

SERFF Tracking Number: LLNS-127326271 State: Arkansas
Filing Company: Illinois Mutual Life Insurance Company State Tracking Number: 49337
Company Tracking Number: OCBE105 (2)
TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other
Product Name: OCBE105
Project Name/Number: OCBE105/OCBE105

Filing at a Glance

Company: Illinois Mutual Life Insurance Company

Product Name: OCBE105

SERFF Tr Num: LLNS-127326271 State: Arkansas

TOI: H21 Health - Other

SERFF Status: Closed-Approved-
Closed State Tr Num: 49337

Sub-TOI: H21.000 Health - Other

Co Tr Num: OCBE105 (2)

State Status: Approved-Closed

Filing Type: Form

Reviewer(s): Rosalind Minor

Author: Jennifer May-Roseboom

Disposition Date: 07/19/2011

Date Submitted: 07/18/2011

Disposition Status: Approved-
Closed

Implementation Date Requested: 08/15/2011

Implementation Date:

State Filing Description:

General Information

Project Name: OCBE105

Status of Filing in Domicile: Pending

Project Number: OCBE105

Date Approved in Domicile:

Requested Filing Mode: Informational

Domicile Status Comments:

Explanation for Combination/Other:

Market Type: Individual

Submission Type: New Submission

Individual Market Type: Individual

Overall Rate Impact:

Filing Status Changed: 07/19/2011

State Status Changed: 07/19/2011

Deemer Date:

Created By: Jennifer May-Roseboom

Submitted By: Jennifer May-Roseboom

Corresponding Filing Tracking Number: LLNS-
126612929

PPACA: Not PPACA-Related

PPACA Notes: null

Filing Description:

Ref: Illinois Mutual Life Insurance Company

NAIC #64580; FEIN 37-0344290

RE: Form OCBE105, Outline of Coverage for Business Expense Policy

A corrected OCBE105 Outline of Coverage is submitted for your information and to substitute for the prior submitted OCBE105, which was Approved on 05/05/2010 . We inadvertently did not show the Rider Form 9255 Two Year Pure

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Own Occupation as an Optional Benefit Rider in the Business Expense Outline of Coverage. This benefit was approved by the Department on 05/05/2010 in Rider Form 9255 and on the application Form App105-D(AR) on 05/05/2010.

We certify that we have not issued or used any of these forms as of this date. We appreciate your acceptance of this substitution. Should you have any questions or need any additional information, please feel free to contact Ms. Jennifer May of my staff at 800-437-7355 Ext 436.

As always thank you for your assistance with this filing.

Company and Contact

Filing Contact Information

Maureen Mulville, Vice President of Compliance mtmulville@illinoismutual.com
 and General Counsel

Illinois Mutual Life Insurance Company 800-437-7355 [Phone] 471 [Ext]
 300 SW Adams ST 309-674-2076 [FAX]
 Peoria, IL 61634

Filing Company Information

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

Filing Fees

Fee Required? No
 Retaliatory? No
 Fee Explanation:
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Illinois Mutual Life Insurance Company	\$20.00	07/18/2011	49871720
Illinois Mutual Life Insurance Company	\$30.00	07/18/2011	49877545

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	07/19/2011	07/19/2011

Filing Notes

Subject	Note Type	Created By	Created On	Date Submitted
I submitted additional fees of \$30	Note To Reviewer	Jennifer May-Roseboom	07/18/2011	07/18/2011

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Disposition

Disposition Date: 07/19/2011

Implementation Date:

Status: Approved-Closed

HHS Status: HHS Approved

State Review: Reviewed-No Actuary

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
Supporting Document	PPACA Uniform Compliance Summary	Approved-Closed	No
Form	Outline of Coverage for Business Expense Policy	Approved-Closed	Yes

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Note To Reviewer

Created By:

Jennifer May-Roseboom on 07/18/2011 03:21 PM

Last Edited By:

Rosalind Minor

Submitted On:

07/19/2011 01:02 PM

Subject:

I submitted additional fees of \$30

Comments:

I reviewed the gen instructions and saw the fees as \$50 per form so I submitted \$30 in addition to the \$20 submitted earlier today.

If you have any questions, please call me.

Jennifer May

800-437-7355 Ext 436

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Form Schedule

Lead Form Number:

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 07/19/2011	OCBE105	Outline of Coverage	Outline of Coverage for Business Expense Policy	Initial		53.300	OCBE105.pdf



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.

I. Optional Two Year Pure Own Occupation Rider, Form 9255 Included
 Not Included
 Premium: \$_____Per

 This Rider changes the definition of Total Disability during the first 24 months to your inability to perform the substantial and material duties of your occupation only.

(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

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Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification	Approved-Closed	07/19/2011
Comments:			
Attachment:			
Readability.pdf			
		Item Status:	Status Date:
Bypassed - Item:	Application	Approved-Closed	07/19/2011
Bypass Reason:	n/a		
Comments:			
		Item Status:	Status Date:
Bypassed - Item:	Health - Actuarial Justification	Approved-Closed	07/19/2011
Bypass Reason:	n/a		
Comments:			
		Item Status:	Status Date:
Satisfied - Item:	Outline of Coverage	Approved-Closed	07/19/2011
Comments:			
submitted in the Form tab.			
		Item Status:	Status Date:
Bypassed - Item:	PPACA Uniform Compliance Summary	Approved-Closed	07/19/2011
Bypass Reason:	n/a		
Comments:			

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:

53.3% Form OCBE105, Outline of Coverage for Business Expense Policy

ILLINOIS MUTUAL LIFE INSURANCE COMPANY

By:



Maureen Mulville, Vice President of Compliance and
General Counsel

Illinois Mutual Life Insurance Company

300 SW Adams ST

Peoria, IL 61634

(800)437-7355, Ext. 471

Dated: July 18, 2011