form 9253..... Included
 Not Included
 Premium: \$_____Per _____
 If injury causes your total disability within 30 days of your injury, we will pay Benefit A from the 1st day of your total disability. You must have been continuously totally disabled from your injury for the entire Elimination Period stated in Benefit A.

F. Optional Return of Premium Rider, Form 9266..... Included
 Not Included
 Premium: \$_____Per _____
 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.

G. Optional Guaranteed Insurability Option Business Expense Rider, Form 3166..... Included
 Not Included
 Premium: \$_____Per _____
 This Rider affords you 5 options to buy more coverage prior to your 60th birthday without regard to your health status. You may choose to exercise your options at any time after 12 months from the Date of Issue. But, each such purchase must be at least 12 months apart. Each purchase is subject to our writing and participation limits. Each purchase may be for no more than \$_____ per month.

H. Optional Full Benefits for Mental or Nervous Disorders, Alcoholism or Drug Abuse Rider, Form 9265 Included
 Not Included
 Premium: \$_____Per _____
 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.

(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. We will pay no benefits for any salaries, fees, drawing account or other remuneration, or the taxes thereon, for you or any member of your profession or occupation hired by or working with you. This includes a member of your family who is not employed on a regular basis for at least 3 months prior to the start of your total or partial disability.

E. 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. 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. This Policy has a 31 day grace period.

Date

Signature of Agent

RETAIN FOR YOUR RECORDS

SERFF Tracking Number: LLNS-126612929 State: Arkansas
 Filing Company: Illinois Mutual Life Insurance Company State Tracking Number: 45581
 Company Tracking Number: BE105(AR)
 TOI: H111 Individual Health - Disability Income Sub-TOI: H111.001 Business Overhead Expense -
 Unrelated to marketing with employer or
 association groups
 Product Name: BE105(AR)
 Project Name/Number: BE105(AR)/BE105(AR)

Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification	Approved-Closed	05/05/2010
Comments:			
Attachment:			
	BE105 Readability.pdf		

		Item Status:	Status Date:
Satisfied - Item:	Application	Approved-Closed	05/05/2010
Comments:			
	The attached applications have been submitted for your review and approval under Serff Tracking #LLNS-126599604		
Attachments:			
	App105 (AR).pdf		
	App105-D (AR).pdf		

		Item Status:	Status Date:
Satisfied - Item:	Outline of Coverage	Approved-Closed	05/05/2010
Comments:			
	Outline of Coverage is attached to the Form Schedule Tab of this filing 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:

50.2% Form BE105, Business Expense 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

Application for Insurance

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

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

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

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

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

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

2. General Information

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

PART C

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

Agreement and Declaration

I represent and agree that all statements and information found in the application are deemed representations and not warranties. I further represent and agree that all statements and answers recorded in this application are true, complete and correctly recorded to the best of my knowledge and belief. I understand that this application and any medical examination which may be required will become a part of any policy issued. I understand that acceptance of any policy issued on this application indicates my agreement to any amendments made by the Company in the "Home Office Endorsement Only" space except changes in the amounts of insurance or premium, classification of risk, and plan of insurance shall require my written acceptance. I understand and agree that no policy issued on this application shall become effective until I have received and accepted it and the first full premium paid. However, if a Receipt has been delivered, then liability of the Company shall be as stated in the Receipt. I have received a MIB Notice, Fair Credit Reporting Act Notice and an Outline of Coverage if applying for disability insurance.

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

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

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

When completed electronically, I verify that the unique identifier used to sign this application is mine and that by clicking the "Submit" button, I am signing the application electronically.

Signed at _____
CITY AND STATE

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

Date _____

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

SIGNATURE OF PROPOSED RIDER INSURED

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

Agent's Certification: An Outline of Coverage was given to the Proposed Insured for disability insurance. I, do do not, have knowledge that the insurance applied for will replace any existing disability insurance and/or life insurance.

PRINT WRITING AGENT NAME

WRITING AGENT'S SIGNATURE

Agent's Code # _____

Agent's Phone # _____

Agent's E-mail _____

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

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

Split Commission Information

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

Name _____ Code # _____ % of Commission _____

Name _____ Code # _____ % of Commission _____

Examination Requirements

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

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 \$ _____

