

SERFF Tracking Number: LLNS-128459787 State: Arkansas
Filing Company: Illinois Mutual Life Insurance Company State Tracking Number:
Company Tracking Number: MIB
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
Product Name: Life Applications
Project Name/Number: MIB Authorization Change/APP105

Filing at a Glance

Company: Illinois Mutual Life Insurance Company

Product Name: Life Applications

SERFF Tr Num: LLNS-128459787 State: Arkansas

TOI: L08 Life - Other

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

Sub-TOI: L08.000 Life - Other

Co Tr Num: MIB

State Status: Approved-Closed

Filing Type: Form

Reviewer(s): Linda Bird

Author: Laura VanLaningham

Disposition Date: 06/22/2012

Date Submitted: 06/18/2012

Disposition Status: Approved-
Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: MIB Authorization Change

Status of Filing in Domicile: Pending

Project Number: APP105

Date Approved in Domicile:

Requested Filing Mode:

Domicile Status Comments:

Explanation for Combination/Other:

Market Type: Individual

Submission Type: New Submission

Individual Market Type:

Overall Rate Impact:

Filing Status Changed: 06/22/2012

State Status Changed: 06/22/2012

Deemer Date:

Created By: Laura VanLaningham

Submitted By: Laura VanLaningham

Corresponding Filing Tracking Number:

Filing Description:

Re: Form 5580(6/12), Application for Level Death Benefit Life Insurance

Form WSL-APP07(6/12), Application for Workplace Voluntary Life Insurance

The attached forms are submitted for your review and approval. They are updated versions of previously approved forms that reflect a directive from MIB, Inc., to member companies to add a statement to the authorization on their applications, effective January 1, 2013:

"I authorize Illinois Mutual Life Insurance Company, or its reinsurers, to make a brief report of my personal health information to MIB."

Please note, this is the only change we are making to these applications at this time, and we respectfully request that you expedite this process to the extent possible.

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The affected documents are:

Form 5580(6/12), Application for Level Death Benefit Life Insurance, which updates Form 5580, approved 7/19/2007 under SERFF filing No. LLNS-125179550

Form WSL-APP07(6/12), Application for Workplace Voluntary Life Insurance, which updates Form WSL-APP07, approved 1/24/2007 under SERFF filing No. LLNS-125074246

Copies of the forms highlighting the new language are included under the Supporting Documentation tab.

A similar filing addressing the MIB language directive on previously approved Health applications is being filed under SERFF No. LLNS-128462306.

Thank you for your assistance.

State Narrative:

Company and Contact

Filing Contact Information

Hollie Henderson, Manager Corporate Compliance
 300 SW Adams Street
 Peoria, IL 61634
 hghenderson@illinoismutual.com
 309-674-8255 [Phone] 437 [Ext]
 309-674-2076 [FAX]

Filing Company Information

Illinois Mutual Life Insurance Company
 300 SW Adams Street
 Peoria, IL 61634
 (309) 674-8255 ext. [Phone]

 CoCode: 64580 State of Domicile: Illinois
 Group Code: Company Type:
 Group Name: State ID Number:
 FEIN Number: 37-0344290

Filing Fees

Fee Required? Yes
 Fee Amount: \$100.00
 Retaliatory? Yes
 Fee Explanation: Two forms. Illinois filing fees are \$50 per form as in Arkansas.
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Illinois Mutual Life Insurance Company	\$100.00	06/18/2012	60220730

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CHECK NUMBER	CHECK AMOUNT	CHECK DATE
	\$0.00	

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	06/22/2012	06/22/2012

SERFF Tracking Number: LLNS-128459787 State: Arkansas
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Company Tracking Number: MIB
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
Product Name: Life Applications
Project Name/Number: MIB Authorization Change/APP105

Disposition

Disposition Date: 06/22/2012

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: LLNS-128459787 State: Arkansas
 Filing Company: Illinois Mutual Life Insurance Company State Tracking Number:
 Company Tracking Number: MIB
 TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
 Product Name: Life Applications
 Project Name/Number: MIB Authorization Change/APP105

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		No
Supporting Document	Highlighted versions of forms		Yes
Form	Application for Level Death Benefit Life Insurance		Yes
Form	Application for Workplace Voluntary Life Insurance		Yes

SERFF Tracking Number: LLNS-128459787 State: Arkansas
 Filing Company: Illinois Mutual Life Insurance Company State Tracking Number:
 Company Tracking Number: MIB
 TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
 Product Name: Life Applications
 Project Name/Number: MIB Authorization Change/APP105

Form Schedule

Lead Form Number: 5580 (6/12)

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	5580 (6/12)	Application/Enrollment Form	Application for Level Death Benefit Life Insurance	Initial		50.200	5580 (6-12).pdf
	WSL-APP07 (6/12)	Application/Enrollment Form	Application for Workplace Voluntary Life Insurance	Initial		51.311	WSL-APP07 (6-12).pdf

Application for Level Death Benefit Life Insurance

(The questions and declarations must be read in person to the Proposed Insured and/or Owner.)

1. Proposed Insured

- a. Full Name _____ Male Female SS# _____
- b. Address _____ City _____ State _____ Zip _____
- c. Date of Birth _____ d. Birth Place _____
- e. Phone (_____) _____ f. Height _____ Weight _____
- g. Have you used any form of tobacco products during the past 12 months? Yes No

Telephone Interview Completed

- Yes Reference # _____
- No

2. Owner (if other than Proposed Insured)

- a. Full Name _____ b. SS# or TIN# _____
- c. Address _____ City _____ State _____ Zip _____

3. Beneficiary

- a. Primary _____ Relationship _____
- b. Contingent _____ Relationship _____

4. Plan and Billing Information

- a. Amount of Insurance _____
- b. Effective Date: Application Date Issue Date Date to Save Age Special Requests _____
- c. Premium Mode: Annual Semi-Annual Quarterly Monthly Authorized Check Draft 1st Premium on _____
- d. Premium Amount \$ _____ e. Cash with application? Yes No Amount \$ _____
- f. Send Premium Notices to: Insured Owner Other _____
- g. Mail Policy to: Agent Owner (Policy will be mailed to Agent if not marked)
- h. Secondary Addressee (Optional) _____
Name Address
- i. Automatic Premium Loan Requested? Yes No
- j. Dividend Option: Cash Accumulate at Interest Reduce Premium Buy Paid Up Additions
- k. Do you have any existing life insurance or annuities? Yes No
- l. Will you replace any existing life insurance or annuity? Yes No
- If yes, list Company Name and Contract # _____

5. Underwriting Information

All of the following questions refer to the Proposed Insured as "You."

- | | Yes | No |
|--|--------------------------|--------------------------|
| a. Are you now hospitalized, confined to a nursing home, receiving hospice, home health care, or personal assistance performing activities of daily living such as bathing, dressing, eating, toileting or moving about? | <input type="checkbox"/> | <input type="checkbox"/> |
| b. In the past 90 days, have you had or been treated (office visits, medications or surgery) for congestive heart failure, heart surgery, internal cancer, leukemia or malignant melanoma, renal (kidney) failure, cirrhosis, or used oxygen equipment to assist in breathing? | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Have you had or been advised to have kidney dialysis or an organ transplant? | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Have you been advised or scheduled to have a biopsy, surgery, or hospitalization which has not been completed or results that have not been received? | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Have you been diagnosed or treated by a medical practitioner for Acquired Immune Deficiency Syndrome (AIDS)/AIDS Related Complex (ARC) or tested positive for antibodies to the AIDS virus? | <input type="checkbox"/> | <input type="checkbox"/> |

- | | Yes | No |
|---|--------------------------|--------------------------|
| f. In the past 2 years, have you had or been treated (office visits, medications or surgery) for: | | |
| 1. Pacemaker, heart attack, heart surgery, congestive heart failure, angina (chest pain) or other heart or circulatory disease or disorder? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Systemic Lupus, brain tumor, stroke or aneurysm? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Alzheimer's disease, Parkinson's disease, dementia, Cerebral Palsy, epilepsy (seizures, convulsions), Huntington's disease, muscular dystrophy, multiple sclerosis, Lou Gehrig's disease (ALS) or Schizophrenia? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Cirrhosis, chronic hepatitis, Hepatitis C or other liver disease, kidney failure, chronic glomerulonephritis, polycystic kidney disease or other kidney disease? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Alcohol and/or drug abuse? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Diabetes, which includes treatment by oral medication or insulin? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Chronic obstructive pulmonary disease (COPD), emphysema, chronic bronchitis that is not seasonal or other chronic respiratory disorder excluding allergies or asthma? | <input type="checkbox"/> | <input type="checkbox"/> |
| g. In the past 5 years, have you had or been treated (office visits, medications or surgery) for internal cancer, leukemia or malignant melanoma? | <input type="checkbox"/> | <input type="checkbox"/> |

Home Office Endorsement Only. Question # _____ corrected to read as follows:

Agreement: I represent and agree that: (1) all statements and answers herein are true and correctly recorded to the best of my knowledge and belief; (2) I received a MIB Notice; (3) this application will be a part of any contract issued; (4) I agree to accept any amendments made by the Company in the "Home Office Endorsement Only" space except that changes in the amount of insurance, premium, classification of risk, and plan of insurance shall require my written acceptance; and (5) no policy issued on this application shall be effective until received and accepted by me and the first full premium paid. However, if the first premium has been paid, then the liability of the Company shall be as stated in the receipt that I hold.

Authorization: I hereby authorize any physician, medical practitioner, hospital, clinic, pharmacy or pharmacy benefit manager or MIB, Inc. that possesses health information, including prescription history, about me to furnish all such health information to Illinois Mutual Life Insurance Company for the purpose of evaluating my application for insurance. Health information obtained will not be re-disclosed without my authorization unless permitted or required by law, in which case it may not be protected under federal privacy rules. I authorize Illinois Mutual Life Insurance Company, or its reinsurers, to make a brief report of my personal health information to MIB.

I acknowledge that I have read this authorization and that I may receive a copy upon request. This authorization shall be valid for two years from the date of signature below. I may revoke this authorization by sending written notice to Illinois Mutual.

Signed at _____ Date _____

OWNER'S SIGNATURE, IF OTHER THAN PROPOSED INSURED

PROPOSED INSURED'S SIGNATURE

NOTICE: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines and denial of insurance benefits.

For Agent: To the best of my knowledge, the answers and information on the above application are correct and the insurance applied for will will not replace any existing life insurance or annuity.

PRINT AGENT'S NAME

LICENSED AGENT'S SIGNATURE

CODE #

Form 5580 (6/12)

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 _____



Application for Workplace Voluntary Life Insurance

1. Employee Information (Complete All)

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

b. Address _____
STREET CITY STATE ZIP CODE

c. Home Ph. (_____) _____ d. E-mail Address _____

e. Soc. Sec. # _____ f. Employer's Name _____

g. Date of Employment _____ h. Are you actively at work? Yes No i. Employee/Payroll # _____

2. Additional Employee Information (To be completed if Employee is applying for coverage)

a. Date of Birth _____ b. State of Birth _____

c. Occupation _____

d. Hours worked per week _____ e. Monthly Salary \$ _____ (excluding bonuses and overtime)

3. Spouse (To be completed only if applying for Spouse coverage)

a. Name _____
LAST FIRST MI MAIDEN/FORMER SEX

b. Address (if different) _____

c. Soc. Sec. # _____ d. Date of Birth _____

e. Does spouse live in the U.S.? Yes No

f. During the past 12 months, has your spouse been hospitalized or treated, including prescription medication, for an injury or sickness (excluding pregnancy, colds, allergies, flu and back problems)? Yes No If "Yes," answer Questions under Section 7 & 8 on page 3.

4. Child and/or Grandchild (To be completed if applying for Child and/or Grandchild coverage)

Full Name	Social Security No.	Date of Birth	Relationship	Sex	Policy or Rider
1. _____	_____	_____	_____	_____	_____
2. _____	_____	_____	_____	_____	_____
3. _____	_____	_____	_____	_____	_____
4. _____	_____	_____	_____	_____	_____

Do all of the Children/Grandchildren listed above live in the U.S.? Yes No If "No," which ones do not live in the U.S.? _____

Have any of the Children/Grandchildren listed above been diagnosed with or treated for Down's Syndrome, Cerebral Palsy, Muscular Dystrophy or Cystic Fibrosis? Yes No If "Yes," which ones? _____

5. Policy Information (Complete All)

a. Has any proposed insured used any tobacco products (such as cigarettes, cigars, snuff, dip, chew or pipe) or any nicotine delivery system in the past 12 months?

b. (1) Do any proposed insureds have existing individual life insurance coverage?

(2) Will coverage applied for replace any existing individual life insurance coverage?

If "Yes," list: Full Name

Employee		Spouse		#1		#2		#3		#4	
Yes	No										
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	n/a		n/a		n/a		n/a	
<input type="checkbox"/>											
<input type="checkbox"/>											

Company _____ Policy Number _____

c. Face/Specified Amount

d. Base Policy Weekly Premium

e. Riders and Premiums

(1) Term Insurance Rider

Coverage Amount

Weekly Premium

(2) Child Term Insurance Rider

Coverage Amount

Weekly Premium

(3) Accidental Death Benefit

Weekly Premium

(4) Waiver of Premium

Weekly Premium

Employee		Spouse		#1		#2		#3		#4	
\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____
\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____
<input type="checkbox"/>											
\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____
\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____
\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____
\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____

f. Payroll Frequency: Weekly Bi-Weekly Semi-Monthly Monthly Other

TOTAL PAYROLL PREMIUM DEDUCTED: \$ _____

g. Automatic Premium Loan Elected

h. **Dividend Option** Cash Accumulate at Interest Reduce Premium

6. Beneficiary Information (Complete All)

Employee

Primary _____ Relationship to Insured _____

Contingent _____ Relationship to Insured _____

Spouse

Primary _____ Relationship to Insured _____

Contingent _____ Relationship to Insured _____

Children/Grandchildren

The Children/Grandchildren's Beneficiary will automatically be the employee, if living, otherwise the Spouse named in the application. If another beneficiary is preferred, please indicate below in special requests.

Special Request _____

7. Modified Issue

	Employee		Spouse		# 1		Child/Grandchild #2		#3		#4	
	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
a. Has any proposed insured tested positive for exposure to the Human Immunodeficiency Virus (HIV), been diagnosed as having Acquired Immune Deficiency Syndrome (AIDS), AIDS related complex (ARC), or other sickness or condition derived from such infection?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						
b. In the past 12 months, has any proposed insured for any reason other than vacation, colds, flu, pregnancy, allergies or back problems been hospitalized more than 5 consecutive days, or if employed, missed more than 10 consecutive days of work?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						
c. In the past 5 years, has any proposed insured been diagnosed, received medical advice, sought treatment including surgery, or taken medication for any of the following:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						
• Atrial Fibrillation, chest pain, heart attack, coronary artery disease or surgery on the heart or heart valves												
• Congestive Heart Failure or cardiomyopathy												
• Stroke or transient ischemic attack (TIA)												
• High blood pressure treated with 3 or more medications												
• Alcohol or drug abuse												
• Diabetes (excluding gestational or diet controlled)												
• Chronic obstructive pulmonary disease (COPD), emphysema or chronic lung disease (excluding asthma)												
d. In the past 10 years, have you or any proposed insured been diagnosed, received medical advice, sought treatment, or taken medication for cancer or malignancy of any kind, excluding basal cell carcinoma?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						

8. Simplified Issue

	Employee		Spouse		# 1		Child/Grandchild #2		#3		#4	
	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
a. Provide Height and Weight Employee _____ ft. _____ in. _____ lbs. Spouse _____ ft. _____ in. _____ lbs.												
b. Has any proposed insured ever been diagnosed, received medical advice, sought treatment including surgery, or taken medication for any of the following:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						
• Cirrhosis of the liver or hepatitis B or C												
• Kidney disease or failure (excluding kidney stones, sponge, horseshoe or ectopic kidney and kidney removal due to trauma)												
• Atrial fibrillation, chest pain, heart attack, coronary artery disease or surgery on the heart or heart valve(s)												
• Congestive heart failure or cardiomyopathy												
• Stroke or transient ischemic attack (TIA)												
• Peripheral Vascular Disease												
• Cancer (excluding basal cell carcinoma)												
• Any condition requiring an organ transplant (excluding corneal)												
• Diabetes (excluding gestational or diet controlled)												
• Chronic obstructive pulmonary disease (COPD), emphysema or chronic lung disease (excluding asthma)												
c. In the past 5 years, has any proposed insured been diagnosed, received medical advice, sought treatment including surgery, or taken medication for any of the following:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						
• Multiple Sclerosis, Muscular Dystrophy, or Parkinson's disease, amyotrophic lateral sclerosis (ALS or Lou Gehrig's Disease) or Huntington's Disease												
• Schizophrenia, psychosis, bipolar disorder or post traumatic stress disorder												
• Crohn's disease or ulcerative colitis												
• Systemic lupus or any connective tissue disease												
d. In the past 2 years, has any proposed insured:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						
• Pled guilty or no contest or been convicted of a felony or misdemeanor												
• Been charged with operating a motor vehicle under the influence of drugs and/or alcohol												

Agreement: I represent and agree that: (1) all statements and information found in the application are deemed representations and not warranties; (2) all statements and answers herein are true and correctly recorded to the best of my knowledge and belief; (3) this application will be a part of any contract issued; **(4) the insurance applied for shall become effective as of the date the payroll deduction authorization or authorized check form is signed by me.** The Company may modify coverage applied for depending upon eligibility of each insured person. The representations on this application must be true and correct for coverage to begin before the policy effective date and such interim coverage will not extend beyond 90 days; and (5) I have received a MIB Notice.

Authorization: I hereby authorize my employer, MIB, Inc., or any consumer reporting agency who possess information on me, to furnish such information to Illinois Mutual Life Insurance Company, hereinafter called the Company, or its legal representative upon presenting this Authorization or a photocopy. The Company or its authorized representatives may obtain information, in order to evaluate my application for insurance. I authorize Illinois Mutual Life Insurance Company, or its reinsurers, to make a brief report of my personal health information to MIB.

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

Signed at _____
CITY AND STATE SIGNATURE OF EMPLOYEE

Date _____

NOTICE: Any person who knowingly and with the 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

I certify that I asked the above questions of the Employee in person and have recorded the information correctly. I do do not have knowledge that the insurance applied for will replace any existing life insurance.

PRINT WRITING AGENT'S NAME AGENT'S SIGNATURE

Agent's Code # _____ Agent's Phone # _____

SERFF Tracking Number: LLNS-128459787 State: Arkansas
Filing Company: Illinois Mutual Life Insurance Company State Tracking Number:
Company Tracking Number: MIB
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
Product Name: Life Applications
Project Name/Number: MIB Authorization Change/APP105

Supporting Document Schedules

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

	Item Status:	Status Date:
Bypassed - Item: Application Bypass Reason: Filing includes only applications, not policies. Comments:		

	Item Status:	Status Date:
Satisfied - Item: Highlighted versions of forms Comments: These copies of the applications highlight the line that includes the new MIB language. Attachments: 5580 (6-12) MIB change highlighted.pdf WSL-APP07 (6-12) MIB change highlighted.pdf		

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 Flesch score analysis readability procedures and we certify that the forms have a Flesch score as follows:

50.2%	Form 5580 (6/12), Application for Level Death Benefit Life Insurance
51.311%	Form WSL-APP07 (6/12), Application for Workplace Voluntary Life Insurance

ILLINOIS MUTUAL LIFE INSURANCE COMPANY



By:

Maureen T. Mulville
Vice President, Compliance & General Counsel
Illinois Mutual Life Insurance Company
300 SW Adams St.
Peoria, IL 61634
(800) 437-7355, ext. 471
Dated: June 15, 2012

Application for Level Death Benefit Life Insurance

(The questions and declarations must be read in person to the Proposed Insured and/or Owner.)

1. Proposed Insured

- a. Full Name _____ Male Female SS# _____
- b. Address _____ City _____ State _____ Zip _____
- c. Date of Birth _____ d. Birth Place _____
- e. Phone (_____) _____ f. Height _____ Weight _____
- g. Have you used any form of tobacco products during the past 12 months? Yes No

Telephone Interview Completed

- Yes Reference # _____
- No

2. Owner (if other than Proposed Insured)

- a. Full Name _____ b. SS# or TIN# _____
- c. Address _____ City _____ State _____ Zip _____

3. Beneficiary

- a. Primary _____ Relationship _____
- b. Contingent _____ Relationship _____

4. Plan and Billing Information

- a. Amount of Insurance _____
- b. Effective Date: Application Date Issue Date Date to Save Age Special Requests _____
- c. Premium Mode: Annual Semi-Annual Quarterly Monthly Authorized Check Draft 1st Premium on _____
- d. Premium Amount \$ _____ e. Cash with application? Yes No Amount \$ _____
- f. Send Premium Notices to: Insured Owner Other _____
- g. Mail Policy to: Agent Owner (Policy will be mailed to Agent if not marked)
- h. Secondary Addressee (Optional) _____
Name Address
- i. Automatic Premium Loan Requested? Yes No
- j. Dividend Option: Cash Accumulate at Interest Reduce Premium Buy Paid Up Additions
- k. Do you have any existing life insurance or annuities? Yes No
- l. Will you replace any existing life insurance or annuity? Yes No
- If yes, list Company Name and Contract # _____

5. Underwriting Information

All of the following questions refer to the Proposed Insured as "You."

- | | Yes | No |
|--|--------------------------|--------------------------|
| a. Are you now hospitalized, confined to a nursing home, receiving hospice, home health care, or personal assistance performing activities of daily living such as bathing, dressing, eating, toileting or moving about? | <input type="checkbox"/> | <input type="checkbox"/> |
| b. In the past 90 days, have you had or been treated (office visits, medications or surgery) for congestive heart failure, heart surgery, internal cancer, leukemia or malignant melanoma, renal (kidney) failure, cirrhosis, or used oxygen equipment to assist in breathing? | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Have you had or been advised to have kidney dialysis or an organ transplant? | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Have you been advised or scheduled to have a biopsy, surgery, or hospitalization which has not been completed or results that have not been received? | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Have you been diagnosed or treated by a medical practitioner for Acquired Immune Deficiency Syndrome (AIDS)/AIDS Related Complex (ARC) or tested positive for antibodies to the AIDS virus? | <input type="checkbox"/> | <input type="checkbox"/> |

- | | Yes | No |
|---|--------------------------|--------------------------|
| f. In the past 2 years, have you had or been treated (office visits, medications or surgery) for: | | |
| 1. Pacemaker, heart attack, heart surgery, congestive heart failure, angina (chest pain) or other heart or circulatory disease or disorder? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Systemic Lupus, brain tumor, stroke or aneurysm? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Alzheimer's disease, Parkinson's disease, dementia, Cerebral Palsy, epilepsy (seizures, convulsions), Huntington's disease, muscular dystrophy, multiple sclerosis, Lou Gehrig's disease (ALS) or Schizophrenia? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Cirrhosis, chronic hepatitis, Hepatitis C or other liver disease, kidney failure, chronic glomerulonephritis, polycystic kidney disease or other kidney disease? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Alcohol and/or drug abuse? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Diabetes, which includes treatment by oral medication or insulin? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Chronic obstructive pulmonary disease (COPD), emphysema, chronic bronchitis that is not seasonal or other chronic respiratory disorder excluding allergies or asthma? | <input type="checkbox"/> | <input type="checkbox"/> |
| g. In the past 5 years, have you had or been treated (office visits, medications or surgery) for internal cancer, leukemia or malignant melanoma? | <input type="checkbox"/> | <input type="checkbox"/> |

Home Office Endorsement Only. Question # _____ corrected to read as follows:

Agreement: I represent and agree that: (1) all statements and answers herein are true and correctly recorded to the best of my knowledge and belief; (2) I received a MIB Notice; (3) this application will be a part of any contract issued; (4) I agree to accept any amendments made by the Company in the "Home Office Endorsement Only" space except that changes in the amount of insurance, premium, classification of risk, and plan of insurance shall require my written acceptance; and (5) no policy issued on this application shall be effective until received and accepted by me and the first full premium paid. However, if the first premium has been paid, then the liability of the Company shall be as stated in the receipt that I hold.

Authorization: I hereby authorize any physician, medical practitioner, hospital, clinic, pharmacy or pharmacy benefit manager or MIB, Inc. that possesses health information, including prescription history, about me to furnish all such health information to Illinois Mutual Life Insurance Company for the purpose of evaluating my application for insurance. Health information obtained will not be re-disclosed without my authorization unless permitted or required by law, in which case it may not be protected under federal privacy rules. **I authorize Illinois Mutual Life Insurance Company, or its reinsurers, to make a brief report of my personal health information to MIB.**

I acknowledge that I have read this authorization and that I may receive a copy upon request. This authorization shall be valid for two years from the date of signature below. I may revoke this authorization by sending written notice to Illinois Mutual.

Signed at _____ Date _____

OWNER'S SIGNATURE, IF OTHER THAN PROPOSED INSURED

PROPOSED INSURED'S SIGNATURE

NOTICE: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines and denial of insurance benefits.

For Agent: To the best of my knowledge, the answers and information on the above application are correct and the insurance applied for will will not replace any existing life insurance or annuity.

PRINT AGENT'S NAME

LICENSED AGENT'S SIGNATURE

CODE #

Form 5580 (6/12)

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 _____



Application for Workplace Voluntary Life Insurance

1. Employee Information (Complete All)

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

b. Address _____
STREET CITY STATE ZIP CODE

c. Home Ph. (_____) _____ d. E-mail Address _____

e. Soc. Sec. # _____ f. Employer's Name _____

g. Date of Employment _____ h. Are you actively at work? Yes No i. Employee/Payroll # _____

2. Additional Employee Information (To be completed if Employee is applying for coverage)

a. Date of Birth _____ b. State of Birth _____

c. Occupation _____

d. Hours worked per week _____ e. Monthly Salary \$ _____ (excluding bonuses and overtime)

3. Spouse (To be completed only if applying for Spouse coverage)

a. Name _____
LAST FIRST MI MAIDEN/FORMER SEX

b. Address (if different) _____

c. Soc. Sec. # _____ d. Date of Birth _____

e. Does spouse live in the U.S.? Yes No

f. During the past 12 months, has your spouse been hospitalized or treated, including prescription medication, for an injury or sickness (excluding pregnancy, colds, allergies, flu and back problems)? Yes No If "Yes," answer Questions under Section 7 & 8 on page 3.

4. Child and/or Grandchild (To be completed if applying for Child and/or Grandchild coverage)

Full Name	Social Security No.	Date of Birth	Relationship	Sex	Policy or Rider
1. _____	_____	_____	_____	_____	_____
2. _____	_____	_____	_____	_____	_____
3. _____	_____	_____	_____	_____	_____
4. _____	_____	_____	_____	_____	_____

Do all of the Children/Grandchildren listed above live in the U.S.? Yes No If "No," which ones do not live in the U.S.? _____

Have any of the Children/Grandchildren listed above been diagnosed with or treated for Down's Syndrome, Cerebral Palsy, Muscular Dystrophy or Cystic Fibrosis? Yes No If "Yes," which ones? _____

5. Policy Information (Complete All)

a. Has any proposed insured used any tobacco products (such as cigarettes, cigars, snuff, dip, chew or pipe) or any nicotine delivery system in the past 12 months?

b. (1) Do any proposed insureds have existing individual life insurance coverage?

(2) Will coverage applied for replace any existing individual life insurance coverage?

If "Yes," list: Full Name

Employee		Spouse		#1		#2		#3		#4	
Yes	No										
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	n/a		n/a		n/a		n/a	
<input type="checkbox"/>											
<input type="checkbox"/>											

Company _____ Policy Number _____

c. Face/Specified Amount

d. Base Policy Weekly Premium

e. Riders and Premiums

(1) Term Insurance Rider

Coverage Amount

Weekly Premium

(2) Child Term Insurance Rider

Coverage Amount

Weekly Premium

(3) Accidental Death Benefit

Weekly Premium

(4) Waiver of Premium

Weekly Premium

Employee		Spouse		#1		#2		#3		#4	
\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____
\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____
<input type="checkbox"/>											
\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____
\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____
\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____
\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____

f. Payroll Frequency: Weekly Bi-Weekly Semi-Monthly Monthly Other

TOTAL PAYROLL PREMIUM DEDUCTED: \$ _____

g. Automatic Premium Loan Elected

h. **Dividend Option** Cash Accumulate at Interest Reduce Premium

6. Beneficiary Information (Complete All)

Employee

Primary _____ Relationship to Insured _____

Contingent _____ Relationship to Insured _____

Spouse

Primary _____ Relationship to Insured _____

Contingent _____ Relationship to Insured _____

Children/Grandchildren

The Children/Grandchildren's Beneficiary will automatically be the employee, if living, otherwise the Spouse named in the application. If another beneficiary is preferred, please indicate below in special requests.

Special Request _____

7. Modified Issue

	Employee		Spouse		# 1		Child/Grandchild #2		#3		#4	
	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
a. Has any proposed insured tested positive for exposure to the Human Immunodeficiency Virus (HIV), been diagnosed as having Acquired Immune Deficiency Syndrome (AIDS), AIDS related complex (ARC), or other sickness or condition derived from such infection?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						
b. In the past 12 months, has any proposed insured for any reason other than vacation, colds, flu, pregnancy, allergies or back problems been hospitalized more than 5 consecutive days, or if employed, missed more than 10 consecutive days of work?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						
c. In the past 5 years, has any proposed insured been diagnosed, received medical advice, sought treatment including surgery, or taken medication for any of the following:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						
• Atrial Fibrillation, chest pain, heart attack, coronary artery disease or surgery on the heart or heart valves												
• Congestive Heart Failure or cardiomyopathy												
• Stroke or transient ischemic attack (TIA)												
• High blood pressure treated with 3 or more medications												
• Alcohol or drug abuse												
• Diabetes (excluding gestational or diet controlled)												
• Chronic obstructive pulmonary disease (COPD), emphysema or chronic lung disease (excluding asthma)												
d. In the past 10 years, have you or any proposed insured been diagnosed, received medical advice, sought treatment, or taken medication for cancer or malignancy of any kind, excluding basal cell carcinoma?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						

8. Simplified Issue

a. Provide Height and Weight	Employee		Spouse		# 1		Child/Grandchild #2		#3		#4	
	ft.	in.	lbs.	ft.	in.	lbs.	Yes	No	Yes	No	Yes	No
Employee _____ ft. _____ in. _____ lbs.												
Spouse _____ ft. _____ in. _____ lbs.												
b. Has any proposed insured ever been diagnosed, received medical advice, sought treatment including surgery, or taken medication for any of the following:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						
• Cirrhosis of the liver or hepatitis B or C												
• Kidney disease or failure (excluding kidney stones, sponge, horseshoe or ectopic kidney and kidney removal due to trauma)												
• Atrial fibrillation, chest pain, heart attack, coronary artery disease or surgery on the heart or heart valve(s)												
• Congestive heart failure or cardiomyopathy												
• Stroke or transient ischemic attack (TIA)												
• Peripheral Vascular Disease												
• Cancer (excluding basal cell carcinoma)												
• Any condition requiring an organ transplant (excluding corneal)												
• Diabetes (excluding gestational or diet controlled)												
• Chronic obstructive pulmonary disease (COPD), emphysema or chronic lung disease (excluding asthma)												
c. In the past 5 years, has any proposed insured been diagnosed, received medical advice, sought treatment including surgery, or taken medication for any of the following:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						
• Multiple Sclerosis, Muscular Dystrophy, or Parkinson's disease, amyotrophic lateral sclerosis (ALS or Lou Gehrig's Disease) or Huntington's Disease												
• Schizophrenia, psychosis, bipolar disorder or post traumatic stress disorder												
• Crohn's disease or ulcerative colitis												
• Systemic lupus or any connective tissue disease												
d. In the past 2 years, has any proposed insured:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						
• Pled guilty or no contest or been convicted of a felony or misdemeanor												
• Been charged with operating a motor vehicle under the influence of drugs and/or alcohol												

Agreement: I represent and agree that: (1) all statements and information found in the application are deemed representations and not warranties; (2) all statements and answers herein are true and correctly recorded to the best of my knowledge and belief; (3) this application will be a part of any contract issued; (4) **the insurance applied for shall become effective as of the date the payroll deduction authorization or authorized check form is signed by me.** The Company may modify coverage applied for depending upon eligibility of each insured person. The representations on this application must be true and correct for coverage to begin before the policy effective date and such interim coverage will not extend beyond 90 days; and (5) I have received a MIB Notice.

Authorization: I hereby authorize my employer, MIB, Inc., or any consumer reporting agency who possess information on me, to furnish such information to Illinois Mutual Life Insurance Company, hereinafter called the Company, or its legal representative upon presenting this Authorization or a photocopy. The Company or its authorized representatives may obtain information, in order to evaluate my application for insurance. **I authorize Illinois Mutual Life Insurance Company, or its reinsurers, to make a brief report of my personal health information to MIB.**

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

Signed at _____
CITY AND STATE SIGNATURE OF EMPLOYEE

Date _____

NOTICE: Any person who knowingly and with the 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

I certify that I asked the above questions of the Employee in person and have recorded the information correctly. I do do not have knowledge that the insurance applied for will replace any existing life insurance.

PRINT WRITING AGENT'S NAME AGENT'S SIGNATURE

Agent's Code # _____ Agent's Phone # _____