Filing at a Glance

Company: Illinois Mutual Life Insurance Company

Product Name: Critical Illness
TOI: H07I Individual Health - Specified Disease - - Limited Benefit
Sub-TOI: H07I.001 Critical Illness
Filing Type: Form

SERFF Tr Num: LLNS-126822896
SERFF Status: Closed-Approved-Closed
Co Tr Num: 622

Author: Jennifer Roseboom
Date Submitted: 02/15/2011

State: Arkansas
State Tr Num: 47998

State Status: Approved-Closed
Reviewer(s): Rosalind Minor
Disposition Date: 03/02/2011
Disposition Status: Approved-Closed
Implementation Date:

Implementation Date Requested: On Approval
State Filing Description:

General Information

Project Name: 622 Critical Illness
Project Number: 622 Critical Illness
Requested Filing Mode: Review & Approval
Explanation for Combination/Other:
Submission Type: New Submission
Overall Rate Impact:

Deemer Date:
Submitted By: Jennifer Roseboom
Filing Description:
Ref: Illinois Mutual Life Insurance Company
NAIC #64580, FEIN 37-0344290

Status of Filing in Domicile: Pending
Date Approved in Domicile:
Domicile Status Comments:
Market Type: Individual
Individual Market Type:
Filing Status Changed: 03/02/2011
State Status Changed: 03/02/2011
Created By: Jennifer Roseboom
Corresponding Filing Tracking Number:

RE: Form 622 Critical Illness Policy
Form OC622 Outline of Coverage
Form APP105-C Application for Critical Illness Insurance
Enclosed is a new Critical Illness Policy, Outline of Coverage, and Application for your review and approval.

Form 622 is a Critical Illness Policy classified as a Specified Disease Policy which pays a specified benefit for the first

ever diagnosis of a covered critical illness which includes Cancer, Heart Attack, Kidney Failure, Stroke, and Major Organ Transplant.

Form OC622 is an Outline of Coverage for the Critical Illness Policy.

Form APP105-C is an Application for Critical Illness Insurance Part A, which will be used with Form APP105 Part B and C and was previously Approved by your Department on 05/05/2010.

The Actuarial Memorandum is enclosed.

The policy and rider will be marketed through licensed agents.

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

Fee Required?	Yes
Fee Amount:	$150.00
Retaliatory?	Yes
Fee Explanation:	3 forms x $50 per form = $150
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #

SERFF Tracking Number:	*LLNS-126822896*	*State:*	*Arkansas*
Filing Company:	*Illinois Mutual Life Insurance Company*	*State Tracking Number:*	*47998*
Company Tracking Number:	*622*		
TOI:	*H07I Individual Health - Specified Disease - Limited Benefit*	*Sub-TOI:*	*H07I.001 Critical Illness*
Product Name:	*Critical Illness*		
Project Name/Number:	*622 Critical Illness /622 Critical Illness*		

Illinois Mutual Life Insurance Company	$150.00	02/15/2011	44739040

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	03/02/2011	03/02/2011

Objection Letters and Response Letters

Objection Letters				Response Letters		
Status	**Created By**	**Created On**	**Date Submitted**	**Responded By**	**Created On**	**Date Submitted**
Pending Industry Response	Rosalind Minor	02/28/2011	02/28/2011	Jennifer Roseboom	03/01/2011	03/01/2011

Disposition

Disposition Date: 03/02/2011

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*LLNS-126822896*	*State:*	*Arkansas*
Filing Company:	*Illinois Mutual Life Insurance Company*	*State Tracking Number:*	*47998*
Company Tracking Number:	*622*		
TOI:	*H07I Individual Health - Specified Disease - Limited Benefit*	*Sub-TOI:*	*H07I.001 Critical Illness*
Product Name:	*Critical Illness*		
Project Name/Number:	*622 Critical Illness /622 Critical Illness*		

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 *(revised)*	Specified Disease Insurance Policy	Approved-Closed	Yes
Form	Specified Disease Insurance Policy	Replaced	Yes
Form	Outline of Coverage for Specified Disease Insurance Policy	Approved-Closed	Yes
Form	Application for specified disease insurance	Approved-Closed	Yes

Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	02/28/2011
Submitted Date	02/28/2011
Respond By Date	03/28/2011

Dear David Storlie,

This will acknowledge receipt of the captioned filing.

Objection 1

- Specified Disease Insurance Policy, 622 (Form)

Comment:

There needs to be a provision for the refund of unearned premium in the event of death of the insured. Refer to ACA 23-85-134.

Please feel free to contact me if you have questions.

Sincerely,

Rosalind Minor

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	03/01/2011
Submitted Date	03/01/2011

Dear Rosalind Minor,

Comments:
Thank you for your letter of 2/28/11 regarding the refund of unearned premium.

Response 1

Comments: I have revised the policy form on page 8 for #16 Refund of Premium Upon Death of Insured.

Related Objection 1

Applies To:

- Specified Disease Insurance Policy, 622 (Form)

Comment:

There needs to be a provision for the refund of unearned premium in the event of death of the insured. Refer to ACA 23-85-134.

Changed Items:

No Supporting Documents changed.

Form Schedule Item Changes

Form Name	Form Number	Edition Date	Form Type	Action	Action Specific Data	Readability Score	Attach Document
Specified Disease Insurance Policy	622(AR)		Policy/Contract/Fraternal Certificate	Initial		50.100	622 (AR).pdf
Previous Version							
Specified Disease Insurance Policy	*622*		*Policy/Contract/Fraternal Certificate*	*Initial*		*50.100*	622.pdf

No Rate/Rule Schedule items changed.

Thank you for your assistance with this filing.
Jennifer Roseboom
800-437-7355, Ext 436

Sincerely,
Jennifer Roseboom

Form Schedule

Lead Form Number:

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 03/02/2011	622(AR)	Policy/Contract/Fraternal Certificate	Specified Disease Insurance Policy	Initial		50.100	622 (AR).pdf
Approved-Closed 03/02/2011	OC622	Outline of Coverage	Outline of Coverage for Specified Disease Insurance Policy	Initial		50.000	OC622.pdf
Approved-Closed 03/02/2011	APP105-C	Application/Enrollment Form	Application for specified disease insurance	Initial		57.800	App105-C.pdf

ILLINOIS MUTUAL®

A Mutual Life Insurance Company

This Policy provides benefits, as shown in the Policy Schedule, for loss resulting from specified disease. It is renewable until the renewal date that follows your Renewal Age birthday shown in the Policy Schedule, but subject to our right to increase premiums by class.

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 specified disease 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, subject to the Policy's Termination Provision.

We reserve the right to increase premium rates on all or classes of like policies. 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.

This Is a Specified Disease Policy Which Only Provides Benefits
For The Diagnosis Of Illnesses Specified And Defined In This Policy.
It Does Not Pay Benefits For Loss From Any Other Cause.
Please Read The Policy Carefully - It Contains Waiting Periods and Exclusions.

Illinois Mutual Life Insurance Company
Home Office 300 S.W. Adams Street Peoria, IL 61634 Phone 800.437.7355

SPECIFIED DISEASE POLICY
Form 622 (AR)

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

READ YOUR POLICY CAREFULLY.

This SPECIFIED DISEASE Policy provides benefits for loss resulting from specified disease. This Policy 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.

ALPHABETIC GUIDE TO YOUR POLICY

	Page		Page
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Benefit Payment Conditions	4	Payment of Claims	7
Claim Forms	7	Proofs of Loss	7
Date of Issue	Schedule	Reinstatement	7
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Diagnostic Requirements for all Critical Illnesses	5	Right to Examine Policy	1
Exclusions	5	Termination Provision	6
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Insured	Schedule	Time of Payment of Claims	7
Misstatement of Age or Gender	7	Unpaid Premium	7
		Waiting Period	Schedule

DEFINITIONS

As used in this Policy, the terms listed below will have the meanings as defined. Defined terms, when used in this policy, will appear with initial capitalization other than defined pronouns. The plural use of a term will share the same meaning as the singular.

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

You or Your refers to the Insured.

Age means the attained age as of your last birthday.

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, tobacco use or state of issue.

Clinical Diagnosis means a clinical identification of Cancer on history, laboratory study and symptoms. We will pay benefits for a Clinical Diagnosis only if:

1. a pathological diagnosis cannot be made because it is medically inappropriate or life threatening;
2. there is medical evidence to support such diagnosis; and
3. a Physician is treating You for Cancer or has prescribed palliative care.

Covered Event means Cancer, Heart Attack, Kidney Failure, Stroke, and Major Organ Transplant as each is defined in this Policy.

Critical Illness means only the illnesses listed in the Policy Schedule and defined within this Policy. See the Benefit Payment Conditions Provision for definitions, exclusions and limitations.

Date of Issue means the date that this Policy becomes effective

Diagnosed means a definitive diagnosis made by a Physician (where applicable, specializing in a particular area of medicine) and supported by documentation of all appropriate and defined studies:

1. based upon the use of diagnostic evaluations, clinical and/or laboratory investigations, tests and observations; and
2. meeting any diagnostic requirements stated in this Policy for the particular Critical Illness being Diagnosed.

Immediate Family Member means a person who is related to the Insured by marriage, blood, or legal adoption.

Incurs or Incurred means an event, incident, or diagnosis that:

1. initially occurs on or after the Date of Issue of this Policy, and
2. initially occurs while this Policy is in force, and
3. is Diagnosed during the life of the Insured, and
4. is not specifically excluded by any definitions or exclusions in this Policy

Insured means the person named as “Insured” in the Policy Schedule.

Manifests or Manifested means a condition or symptom that would cause an ordinary prudent person to seek medical advice, care, or treatment.

Month means a calendar month.

Pathological Diagnosis means a report of microscopic examination of fixed tissues (histopathology) or preparations of blood or bone marrow. Diagnosis must be made by a Physician who is board certified in Pathology and conform to the standards of the American Board of Pathology.

Physician means a person who:

1. is a doctor or practitioner who is duly licensed by the proper authority and who is practicing within the scope of his license; and
2. practices within the scope of his or her license and specialty in the United States; and
3. is not the Insured; and

DEFINITIONS (cont.)

4. is not the Insured's Immediate Family Member; and
5. does not customarily reside in the same household as the Insured.

Waiting Period means the number of days shown in the Policy Schedule following the Date of Issue or reinstatement effective date.

CRITICAL ILLNESS BENEFITS

We will pay the Critical Illness Benefit stated in the Policy Schedule if a Critical Illness is Manifested and Diagnosed after the Waiting Period subject to the Benefit Payment Conditions Provision of this Policy.

In no event will more than one Critical Illness Benefit be paid. This Policy will terminate when a Critical Illness Benefit is paid.

BENEFIT PAYMENT CONDITIONS

The payment of benefits for a Critical Illness stated in the Policy Schedule is subject to the following conditions:

(a) the Critical Illness initially Incurs and/or Manifests as stated in the Policy; and
(b) the Critical Illness is initially Diagnosed while the coverage on an Insured is effective under this Policy; and
(c) the Critical Illness is Diagnosed, or the diagnosis is confirmed, within the United States or its territories; and
(d) the benefit payment is not excluded by any general or specific exclusion or limitation; and
(e) the Critical Illness diagnosis is made during the lifetime of the Insured

CANCER, for the purposes of this Policy, means a malignant tumor characterized by uncontrolled growth of malignant cells and invasion of normal tissue. The Cancer benefit also covers the following cancers: leukemia (except as noted below), lymphoma, multiple myeloma, and sarcoma. Cancer must be positively Diagnosed with histopathological confirmation. A Clinical Diagnosis will be accepted only if:

(a) a Pathological Diagnosis cannot be made because it is medically inappropriate or life threatening;
(b) there is medical evidence to support the diagnosis; and
(c) a Physician is treating you for Cancer or has prescribed palliative care.

The following tumors are excluded:

- Chronic lymphocytic leukemia that has not progressed to at least Rai Stage I or Binet Stage B;
- All tumors that are histologically described as noncancerous, benign, premalignant, noninvasive, borderline malignant, low malignant potential, dysplasia (all grades) or carcinoma in situ;
- All skin cancers, unless there is metastasis, or the tumor is a malignant melanoma of greater than 1.0 mm maximum thickness (regardless of Clark level or ulceration) as determined by histological examination using the Breslow method;
- Prostate cancer that is histologically classified as Gleason score 6 or lower, or TNM classification T1N0M0 or lower; and
- Noninvasive papillary cancer of the bladder histologically described as TNM classification TaN0M0 or lower.

BENEFIT PAYMENT CONDITIONS (cont.)

HEART ATTACK, for the purposes of this Policy, means death of heart muscle due to inadequate blood supply. All of the following criteria for acute myocardial infarction must be satisfied:

1. typical clinical symptoms, for example, central chest pain; and
2. diagnostic increase of specific cardiac markers; and
3. new electrocardiographic changes of infarction.

Heart Attack that occurred during or within 24 hours after a cardiac or coronary artery procedure is excluded.

KIDNEY FAILURE, for the purposes of this Policy, means chronic irreversible failure of both kidneys to function, as a result of which either regular renal or peritoneal dialysis, or renal transplant is initiated.

STROKE, for the purposes of this Policy, means death of brain tissue due to an acute cerebrovascular event. All of the following criteria for stroke must be satisfied:

1. clinical evidence of infarction of brain tissue, or intracranial or subarachnoid hemorrhage;
2. clear evidence on a CT, MRI or similar imaging technique that a stroke has occurred; and
3. permanent neurologic deficit measured 30 days or more after the event that results in a score of 2 or higher on the Modified Rankin Scale for stroke outcome.

Symptoms due to transient ischemic attack, migraine, hypoxia, traumatic injury to brain tissue or blood vessels, and vascular disease affecting the eye, optic nerve or vestibular functions are excluded.

MAJOR ORGAN TRANSPLANT, for the purposes of this Policy, means human to human organ transplant from a donor to the Insured of bone marrow solely for treatment of Cancer or bone marrow failure, or transplant of an entire kidney, liver, heart, lung, or pancreas.

The following are excluded:

- Transplant of any other organs, parts of organs, tissues or cells.

The need for a Major Organ Transplant must be Diagnosed after the Waiting Period. The Insured must undergo the Major Organ Transplant.

DIAGNOSTIC REQUIREMENTS FOR ALL CRITICAL ILLNESSES

We reserve the right to conduct a physical examination of the Insured and/or to review any Critical Illness Diagnosed by a Physician of our choosing. This Physician must:

(a) have specialty training and board certification in the field of Medicine specific to the Critical Illness being Diagnosed; and
(b) must follow all routinely accepted procedures and protocols in the Diagnosis of the Critical Illness.

EXCLUSIONS

We will not pay benefits for a loss caused by, contributed to, or resulting from:

(a) any act of war, declared or undeclared, or
(b) active duty in the armed forces, National Guard, or any reserve unit, or
(c) engaging in a felony; or participating in any riot or civil insurrection; or
(d) any intentionally self-inflicted injury or suicide or suicide attempt; or
(e) being addicted to drugs or suffering from alcoholism; or
(f) being under the influence of alcohol (including the operation of a motor vehicle with a blood alcohol concentration in excess of the legal limit of the state in which the accident occurs) or a controlled substance unless legally prescribed and used in the manner consistent with that prescription; or

EXCLUSIONS (cont.)

(g) any benefits for conditions Diagnosed outside of the United States unless the Diagnosis can be confirmed in the United States; or
(h) any illness, loss, or condition specifically excluded from the definition of any Critical Illness.

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.

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.

TERMINATION PROVISION

This Policy will terminate on the earliest of:
(1) the date the Grace Period ends where any Policy or Rider Premium is not paid before the Grace Period ends;
(2) the date that the Critical Illness Benefit is paid; or
(3) the date the Owner requests termination; or
(4) the date of the first Policy renewal date that follows your Renewal Age birthday.

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: 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 that starts after the Policy has been in force for 2 years.

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, we will not pay benefits for any Critical Illness that Incurs or Manifests, whichever is applicable, as stated in this Policy, or is Diagnosed before the end of the Waiting Period after the reinstatement effective date.

5. Notice of Claim: Written notice of a claim must be given to us within 60 days after a loss starts or as soon as reasonably possible but in no event later than 180 days from the Date of the Covered Event. 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 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: Benefits for 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.

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 or Gender: If your age or gender has been misstated, the benefits of this Policy will be such as the premium paid would have purchased at the correct age or gender. 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. Conformity With State Statutes: Any provision of this Policy which, on its Date of Issue, 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.

GENERAL PROVISIONS

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

16. 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.

17. 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.

18. 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.

19. 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 Policy Schedule.

Secretary

Chairman & CEO

This Is a Specified Disease Policy Which Only Provides Benefits For The Diagnosis Of Illnesses Specified And Defined In This Policy. It Does Not Pay Benefits For Loss From Any Other Cause. Please Read The Policy Carefully - It Contains Waiting Periods and Exclusions.

Illinois Mutual Life Insurance Company
Home Office 300 S.W. Adams Street Peoria, IL 61634 Phone 800.437.7355

ILLINOIS MUTUAL®
Life Insurance Company
300 S.W. Adams Street Peoria, IL 61634
800.437.7355

POLICY FORM 622

SPECIFIED DISEASE POLICY

REQUIRED OUTLINE OF COVERAGE

(1) This coverage is designed only as a supplement to a comprehensive medical expense insurance policy and should not be purchased unless you have the underlying coverage. Persons covered under Medicaid should not purchase it.

(2) READ YOUR POLICY CAREFULLY. This Outline of Coverage provides a very brief description of the important features of your Policy. This is not the insurance contract and 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, therefore, important to **READ YOUR POLICY CAREFULLY!**

(3) SPECIFIED DISEASE COVERAGE is designed to provide, to persons insured, restricted coverage paying benefits ONLY when certain losses occur as the result of specified diseases. Coverage is not provided for basic hospital, basic medical-surgical, or major medical expenses.

(4) BENEFITS

We will pay a Critical Illness Benefit in the amount of $_____ if a Critical Illness is initially Manifested and Diagnosed after [30] days from the Date of Issue of this Policy during the lifetime of the insured. In no event will more than one Critical Illness Benefit be paid and this Policy will terminate when a Critical Illness Benefit is paid.

The Critical Illnesses for which a benefit will be paid as set forth and defined below:

A. CANCER means a malignant tumor characterized by uncontrolled growth of malignant cells and invasion of normal tissue. The Cancer benefit also covers the following cancers: leukemia (except as noted below), lymphoma, multiple myelona, and sarcoma. The following tumors are excluded:

- Chronic lymphocytic leukemia that has not progressed to at least Rai Stage I or Binet Stage B;
- All tumors that are histologically described as noncancerous, benign, premalignant, noninvasive, dysplasia (all grades) or carcinoma in situ;
- All skin cancers, unless there is evidence of metastasis, or the tumor is a malignant melanoma of greater than 1.0 mm maximum thickness (regardless of Clark level or ulceration) as determined by histological examination using the Breslow method;
- Prostate cancer that is histologically classified as Gleason score 6 or lower, or TNM classification T1N0M0 or lower; and
- Noninvasive papillary cancer of the bladder histologically described as TNM classification TaN0M0 or lower.

B. HEART ATTACK means death of heart muscle due to inadequate blood supply. All of the following criteria for acute myocardial infarction must be satisfied:

1. typical clinical symptoms, for example, central chest pain; and
2. diagnostic increase of specific cardiac markers; and
3. new electrocardiographic changes of infarction.

Heart Attack that occurred during or within 24 hours after a cardiac or coronary artery procedure is excluded.

C. KIDNEY FAILURE means chronic irreversible failure of both kidneys to function, as a result of which either regular renal or peritoneal dialysis, or renal transplant is initiated.

D. STROKE means death of brain tissue due to an acute cerebrovascular event. All of the following criteria for Stroke must be satisfied:

1. clinical evidence of infarction of brain tissue, or intracranial or subarachnoid hemorrhage;
2. clear evidence on a CT, MRI or similar imaging technique that a Stroke has occurred; and
3. permanent neurologic deficit measured 30 days or more after the event that results in a score of 2 or higher on the Modified Rankin Scale for stroke outcome.

Symptoms due to transient ischemic attack, migraine, hypoxia, traumatic injury to brain tissue or blood vessels, and vascular disease affecting the eye, optic nerve or vestibular functions are excluded.

E. MAJOR ORGAN TRANSPLANT means human to human organ transplant from a donor to the Insured of bone marrow solely for treatment of Cancer or bone marrow failure, or transplant of an entire kidney, liver, heart, lung, or pancreas.

The following are excluded:

- Transplant of any other organs, parts of organs, tissues or cells.

The need for a Major Organ Transplant must be diagnosed after the Waiting Period. The Insured must undergo the Major Organ Transplant.

(5) EXCLUSIONS

We will not pay benefits for a loss caused by, contributed to, or resulting from:

(a) any act of war, declared or undeclared; or
(b) active duty in the armed forces, National Guard, or any reserve unit; or
(c) engaging in a felony; or participating in any riot or civil insurrection; or
(d) any intentionally self-inflicted injury or suicide or suicide attempt; or
(e) being addicted to drugs or suffering from alcoholism; or
(f) being under the influence of alcohol (including the operation of a motor vehicle with a blood alcohol concentration in excess of the legal limit of the state in which the accident occurs) or a controlled substance unless legally prescribed and used in the manner consistent with that prescription; or
(g) any benefits for conditions diagnosed outside of the United States unless the Diagnosis can be confirmed in the United States; or
(h) any illness, loss, or condition specifically excluded from the definition of any Critical Illness.

(6) 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.

(7) PREMIUM –

Proposed
Insured: _____ Total Premium: $_____ Per _____.

Total Premium: $_____ Per Year.

_____ _____
Date Signature of Agent

RETAIN FOR YOUR RECORDS

ILLINOIS MUTUAL®
Life Insurance Company
300 S.W. Adams Street Peoria, IL 61634
800.437.7355

Application for Critical Illness Insurance

PART A

1. Proposed Insured

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

b. Address _____
STREET CITY STATE ZIP CODE

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

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

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

h. Are you a U.S. Citizen? ☐ Yes ☐ No

(1) If no, have you resided in the U.S. for the past 2 years? ☐ Yes ☐ No

(1a.) If yes, have you been granted permanent resident (green card) status? ☐ Yes ☐ No

i. In the past 12 months, have you used any form of tobacco or nicotine-based product? ☐ Yes ☐ No ☐ Never

j. Occupation and duties:

_____

k. Annual income (after business expenses) as reported for federal income tax purposes: $ _____

2. Critical Illness Plan Information

Benefit Amount $ _____

Beneficiary _____ Relationship _____

3. Other Coverage

a. Do you have medical expense insurance in force? ☐ Yes ☐ No

b. Do you have other Critical Illness coverage in force? ☐ Yes ☐ No

(1) If yes, provide name of Company and face amount. _____

(2) Will policy be replaced? ☐ Yes ☐ No

4. Owner (If other than the Proposed Insured)

a. Name _____ b. Social Security or Tax ID Number _____

c. Address _____
STREET CITY STATE ZIP CODE

5. Billing and Payment

a. Effective Date: ☐ Application Date ☐ Issue Date ☐ Other _____

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

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

d. Premium Amount Quoted: $ _____

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

If using the traditional application process, complete Parts B and C.

If using the teleapplication process, complete Part C.

Page 2 intentionally left blank.

Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification	Approved-Closed	03/02/2011

Comments:

Attachments:

Readability.pdf

3101_AR Rider (print).pdf

		Item Status:	Status Date:
Satisfied - Item:	Application	Approved-Closed	03/02/2011

Comments:

APP105 (AR) Approved 5/5/2010 will be used with submitted form APP105-C

Attachment:

App105 (AR).pdf

		Item Status:	Status Date:
Satisfied - Item:	Outline of Coverage	Approved-Closed	03/02/2011

Comments:

The outline of coverage was submitted in the Form Doc Tab.

Attachment:

OC622.pdf

300 S.W. Adams Street Peoria, IL 61634
Phone 309.674.8255
www.IllinoisMutual.com

ILLINOIS MUTUAL®

READABILITY CERTIFICATION

RE: Form 622, Specified Disease Insurance Policy
Form OC622, Outline of Coverage for Specified Disease Insurance Policy
Form APP105-C, Application for specified disease insurance

On behalf of Illinois Mutual Life Insurance Company, I hereby certify that we have carefully analyzed and scored the forms submitted with this certification in accord with the Flesch score analysis readability procedures and we certify that the forms have a Flesch score as follows:

Form 622	50.1
Form OC622	50.0
Form APP105-C	57.8

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: February 15, 2011

ILLINOIS MUTUAL®
Life Insurance Company

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

ARKANSAS IMPORTANT NOTICE

The following information is provided as required by Arkansas Act 197 of 1987:

Illinois Mutual Life Insurance Company
Policy Service Department
300 S.W. Adams Street
Peoria, IL 61634
(800) 437-7355

Agent _____
Address _____
_____
Phone _____

If we at Illinois Mutual Life Insurance Company fail to provide you with reasonable and adequate service, you should feel free to contact:

Arkansas Insurance Department
Consumer Services Division
1200 W. Third Street
Little Rock, AR 72201-1904
(501) 371-2640
(800) 852-5494

ILLINOIS MUTUAL®

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.

_____

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

PART B (continued)

3. Medical Information (If answering yes, please provide full details below.)

a. Have you ever had symptoms, received treatment, or been diagnosed with any injury, disease or disorder of:	Yes	No
(1) The back, neck, knees, shoulders, wrists, hips, joints, bones, muscles, arthritis or fibromyalgia?	☐	☐
(2) High blood pressure, chest pain, heart attack, stroke or any other disease or disorder of the heart, arteries or veins?	☐	☐
(3) Diabetes or borderline diabetes, thyroid, or any other glandular disease or disorder?	☐	☐
(4) Headaches, seizure, paralysis, multiple sclerosis or any other disease or disorder of the brain or nervous system?	☐	☐
(5) Cancer, cyst, polyp or tumor?	☐	☐
(6) Asthma, sleep apnea, chronic bronchitis, emphysema or any other disease or disorder of the lungs or respiratory system?	☐	☐
(7) Anxiety, depression, stress, chronic fatigue or any other mental or nervous disorder?	☐	☐
(8) Irritable bowel, ulcer, colitis, hepatitis or any other disease or disorder of the stomach, intestines, pancreas or liver?	☐	☐
(9) The prostate, kidney, bladder, breast, genital or reproductive organs?	☐	☐
(10) The eyes, ears, nose, throat or skin?	☐	☐

b. Using the list below, provide full details to all "Yes" answers for 3a.(1) thru 3a.(10).

- Question #
- Symptoms, illness, injury or other
- Dates seen (first visit, last visit & how often)
- Type of testing (include dates and results)
- Diagnosis or clinical assessment
- Treatment plan (medication, surgery, other) and follow-up
- Degree of recovery or control
- Length of disability or time off work
- Healthcare provider's name, address & phone

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

PART B (continued)

3. Medical Information, continued (If answering yes, please provide full details below.)

c. Who is your primary physician? ☐ None

(1) _____

NAME ADDRESS PHONE NUMBER

(2) Date last seen, reason and details _____

	Yes	No
d. Are you currently pregnant? (If yes, due date____/____/____)	☐	☐
e. In the past 10 years, have you had a miscarriage, Cesarean section or other complications of pregnancy?	☐	☐
f. In the past 10 years, have you been diagnosed or treated by a medical practitioner for Acquired Immune Deficiency Syndrome (AIDS), or AIDS related complex (ARC)?	☐	☐
g. In the past 10 years, have you tested positive for antibodies to the AIDS virus?	☐	☐
h. Have you had any natural parent or sibling who was diagnosed with cancer, heart disease, stroke, high blood pressure, diabetes or Huntington's disease prior to the age of 60? (If yes, provide relationship, condition, age diagnosed, current age or age at death.)	☐	☐
i. In the past 5 years, other than previously stated, have you:		
(1) had any medical advice, treatment, diagnostic test, hospitalization, physical exam, illness or injury?	☐	☐
(2) been referred for or advised to undergo treatment, diagnostic test, hospitalization or surgery that was not completed?	☐	☐
(3) consulted any other doctor, chiropractor, psychiatrist, psychologist, counselor, therapist or other healthcare provider?	☐	☐
j. Other than previously stated, are you currently:		
(1) receiving any medical advice or treatment?	☐	☐
(2) taking any medication?	☐	☐

k. Using the list below, provide full details to all "Yes" answers for 3d. thru 3j.

Question #
Symptoms, illness, injury or other
Dates seen (first visit, last visit & how often)
Type of testing (include dates and results)
Diagnosis or clinical assessment
Treatment plan (medication, surgery, other) and follow-up
Degree of recovery or control
Length of disability or time off work
Healthcare provider's name, address & phone

_____

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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.

ILLINOIS MUTUAL®
Life Insurance Company
300 S.W. Adams Street Peoria, IL 61634
800.437.7355

POLICY FORM 622

SPECIFIED DISEASE POLICY

REQUIRED OUTLINE OF COVERAGE

(1) This coverage is designed only as a supplement to a comprehensive medical expense insurance policy and should not be purchased unless you have the underlying coverage. Persons covered under Medicaid should not purchase it.

(2) READ YOUR POLICY CAREFULLY. This Outline of Coverage provides a very brief description of the important features of your Policy. This is not the insurance contract and 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, therefore, important to **READ YOUR POLICY CAREFULLY!**

(3) SPECIFIED DISEASE COVERAGE is designed to provide, to persons insured, restricted coverage paying benefits ONLY when certain losses occur as the result of specified diseases. Coverage is not provided for basic hospital, basic medical-surgical, or major medical expenses.

(4) BENEFITS

We will pay a Critical Illness Benefit in the amount of $_____ if a Critical Illness is initially Manifested and Diagnosed after [30] days from the Date of Issue of this Policy during the lifetime of the insured. In no event will more than one Critical Illness Benefit be paid and this Policy will terminate when a Critical Illness Benefit is paid.

The Critical Illnesses for which a benefit will be paid as set forth and defined below:

A. CANCER means a malignant tumor characterized by uncontrolled growth of malignant cells and invasion of normal tissue. The Cancer benefit also covers the following cancers: leukemia (except as noted below), lymphoma, multiple myelona, and sarcoma. The following tumors are excluded:

- Chronic lymphocytic leukemia that has not progressed to at least Rai Stage I or Binet Stage B;
- All tumors that are histologically described as noncancerous, benign, premalignant, noninvasive, dysplasia (all grades) or carcinoma in situ;
- All skin cancers, unless there is evidence of metastasis, or the tumor is a malignant melanoma of greater than 1.0 mm maximum thickness (regardless of Clark level or ulceration) as determined by histological examination using the Breslow method;
- Prostate cancer that is histologically classified as Gleason score 6 or lower, or TNM classification T1N0M0 or lower; and
- Noninvasive papillary cancer of the bladder histologically described as TNM classification TaN0M0 or lower.

B. HEART ATTACK means death of heart muscle due to inadequate blood supply. All of the following criteria for acute myocardial infarction must be satisfied:

1. typical clinical symptoms, for example, central chest pain; and
2. diagnostic increase of specific cardiac markers; and
3. new electrocardiographic changes of infarction.

Heart Attack that occurred during or within 24 hours after a cardiac or coronary artery procedure is excluded.

C. KIDNEY FAILURE means chronic irreversible failure of both kidneys to function, as a result of which either regular renal or peritoneal dialysis, or renal transplant is initiated.

D. STROKE means death of brain tissue due to an acute cerebrovascular event. All of the following criteria for Stroke must be satisfied:

1. clinical evidence of infarction of brain tissue, or intracranial or subarachnoid hemorrhage;
2. clear evidence on a CT, MRI or similar imaging technique that a Stroke has occurred; and
3. permanent neurologic deficit measured 30 days or more after the event that results in a score of 2 or higher on the Modified Rankin Scale for stroke outcome.

Symptoms due to transient ischemic attack, migraine, hypoxia, traumatic injury to brain tissue or blood vessels, and vascular disease affecting the eye, optic nerve or vestibular functions are excluded.

E. MAJOR ORGAN TRANSPLANT means human to human organ transplant from a donor to the Insured of bone marrow solely for treatment of Cancer or bone marrow failure, or transplant of an entire kidney, liver, heart, lung, or pancreas.

The following are excluded:

- Transplant of any other organs, parts of organs, tissues or cells.

The need for a Major Organ Transplant must be diagnosed after the Waiting Period. The Insured must undergo the Major Organ Transplant.

(5) EXCLUSIONS

We will not pay benefits for a loss caused by, contributed to, or resulting from:

(a) any act of war, declared or undeclared; or
(b) active duty in the armed forces, National Guard, or any reserve unit; or
(c) engaging in a felony; or participating in any riot or civil insurrection; or
(d) any intentionally self-inflicted injury or suicide or suicide attempt; or
(e) being addicted to drugs or suffering from alcoholism; or
(f) being under the influence of alcohol (including the operation of a motor vehicle with a blood alcohol concentration in excess of the legal limit of the state in which the accident occurs) or a controlled substance unless legally prescribed and used in the manner consistent with that prescription; or
(g) any benefits for conditions diagnosed outside of the United States unless the Diagnosis can be confirmed in the United States; or
(h) any illness, loss, or condition specifically excluded from the definition of any Critical Illness.

(6) 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.

(7) PREMIUM –

Proposed
Insured: _____ Total Premium: $_____ Per _____.

Total Premium: $_____ Per Year.

_____ _____
Date Signature of Agent

RETAIN FOR YOUR RECORDS

Superseded Schedule Items

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Creation Date:	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
02/15/2011	Form	Specified Disease Insurance Policy	03/01/2011	622.pdf (Superceded)

ILLINOIS MUTUAL®

A Mutual Life Insurance Company

This Policy provides benefits, as shown in the Policy Schedule, for loss resulting from specified disease. It is renewable until the renewal date that follows your Renewal Age birthday shown in the Policy Schedule, but subject to our right to increase premiums by class.

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 specified disease 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, subject to the Policy's Termination Provision.

We reserve the right to increase premium rates on all or classes of like policies. 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.

This Is a Specified Disease Policy Which Only Provides Benefits
For The Diagnosis Of Illnesses Specified And Defined In This Policy.
It Does Not Pay Benefits For Loss From Any Other Cause.
Please Read The Policy Carefully - It Contains Waiting Periods and Exclusions.

Illinois Mutual Life Insurance Company
Home Office 300 S.W. Adams Street Peoria, IL 61634 Phone 800.437.7355

SPECIFIED DISEASE POLICY
Form 622

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

READ YOUR POLICY CAREFULLY.

This SPECIFIED DISEASE Policy provides benefits for loss resulting from specified disease. This Policy 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.

ALPHABETIC GUIDE TO YOUR POLICY

	Page		Page
Age	Schedule	Notice of Claim	7
Beneficiary Provision	6	Ownership Provision	6
Benefit Payment Conditions	4	Payment of Claims	7
Claim Forms	7	Proofs of Loss	7
Date of Issue	Schedule	Reinstatement	7
Definitions	3	Renewal Provision	1
Diagnostic Requirements for all Critical Illnesses	5	Right to Examine Policy	1
Exclusions	5	Termination Provision	6
Grace Period	7	Time Limit on Certain Defenses	7
Insured	Schedule	Time of Payment of Claims	7
Misstatement of Age or Gender	7	Unpaid Premium	7
		Waiting Period	Schedule

ILLINOIS MUTUAL®
Life Insurance Company
300 S.W. Adams Street Peoria, IL 61634
800.437.7355

POLICY SCHEDULE

Insured: [John Doe]	Policy Number: [6-000000]
Age: [35]	Date of Issue: [01/28/2011]
Rate Classification: [Non-Tobacco]	State of Issue: [Any state]
Renewal Age: 67	

Total Policy Premium	Annual	[$479.00]
Premium Mode chosen for First Premium	[Quarterly]	[$126.94]

POLICY BENEFITS

Critical Illness Benefit	[$100,000]
Waiting Period	[30] days

The following Critical Illnesses are covered as described in this Policy:

Cancer
Heart Attack
Kidney Failure
Stroke
Major Organ Transplant

DEFINITIONS

As used in this Policy, the terms listed below will have the meanings as defined. Defined terms, when used in this policy, will appear with initial capitalization other than defined pronouns. The plural use of a term will share the same meaning as the singular.

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

You or Your refers to the Insured.

Age means the attained age as of your last birthday.

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, tobacco use or state of issue.

Clinical Diagnosis means a clinical identification of Cancer on history, laboratory study and symptoms. We will pay benefits for a Clinical Diagnosis only if:

1. a pathological diagnosis cannot be made because it is medically inappropriate or life threatening;
2. there is medical evidence to support such diagnosis; and
3. a Physician is treating You for Cancer or has prescribed palliative care.

Covered Event means Cancer, Heart Attack, Kidney Failure, Stroke, and Major Organ Transplant as each is defined in this Policy.

Critical Illness means only the illnesses listed in the Policy Schedule and defined within this Policy. See the Benefit Payment Conditions Provision for definitions, exclusions and limitations.

Date of Issue means the date that this Policy becomes effective

Diagnosed means a definitive diagnosis made by a Physician (where applicable, specializing in a particular area of medicine) and supported by documentation of all appropriate and defined studies:

1. based upon the use of diagnostic evaluations, clinical and/or laboratory investigations, tests and observations; and
2. meeting any diagnostic requirements stated in this Policy for the particular Critical Illness being Diagnosed.

Immediate Family Member means a person who is related to the Insured by marriage, blood, or legal adoption.

Incurs or Incurred means an event, incident, or diagnosis that:

1. initially occurs on or after the Date of Issue of this Policy, and
2. initially occurs while this Policy is in force, and
3. is Diagnosed during the life of the Insured, and
4. is not specifically excluded by any definitions or exclusions in this Policy

Insured means the person named as “Insured” in the Policy Schedule.

Manifests or Manifested means a condition or symptom that would cause an ordinary prudent person to seek medical advice, care, or treatment.

Month means a calendar month.

Pathological Diagnosis means a report of microscopic examination of fixed tissues (histopathology) or preparations of blood or bone marrow. Diagnosis must be made by a Physician who is board certified in Pathology and conform to the standards of the American Board of Pathology.

Physician means a person who:

1. is a doctor or practitioner who is duly licensed by the proper authority and who is practicing within the scope of his license; and
2. practices within the scope of his or her license and specialty in the United States; and
3. is not the Insured; and

DEFINITIONS (cont.)

4. is not the Insured's Immediate Family Member; and
5. does not customarily reside in the same household as the Insured.

Waiting Period means the number of days shown in the Policy Schedule following the Date of Issue or reinstatement effective date.

CRITICAL ILLNESS BENEFITS

We will pay the Critical Illness Benefit stated in the Policy Schedule if a Critical Illness is Manifested and Diagnosed after the Waiting Period subject to the Benefit Payment Conditions Provision of this Policy.

In no event will more than one Critical Illness Benefit be paid. This Policy will terminate when a Critical Illness Benefit is paid.

BENEFIT PAYMENT CONDITIONS

The payment of benefits for a Critical Illness stated in the Policy Schedule is subject to the following conditions:

(a) the Critical Illness initially Incurs and/or Manifests as stated in the Policy; and
(b) the Critical Illness is initially Diagnosed while the coverage on an Insured is effective under this Policy; and
(c) the Critical Illness is Diagnosed, or the diagnosis is confirmed, within the United States or its territories; and
(d) the benefit payment is not excluded by any general or specific exclusion or limitation; and
(e) the Critical Illness diagnosis is made during the lifetime of the Insured

CANCER, for the purposes of this Policy, means a malignant tumor characterized by uncontrolled growth of malignant cells and invasion of normal tissue. The Cancer benefit also covers the following cancers: leukemia (except as noted below), lymphoma, multiple myeloma, and sarcoma. Cancer must be positively Diagnosed with histopathological confirmation. A Clinical Diagnosis will be accepted only if:

(a) a Pathological Diagnosis cannot be made because it is medically inappropriate or life threatening;
(b) there is medical evidence to support the diagnosis; and
(c) a Physician is treating you for Cancer or has prescribed palliative care.

The following tumors are excluded:

- Chronic lymphocytic leukemia that has not progressed to at least Rai Stage I or Binet Stage B;
- All tumors that are histologically described as noncancerous, benign, premalignant, noninvasive, borderline malignant, low malignant potential, dysplasia (all grades) or carcinoma in situ;
- All skin cancers, unless there is metastasis, or the tumor is a malignant melanoma of greater than 1.0 mm maximum thickness (regardless of Clark level or ulceration) as determined by histological examination using the Breslow method;
- Prostate cancer that is histologically classified as Gleason score 6 or lower, or TNM classification T1N0M0 or lower; and
- Noninvasive papillary cancer of the bladder histologically described as TNM classification TaN0M0 or lower.

BENEFIT PAYMENT CONDITIONS (cont.)

HEART ATTACK, for the purposes of this Policy, means death of heart muscle due to inadequate blood supply. All of the following criteria for acute myocardial infarction must be satisfied:

1. typical clinical symptoms, for example, central chest pain; and
2. diagnostic increase of specific cardiac markers; and
3. new electrocardiographic changes of infarction.

Heart Attack that occurred during or within 24 hours after a cardiac or coronary artery procedure is excluded.

KIDNEY FAILURE, for the purposes of this Policy, means chronic irreversible failure of both kidneys to function, as a result of which either regular renal or peritoneal dialysis, or renal transplant is initiated.

STROKE, for the purposes of this Policy, means death of brain tissue due to an acute cerebrovascular event. All of the following criteria for stroke must be satisfied:

1. clinical evidence of infarction of brain tissue, or intracranial or subarachnoid hemorrhage;
2. clear evidence on a CT, MRI or similar imaging technique that a stroke has occurred; and
3. permanent neurologic deficit measured 30 days or more after the event that results in a score of 2 or higher on the Modified Rankin Scale for stroke outcome.

Symptoms due to transient ischemic attack, migraine, hypoxia, traumatic injury to brain tissue or blood vessels, and vascular disease affecting the eye, optic nerve or vestibular functions are excluded.

MAJOR ORGAN TRANSPLANT, for the purposes of this Policy, means human to human organ transplant from a donor to the Insured of bone marrow solely for treatment of Cancer or bone marrow failure, or transplant of an entire kidney, liver, heart, lung, or pancreas.

The following are excluded:

- Transplant of any other organs, parts of organs, tissues or cells.

The need for a Major Organ Transplant must be Diagnosed after the Waiting Period. The Insured must undergo the Major Organ Transplant.

DIAGNOSTIC REQUIREMENTS FOR ALL CRITICAL ILLNESSES

We reserve the right to conduct a physical examination of the Insured and/or to review any Critical Illness Diagnosed by a Physician of our choosing. This Physician must:

(a) have specialty training and board certification in the field of Medicine specific to the Critical Illness being Diagnosed; and
(b) must follow all routinely accepted procedures and protocols in the Diagnosis of the Critical Illness.

EXCLUSIONS

We will not pay benefits for a loss caused by, contributed to, or resulting from:

(a) any act of war, declared or undeclared, or
(b) active duty in the armed forces, National Guard, or any reserve unit, or
(c) engaging in a felony; or participating in any riot or civil insurrection; or
(d) any intentionally self-inflicted injury or suicide or suicide attempt; or
(e) being addicted to drugs or suffering from alcoholism; or
(f) being under the influence of alcohol (including the operation of a motor vehicle with a blood alcohol concentration in excess of the legal limit of the state in which the accident occurs) or a controlled substance unless legally prescribed and used in the manner consistent with that prescription; or

EXCLUSIONS (cont.)

(g) any benefits for conditions Diagnosed outside of the United States unless the Diagnosis can be confirmed in the United States; or
(h) any illness, loss, or condition specifically excluded from the definition of any Critical Illness.

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.

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.

TERMINATION PROVISION

This Policy will terminate on the earliest of:
(1) the date the Grace Period ends where any Policy or Rider Premium is not paid before the Grace Period ends;
(2) the date that the Critical Illness Benefit is paid; or
(3) the date the Owner requests termination; or
(4) the date of the first Policy renewal date that follows your Renewal Age birthday.

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: 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 that starts after the Policy has been in force for 2 years.

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, we will not pay benefits for any Critical Illness that Incurs or Manifests, whichever is applicable, as stated in this Policy, or is Diagnosed before the end of the Waiting Period after the reinstatement effective date.

5. Notice of Claim: Written notice of a claim must be given to us within 60 days after a loss starts or as soon as reasonably possible but in no event later than 180 days from the Date of the Covered Event. 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 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: Benefits for 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.

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 or Gender: If your age or gender has been misstated, the benefits of this Policy will be such as the premium paid would have purchased at the correct age or gender. 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. Conformity With State Statutes: Any provision of this Policy which, on its Date of Issue, 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.

GENERAL PROVISIONS

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

16. 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.

17. 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.

18. 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 Policy Schedule.

Secretary

Chairman & CEO

This Is a Specified Disease Policy Which Only Provides Benefits For The Diagnosis Of Illnesses Specified And Defined In This Policy. It Does Not Pay Benefits For Loss From Any Other Cause. Please Read The Policy Carefully - It Contains Waiting Periods and Exclusions.

Illinois Mutual Life Insurance Company
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