

SERFF Tracking Number: LLNS-128462306 State: Arkansas
Filing Company: Illinois Mutual Life Insurance Company State Tracking Number:
Company Tracking Number: MIB
TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other
Product Name: Accident/Health Applications
Project Name/Number: MIB Authorization Change/APP105

Filing at a Glance

Company: Illinois Mutual Life Insurance Company

Product Name: Accident/Health Applications SERFF Tr Num: LLNS-128462306 State: Arkansas
TOI: H21 Health - Other SERFF Status: Closed-Approved- State Tr Num:
Closed
Sub-TOI: H21.000 Health - Other Co Tr Num: MIB State Status: Approved-Closed
Filing Type: Form Reviewer(s): Rosalind Minor
Author: Laura VanLaningham Disposition Date: 06/21/2012
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: Review & Approval Domicile Status Comments:
Explanation for Combination/Other: Market Type: Individual
Submission Type: New Submission Individual Market Type:
Overall Rate Impact: Filing Status Changed: 06/21/2012
State Status Changed: 06/21/2012
Deemer Date: Created By: Laura VanLaningham
Submitted By: Laura VanLaningham Corresponding Filing Tracking Number:
PPACA: Not PPACA-Related
PPACA Notes: null
Healthcare.gov ID:
Filing Description:
Re: Form APP105(6/12), Application for Insurance
Form WSD-APP07(6/12), Application for Workplace Voluntary Disability Income Insurance
Form WSA-APP07(6/12), Application for Workplace Voluntary Accident Insurance
Form WSA-EAPP(6/12), Application for Workplace Voluntary Accident 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

SERFF Tracking Number: LLNS-128462306 State: Arkansas
Filing Company: Illinois Mutual Life Insurance Company State Tracking Number:
Company Tracking Number: MIB
TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other
Product Name: Accident/Health Applications
Project Name/Number: MIB Authorization Change/APP105

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.

The affected documents are:

Form APP105(6/12), Application for Insurance, which updates Form APP105(AR), approved 5/5/2010 under SERFF filing No. LLNS-126599604

Form WSD-APP07(6/12), Application for Workplace Voluntary Disability Income Insurance, which updates Form WSD-APP07, approved 12/21/2006 under SERFF filing No. LLNS-125064095

Form WSA-APP07(6/12), Application for Workplace Voluntary Accident Insurance, which updates Form WSA-APP07, approved 2/26/2007 under SERFF filing No. LLNS-125093222

Form WSA-EAPP(6/12), Application for Workplace Voluntary Accident Insurance, which updates Form WSA-APP07, approved 12/1/2009 under SERFF filing No. LLNS-126390083

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 Life applications is being filed under SERFF No. LLNS-128459787.

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

Filing Fees

SERFF Tracking Number: LLNS-128462306 State: Arkansas
Filing Company: Illinois Mutual Life Insurance Company State Tracking Number:
Company Tracking Number: MIB
TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other
Product Name: Accident/Health Applications
Project Name/Number: MIB Authorization Change/APP105

Fee Required? Yes
Fee Amount: \$200.00
Retaliatory? Yes
Fee Explanation: Four forms. Illinois filing fees are \$50 per form as in Arkansas.
Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Illinois Mutual Life Insurance Company	\$200.00	06/18/2012	60220714

CHECK NUMBER	CHECK AMOUNT	CHECK DATE
	\$0.00	

SERFF Tracking Number: LLNS-128462306 State: Arkansas
Filing Company: Illinois Mutual Life Insurance Company State Tracking Number:
Company Tracking Number: MIB
TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other
Product Name: Accident/Health Applications
Project Name/Number: MIB Authorization Change/APP105

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	06/21/2012	06/21/2012

SERFF Tracking Number: LLNS-128462306 State: Arkansas
Filing Company: Illinois Mutual Life Insurance Company State Tracking Number:
Company Tracking Number: MIB
TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other
Product Name: Accident/Health Applications
Project Name/Number: MIB Authorization Change/APP105

Disposition

Disposition Date: 06/21/2012

Implementation Date:

Status: Approved-Closed

HHS Status: Not Reported

State Review: Reviewed-No Actuary

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: LLNS-128462306 State: Arkansas
 Filing Company: Illinois Mutual Life Insurance Company State Tracking Number:
 Company Tracking Number: MIB
 TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other
 Product Name: Accident/Health Applications
 Project Name/Number: MIB Authorization Change/APP105

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	Yes
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Supporting Document	PPACA Uniform Compliance Summary	Approved-Closed	Yes
Supporting Document	Highlighted versions of forms	Approved-Closed	Yes
Form	Application for Insurance	Approved-Closed	Yes
Form	Application for Workplace Voluntary Disability Income Insurance	Approved-Closed	Yes
Form	Application for Workplace Voluntary Accident Insurance	Approved-Closed	Yes
Form	Application for Workplace Voluntary Accident Insurance	Approved-Closed	Yes

SERFF Tracking Number: LLNS-128462306 State: Arkansas
 Filing Company: Illinois Mutual Life Insurance Company State Tracking Number:
 Company Tracking Number: MIB
 TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other
 Product Name: Accident/Health Applications
 Project Name/Number: MIB Authorization Change/APP105

Form Schedule

Lead Form Number: APP105 (6/12)

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 06/21/2012	APP105 (6/12)	Application/Enrollment Form	Application for Insurance	Initial		53.800	App105 (6-12).pdf
Approved-Closed 06/21/2012	WSD-APP07 (6/12)	Application/Enrollment Form	Application for Workplace Voluntary Disability Income Insurance	Initial		50.145	WSD_APP07 (6-12).pdf
Approved-Closed 06/21/2012	WSA-APP07 (6/12)	Application/Enrollment Form	Application for Workplace Voluntary Accident Insurance	Initial		58.450	WSA_APP07 (6-12).pdf
Approved-Closed 06/21/2012	WSA-EAPP	Application/Enrollment Form	Application for Workplace Voluntary Accident Insurance	Initial		58.450	WSA_EAPP (6-12).pdf

Application for Insurance

Proposed Insured _____ D.O.B. _____

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

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

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

- g. How many hours are you currently working per week in your primary occupation? _____
- h. Are you self-employed or an owner of a corporation or partnership? Yes No
If yes, indicate percentage of ownership and type of business entity. _____
- i. Do you work from your home? Yes No If yes, specify number of hours per week. _____
- j. Do you intend to change occupation, employer or employment status in the next 6 months? Yes No
If yes, provide details. _____
- k. Do you have other employment currently, full or part-time? Yes No
If yes, specify number of hours per week, dates employed and occupational duties performed. _____
- l. Did you have other employment within the past 5 years, full or part time? Yes No
If yes, specify number of hours per week, dates employed and occupational duties performed. _____

2. General Information

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

PART C

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

Agreement and Declaration

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

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

Signed at _____
CITY AND STATE
SIGNATURE OF PROPOSED INSURED
(OR PARENT IF PROPOSED INSURED UNDER AGE 18)

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

SIGNATURE OF PROPOSED RIDER INSURED

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

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

PRINT WRITING AGENT NAME
WRITING AGENT'S SIGNATURE

Agent's Code # _____ Agent's Phone # _____
Agent's E-mail _____

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

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

Split Commission Information

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

Name _____ Code # _____ % of Commission _____
Name _____ Code # _____ % of Commission _____

Examination Requirements

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

Application for Workplace Voluntary Disability Income 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. Date of Birth _____ g. State of Birth _____

h. Employer's Name _____

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

l. Occupation _____

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

2. Policy Information (Complete All)

a. Industry Class _____ b. Elimination Period for Accident _____ Days c. Elimination Period for Sickness _____ Days

d. Benefit Period for Accident and Sickness _____ Months

e. Coverage Selected:	Monthly Benefit	Weekly Premium
<input type="checkbox"/> Sickness and Off-Job Accident	\$ _____	\$ _____
<input type="checkbox"/> On-Job Accident	\$ _____	\$ _____

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

TOTAL PAYROLL PREMIUM DEDUCTED: \$ _____

g. Will coverage applied for replace or modify any disability insurance? Yes No If "Yes," please list
 Company _____ Policy No. _____

h. Do you have any group or individual disability income insurance? Yes No If "yes", give details

Insurance Company	Monthly Benefit	Elimination/Benefit Period
_____	_____	_____
_____	_____	_____
_____	_____	_____

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) no policy issued on this application shall be effective until the 1st day of the month in which payroll deductions or authorized check deductions begin; and (5) I have received a MIB Notice.

Authorization: I hereby authorize my employer, MIB, Inc., or any consumer reporting agency who possesses 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. An Outline of Coverage was given to the Applicant. I do do not have knowledge that the insurance applied for will replace any existing disability income insurance.

PRINT WRITING AGENT NAME AGENT'S SIGNATURE

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

Application for Workplace Voluntary Accident 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. Date of Birth _____ g. State of Birth _____
- h. Employer's Name _____
- i. Date of Employment _____ j. Are you actively at work? Yes No k. Employee/Payroll # _____
- l. Occupation _____
- m. Hours worked per week _____ n. Monthly Salary \$ _____ (excluding bonuses and overtime)

2. Spouse (Complete 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

3. Child (To be completed if applying for Child coverage)

Full Name	Date of Birth	Relationship	Sex
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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

4. Policy Information (Complete All)

a. Base Accident Plan: Premium \$ _____

- Employee
- Employee/Spouse
- Employee/Children
- Employee/Spouse/Children

b. Additional Riders

Wellness Benefit Rider

Number of Units _____ Benefit Amount \$ _____ Premium \$ _____

Sickness Confinement Rider (if selected, answer Section 6 questions)

Number of Units _____ Benefit Amount \$ _____ Premium \$ _____

Off-the-Job Accident Disability Rider (Employee only)

Benefit Period: 6 month 12 month

Number of Units _____ Benefit Amount \$ _____ Premium \$ _____

Catastrophic Accident Rider Premium \$ _____

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

TOTAL PAYROLL PREMIUM DEDUCTED: \$ _____

d. Will coverage applied for replace any existing individual accident insurance? Yes No If "Yes," please list
Company Policy No.

e. If applying for Off-the-Job Accident Disability Rider, do you have any group or individual disability income insurance? Yes No
If "Yes," give details

Insurance Company	Monthly Benefit	Elimination/Benefit Period
_____	_____	_____
_____	_____	_____
_____	_____	_____

5. Beneficiary Information (Complete All)

Employee

Primary _____ Relationship to Insured _____

Contingent _____ Relationship to Insured _____

Spouse

Primary _____ Relationship to Insured _____

Contingent _____ Relationship to Insured _____

Children

The Children'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 _____

6. Medical Information (To be completed only if applying for Sickness Confinement Rider)

- a. In the past 12 months, other than colds, flu or normal pregnancy, have you taken time off from work or taken vacation for 10 or more consecutive days due to an injury, sickness, back, neck, knee, shoulder, joints, or muscular disorder?..... Yes No
- b. 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? Yes No
- c. In the past 12 months, has any proposed insured received medical advice, sought treatment, including medication, or been hospitalized for any of the following?..... Yes No

- | | |
|--|---|
| <ul style="list-style-type: none"> • Heart Attack/Heart Surgery • Congestive Heart Failure • Stroke/Transient Ischemic Attack (TIA) • High Blood Pressure treated with 3 or more Medications • Kidney disease (except stones) • Respiratory disorders (including asthma) • Seizures | <ul style="list-style-type: none"> • Insulin Dependent Diabetes • Cirrhosis • Hepatitis B or C • Cancer (other than skin cancer) • Cystic Fibrosis |
|--|---|

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. An Outline of Coverage was given to the Applicant. I do do not have knowledge that the insurance applied for will replace any existing disability income insurance.

PRINT WRITING AGENT NAME AGENT'S SIGNATURE

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

Application for Workplace Voluntary Accident 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. Date of Birth _____ g. State of Birth _____

h. Employer's Name _____

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

l. Occupation _____

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

2. Spouse (Complete 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

3. Child (To be completed if applying for Child coverage)

Full Name	Date of Birth	Relationship	Sex
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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

4. Policy Information (Complete All)

a. Base Accident Plan: Premium \$ _____

- Employee
- Employee/Spouse
- Employee/Children
- Employee/Spouse/Children

b. Additional Riders

Wellness Benefit Rider

Number of Units _____ Benefit Amount \$ _____ Premium \$ _____

Sickness Confinement Rider (if selected, answer Section 6 questions)

Number of Units _____ Benefit Amount \$ _____ Premium \$ _____

Off-the-Job Accident Disability Rider (Employee only)

Benefit Period: 6 month 12 month

Number of Units _____ Benefit Amount \$ _____ Premium \$ _____

Catastrophic Accident Rider Premium \$ _____

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

TOTAL PAYROLL PREMIUM DEDUCTED: \$ _____

d. Will coverage applied for replace any existing individual accident insurance? Yes No If "Yes," please list
Company Policy No.

e. If applying for Off-the-Job Accident Disability Rider, do you have any group or individual disability income insurance? Yes No
If "Yes," give details

Insurance Company	Monthly Benefit	Elimination/Benefit Period
_____	_____	_____
_____	_____	_____
_____	_____	_____

5. Beneficiary Information (Complete All)

Employee

Primary _____ Relationship to Insured _____

Contingent _____ Relationship to Insured _____

Spouse

Primary _____ Relationship to Insured _____

Contingent _____ Relationship to Insured _____

Children

The Children'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 _____

6. Medical Information (To be completed only if applying for Sickness Confinement Rider)

a. In the past 12 months, other than colds, flu or normal pregnancy, have you taken time off from work or taken vacation for 10 or more consecutive days due to an injury, sickness, back, neck, knee, shoulder, joints, or muscular disorder?..... Yes No

b. 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? Yes No

c. In the past 12 months, has any proposed insured received medical advice, sought treatment, including medication, or been hospitalized for any of the following?..... Yes No

- | | |
|--|---|
| <ul style="list-style-type: none"> • Heart Attack/Heart Surgery • Congestive Heart Failure • Stroke/Transient Ischemic Attack (TIA) • High Blood Pressure treated with 3 or more Medications • Kidney disease (except stones) • Respiratory disorders (including asthma) • Seizures | <ul style="list-style-type: none"> • Insulin Dependent Diabetes • Cirrhosis • Hepatitis B or C • Cancer (other than skin cancer) • Cystic Fibrosis |
|--|---|

SERFF Tracking Number: LLNS-128462306 State: Arkansas
 Filing Company: Illinois Mutual Life Insurance Company State Tracking Number:
 Company Tracking Number: MIB
 TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other
 Product Name: Accident/Health Applications
 Project Name/Number: MIB Authorization Change/APP105

Supporting Document Schedules

	Item Status:	Status Date:
Satisfied - Item: Flesch Certification	Approved-Closed	06/21/2012
Comments:		
Attachment: AR Readability Cert_Health.pdf		

	Item Status:	Status Date:
Bypassed - Item: Application	Approved-Closed	06/21/2012
Bypass Reason: Filing includes only applications, not policies.		
Comments:		

	Item Status:	Status Date:
Bypassed - Item: Health - Actuarial Justification	Approved-Closed	06/21/2012
Bypass Reason: Not applicable.		
Comments:		

	Item Status:	Status Date:
Bypassed - Item: Outline of Coverage	Approved-Closed	06/21/2012
Bypass Reason: Not applicable.		
Comments:		

	Item Status:	Status Date:
Bypassed - Item: PPACA Uniform Compliance Summary	Approved-Closed	06/21/2012
Bypass Reason: Not applicable.		
Comments:		

SERFF Tracking Number: LLNS-128462306 State: Arkansas
Filing Company: Illinois Mutual Life Insurance Company State Tracking Number:
Company Tracking Number: MIB
TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other
Product Name: Accident/Health Applications
Project Name/Number: MIB Authorization Change/APP105

Item Status:

Status

Date:

Satisfied - Item: Highlighted versions of forms

Approved-Closed

06/21/2012

Comments:

These copies of the applications highlight the line that includes the new MIB language.

Attachments:

- App105 (6-12) MIB change highlighted.pdf
- WSD_APP07 (6-12) MIB change highlighted.pdf
- WSA_APP07 (6-12) MIB change highlighted.pdf
- WSA_EAPP (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:

53.8%	Form APP105 (6/12), Application for Insurance
50.145%	Form WSD-APP07 (6/12), Application for Workplace Voluntary Disability Income Insurance
58.45%	Form WSA-APP07 (6/12), Application for Workplace Voluntary Accident Insurance
58.45%	Form WSA-EAPP (6/12), Application for Workplace Voluntary Accident 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 Insurance

Proposed Insured _____ D.O.B. _____

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

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

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

g. How many hours are you currently working per week in your primary occupation? _____

h. Are you self-employed or an owner of a corporation or partnership? Yes No
If yes, indicate percentage of ownership and type of business entity. _____

i. Do you work from your home? Yes No If yes, specify number of hours per week. _____

j. Do you intend to change occupation, employer or employment status in the next 6 months? Yes No
If yes, provide details. _____

k. Do you have other employment currently, full or part-time? Yes No
If yes, specify number of hours per week, dates employed and occupational duties performed. _____

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

2. General Information

a. What is your current: (1) Height: _____ feet _____ inches (2) Weight: _____ pounds

b. Have you lost more than 10 pounds in the past 12 months? Yes No
If yes, specify number of pounds lost and reason. _____

c. In the past 10 years, have you consumed alcoholic beverages? Yes No If yes, specify type, amount and frequency, and date of last use. _____

d. In the past 10 years, have you used heroin, cocaine, marijuana, barbiturates or any other controlled substance not prescribed by a physician? Yes No If yes, specify type, frequency and date of last use. _____

e. Have you ever been advised to limit or discontinue the use of alcohol or drugs, or received counseling or treatment because of alcohol or drug use? Yes No If yes, provide dates and details. _____

f. In the past 10 years, have you been convicted of a felony? Yes No If yes, provide dates and details. _____

g. In the past 5 years, have you been charged with driving while intoxicated, had more than 3 moving violations, or had your driver's license suspended or revoked? Yes No If yes, provide dates and details. _____

h. In the past 2 years, have you traveled or worked outside the United States for more than 30 days? Yes No
If yes, provide details. _____

i. In the next 2 years, do you plan to travel or work outside the United States for more than 30 days? Yes No
If yes, provide details. _____

j. Do you engage in personal aviation activity, mountain or rock climbing, motor-powered racing, scuba or sky diving, hang gliding or any other hazardous activity? Yes No If yes, provide details. _____

k. In the past 5 years, have you had any insurance application modified or declined? Yes No If yes, provide details. _____

l. In the past 5 years, have you requested or received any disability benefits? Yes No If yes, provide details. _____

PART C

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

Agreement and Declaration

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

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

Signed at _____
CITY AND STATE

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

Date _____

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

SIGNATURE OF PROPOSED RIDER INSURED

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

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

PRINT WRITING AGENT NAME

WRITING AGENT'S SIGNATURE

Agent's Code # _____

Agent's Phone # _____

Agent's E-mail _____

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

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

Split Commission Information

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

Name _____ Code # _____ % of Commission _____

Name _____ Code # _____ % of Commission _____

Examination Requirements

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

Application for Workplace Voluntary Disability Income 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. Date of Birth _____ g. State of Birth _____

h. Employer's Name _____

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

l. Occupation _____

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

2. Policy Information (Complete All)

a. Industry Class _____ b. Elimination Period for Accident _____ Days c. Elimination Period for Sickness _____ Days

d. Benefit Period for Accident and Sickness _____ Months

e. Coverage Selected:	Monthly Benefit	Weekly Premium
<input type="checkbox"/> Sickness and Off-Job Accident	\$ _____	\$ _____
<input type="checkbox"/> On-Job Accident	\$ _____	\$ _____

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

TOTAL PAYROLL PREMIUM DEDUCTED: \$ _____

g. Will coverage applied for replace or modify any disability insurance? Yes No If "Yes," please list
 Company _____ Policy No. _____

h. Do you have any group or individual disability income insurance? Yes No If "yes", give details

Insurance Company	Monthly Benefit	Elimination/Benefit Period
_____	_____	_____
_____	_____	_____
_____	_____	_____

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) no policy issued on this application shall be effective until the 1st day of the month in which payroll deductions or authorized check deductions begin; and (5) I have received a MIB Notice.

Authorization: I hereby authorize my employer, MIB, Inc., or any consumer reporting agency who possesses 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. An Outline of Coverage was given to the Applicant. I do do not have knowledge that the insurance applied for will replace any existing disability income insurance.

PRINT WRITING AGENT NAME AGENT'S SIGNATURE

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

Application for Workplace Voluntary Accident 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. Date of Birth _____ g. State of Birth _____

h. Employer's Name _____

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

l. Occupation _____

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

2. Spouse (Complete 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

3. Child (To be completed if applying for Child coverage)

Full Name	Date of Birth	Relationship	Sex
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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

4. Policy Information (Complete All)

a. Base Accident Plan: Premium \$ _____

- Employee
- Employee/Spouse
- Employee/Children
- Employee/Spouse/Children

b. Additional Riders

Wellness Benefit Rider

Number of Units _____ Benefit Amount \$ _____ Premium \$ _____

Sickness Confinement Rider (if selected, answer Section 6 questions)

Number of Units _____ Benefit Amount \$ _____ Premium \$ _____

Off-the-Job Accident Disability Rider (Employee only)

Benefit Period: 6 month 12 month

Number of Units _____ Benefit Amount \$ _____ Premium \$ _____

Catastrophic Accident Rider Premium \$ _____

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

TOTAL PAYROLL PREMIUM DEDUCTED: \$ _____

d. Will coverage applied for replace any existing individual accident insurance? Yes No If "Yes," please list
Company Policy No.

e. If applying for Off-the-Job Accident Disability Rider, do you have any group or individual disability income insurance? Yes No
If "Yes," give details

Insurance Company	Monthly Benefit	Elimination/Benefit Period
_____	_____	_____
_____	_____	_____
_____	_____	_____

5. Beneficiary Information (Complete All)

Employee

Primary _____ Relationship to Insured _____

Contingent _____ Relationship to Insured _____

Spouse

Primary _____ Relationship to Insured _____

Contingent _____ Relationship to Insured _____

Children

The Children'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 _____

6. Medical Information (To be completed only if applying for Sickness Confinement Rider)

- a. In the past 12 months, other than colds, flu or normal pregnancy, have you taken time off from work or taken vacation for 10 or more consecutive days due to an injury, sickness, back, neck, knee, shoulder, joints, or muscular disorder?..... Yes No
- b. 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? Yes No
- c. In the past 12 months, has any proposed insured received medical advice, sought treatment, including medication, or been hospitalized for any of the following?..... Yes No

- | | |
|--|---|
| <ul style="list-style-type: none"> • Heart Attack/Heart Surgery • Congestive Heart Failure • Stroke/Transient Ischemic Attack (TIA) • High Blood Pressure treated with 3 or more Medications • Kidney disease (except stones) • Respiratory disorders (including asthma) • Seizures | <ul style="list-style-type: none"> • Insulin Dependent Diabetes • Cirrhosis • Hepatitis B or C • Cancer (other than skin cancer) • Cystic Fibrosis |
|--|---|

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. An Outline of Coverage was given to the Applicant. I do do not have knowledge that the insurance applied for will replace any existing disability income insurance.

_____ PRINT WRITING AGENT NAME _____ AGENT'S SIGNATURE

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

Application for Workplace Voluntary Accident 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. Date of Birth _____ g. State of Birth _____

h. Employer's Name _____

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

l. Occupation _____

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

2. Spouse (Complete 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

3. Child (To be completed if applying for Child coverage)

Full Name	Date of Birth	Relationship	Sex
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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

4. Policy Information (Complete All)

a. Base Accident Plan: Premium \$ _____

- Employee
- Employee/Spouse
- Employee/Children
- Employee/Spouse/Children

b. Additional Riders

Wellness Benefit Rider

Number of Units _____ Benefit Amount \$ _____ Premium \$ _____

Sickness Confinement Rider (if selected, answer Section 6 questions)

Number of Units _____ Benefit Amount \$ _____ Premium \$ _____

Off-the-Job Accident Disability Rider (Employee only)

Benefit Period: 6 month 12 month

Number of Units _____ Benefit Amount \$ _____ Premium \$ _____

Catastrophic Accident Rider Premium \$ _____

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

TOTAL PAYROLL PREMIUM DEDUCTED: \$ _____

d. Will coverage applied for replace any existing individual accident insurance? Yes No If "Yes," please list
Company Policy No.

e. If applying for Off-the-Job Accident Disability Rider, do you have any group or individual disability income insurance? Yes No
If "Yes," give details

Insurance Company	Monthly Benefit	Elimination/Benefit Period
_____	_____	_____
_____	_____	_____
_____	_____	_____

5. Beneficiary Information (Complete All)

Employee

Primary _____ Relationship to Insured _____

Contingent _____ Relationship to Insured _____

Spouse

Primary _____ Relationship to Insured _____

Contingent _____ Relationship to Insured _____

Children

The Children'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 _____

6. Medical Information (To be completed only if applying for Sickness Confinement Rider)

a. In the past 12 months, other than colds, flu or normal pregnancy, have you taken time off from work or taken vacation for 10 or more consecutive days due to an injury, sickness, back, neck, knee, shoulder, joints, or muscular disorder?..... Yes No

b. 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? Yes No

c. In the past 12 months, has any proposed insured received medical advice, sought treatment, including medication, or been hospitalized for any of the following?..... Yes No

- | | |
|--|---|
| <ul style="list-style-type: none"> • Heart Attack/Heart Surgery • Congestive Heart Failure • Stroke/Transient Ischemic Attack (TIA) • High Blood Pressure treated with 3 or more Medications • Kidney disease (except stones) • Respiratory disorders (including asthma) • Seizures | <ul style="list-style-type: none"> • Insulin Dependent Diabetes • Cirrhosis • Hepatitis B or C • Cancer (other than skin cancer) • Cystic Fibrosis |
|--|---|

