☐ **ESP**

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

Application for Disability Income Insurance

PART A

1. Proposed Insured

a. Name ____ ________ ______
LAST FIRST MI MAIDEN/FORMER MARITAL STATUS SEX

b. Address ____
STREET CITY STATE ZIP CODE

c. Home Ph. (_________) ____________________ Bus. Ph. (_________) ____________________

d. E-mail address (optional) ____

e. Soc. Sec. #______________________ **f.** Date of Birth ________________ **g.** Place of Birth (State/Country) ______________________

h. Are you a U.S. Citizen? ☐ Yes ☐ No If no, how long have you resided in the U.S.? ______________________

i. Primary Occupation ____

j. Current monthly earned income from primary occupation to be reported for federal income tax purposes $____________________
(If self employed or owner of corporation indicate net earned income after business expenses)

k. Do you have, are you applying for, or will you become eligible for other disability income or business expenses coverage? ☐ Yes ☐ No

l. Do you plan on replacing any existing disability income or business expense coverage with insurance applied for in this application?
☐ Yes ☐ No

m. Have you used any form of tobacco products during the past 12 months? ☐ Yes ☐ No

2. Owner (if other than Proposed Insured)

a. Name ____ **b.** Soc. Sec. or Tax I.D.# ________________________________

c. Address ____
STREET CITY STATE ZIP CODE

3. Individual Plan Information

Base Monthly Benefit $ ________________

Plan	**Occ. Class**			**Elimination Period**				**Benefit Period**		
☐ GR21	☐ 1	☐ 2	☐ 3	☐ 30 Day	☐ 60 Day	☐ 90 Day	☐ 180 Day	☐ 6 Month	☐ 1 Year	☐ 2 Year
☐ NC21	☐ 4	☐ 5		☐ 1 Year	☐ 2 Year			☐ 5 Year	☐ 10 Year	☐ To Age 65

Optional Benefits/Riders

☐ First Year Monthly Amount $ __________________

☐ Retroactive Injury

☐ Integrated Monthly Benefit Amount $ __________________

☐ Surrender Value SVR Beneficiary______________________________________ Relationship ________________

☐ Guaranteed Insurability ☐ $100 ☐ $200 ☐ $300 ☐ $400 ☐ $500 ☐ $600

☐ COLA ☐ Residual Disability

☐ ADL Monthly Amount $__________________ ☐ 2 Year ☐ 5 Year ☐ To Age 65

4. Special Risk Plan Information

Base Monthly Benefit $_________________

Plan
☐ SR21

Elimination Period
☐ 30 Day ☐ 60 Day ☐ 90 Day ☐ 180 Day

Benefit Period
☐ 24 Months ☐ 60 Months

Optional Benefits/Riders

☐ Partial Disability Monthly Amount $_______________________

☐ Surrender Value SVR Beneficiary ____ Relationship __________________

☐ Integrated Monthly Benefit Amount $_______________________

5. Business Expense Plan Information

Base Monthly Benefit $_________________

Plan
☐ BE21
☐ SRBE21

Occ. Class
☐1 ☐2 ☐3 ☐4 ☐5

Elimination Period
☐ 30 Day ☐ 60 Day ☐ 90 Day

Benefit Period
☐ 12 Months ☐ 18 Months ☐ 24 Months

Optional Benefits/Riders

☐ Surrender Value SVR Beneficiary ____ Relationship __________________

☐ Retroactive Injury (BE21 only)

☐ Guaranteed Insurability (BE21 only) ☐ $100 ☐ $200 ☐ $300 ☐ $400 ☐ $500 ☐ $600

☐ Partial Disability Monthly Amount (SRBE21 only) $_________________________

Business Expense Details

Of the expenses listed below, what is the average monthly amount of business expense currently incurred by you? Exclude salary, fees or other remuneration received by you or by a partner(s) or by any other member of your profession employed or working with you:

Employees' Salaries (not members of your profession)
Mortgage and Other Business Interest (but not principal)
Office Maintenance
Periodicals, Magazines & Professional Dues
Professional Services Fees
Property and Casualty Insurance
Rent/Lease
Taxes (property and payroll)
Utilities
Depreciation

TOTAL AVERAGE MONTHLY EXPENSES $________________________

6. Billing and Payment

a. Effective Date: ☐ Application Date ☐ Issue Date ☐ Special Requests

b. Premium Notices: ☐ Insured at Residence ☐ Owner at address shown in 2.c. ☐ Insured at Business ☐ Other

c. Premiums Payable: ☐ Annual ☐ Semi-Annual ☐ Quarterly ☐ Monthly Authorized Check ☐ Special Billing (number if known _________________________)

d. Premium Amount $________________________

e. Cash with application? ☐Yes ☐No $________________________

f. Is employer paying any portion of the premium? ☐Yes ☐No If yes, what percentage? ☐100% ☐Other __________ %

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

Agreement and Declaration

I 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. Also, the first full premium paid must be paid. However, if a Disability Income Receipt has been delivered, then liability of the Company shall be as stated in the receipt. I have received a MIB Notice and an Outline of Coverage.

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 the Veteran's Administration, Social Security Administration, MIB, Inc., my employer, 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 or my eligibility for benefits under an existing policy.

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 shown below.

Signed at ______________________________ ______________________________

CITY AND STATE SIGNATURE OF PROPOSED INSURED

Date ____________________ ______________________________

SIGNATURE OF OWNER/APPLICANT, IF OTHER THAN PROPOSED 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

I certify that I asked the above questions of the Proposed Insured in person and have recorded the information correctly. An Outline of Coverage was given to the Proposed Insured. 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 # ______________________________

Form TELAPP21 (MI)

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 ______

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

HIPAA COMPLIANT
HEALTH INFORMATION AUTHORIZATION

I hereby authorize any physician, medical practitioner, hospital, clinic, pharmacy or pharmacy benefit manager, or other medical or medically related facility, MIB, Inc. or insurance company that possesses health information, including prescription history and medications prescribed about me, to furnish all such health information to Illinois Mutual Life Insurance Company, hereinafter called the Company. Health information includes any medical treatment records which includes treatment for drug abuse, alcoholism, AIDS or mental illness but specifically excludes psychotherapy notes. Illinois Mutual Life Insurance Company may specify the name of the practitioner or facility below.

The Company may obtain health information about me in order to evaluate my application for insurance or my eligibility for benefits under an existing policy. Health information obtained by this Authorization will not be re-disclosed by the Company without my authorization except to reinsurers who may be involved with my application for insurance or otherwise permitted or required by law in which case it may not be protected under federal privacy rules. This Authorization is required for the underwriting of an insurance policy and failure to provide a signed Authorization may result in a decline of the coverage applied for.

I acknowledge that I have read this Authorization and I will receive a copy of it. I understand and agree that this Authorization shall be valid for two years from the date of signature below. I may revoke this Authorization by sending written notice to Privacy Officer, Illinois Mutual Life Insurance Company, 300 SW Adams St., Peoria, IL 61634. Action taken in reliance of this Authorization will not be affected until written notice of revocation is received by the Company.

______________________ Date

______________________ Signature of Proposed Insured or Parent if Proposed Insured under 18

______________________ Print Name of Proposed Insured

______________________ Date of Birth — Social Security Number

______________________ Application Number, if known

Home Office Use Only:

______________________ Practitioner or Facility

NOTE TO MEDICAL PROVIDERS: This Authorization is designed to comply with the requirements of the Health Insurance Portability and Accountability Act of 1996 also known as HIPAA.

AUTHORIZATION FOR MONTHLY AUTHORIZED CHECK. (Attach VOID check and pay 1 full monthly premium.) I hereby authorize and direct the financial institution named below, hereafter referred to as "you," to honor and charge to my account checks or pre-authorized electronic debits drawn on my account by and payable to Illinois Mutual Life Insurance Company. Should any of the above items be dishonored, either with or without cause and whether intentionally or inadvertently, you will be under no liability whatsoever, even though such dishonor will result in the forfeiture of insurance. I agree that your rights in respect to each of the above items shall be the same as if it were a check drawn on you and signed personally by me and that you shall be fully protected in honoring any of the above items.

This authorization shall continue in force until revoked by me in writing and received by you, a copy of which revocation shall be sent by me to Illinois Mutual Life Insurance Company.

Financial Institution Name ______________________________

Policy Numbers ______________________________

Address ______________________ City ______________ State ________ Zip ______________

☐ Checking ☐ Savings Account Number ________________ Financial Institution Routing Number ________________

Draft premium on day ________________ of each month. (Only days 1 thru 28 are valid due to February.)

Account Title, if applicable ______________________________

Account Holder's Signature ______________________________ Date ________________

Form 2534-D (5/09)

Proxy

Having made application for policy in Illinois Mutual Life Insurance Company and if same is issued; KNOW ALL MEN BY THESE PRESENTS, that I, the undersigned, holder of said policy, do hereby constitute and appoint M. A. McCord, K. M. Jenkins, M. E. Martin, J. K. McCord, and T. P. Jenkins, or a majority of them in attendance, my proxy for me and in my name, place and stead to vote for me and cast the number of votes to which I am or may be entitled at all regular and special meetings of the policyholders of the Company, at which I am not personally present, upon all matters coming before any such meeting with like effect as if I had been personally present and voting. I hereby waive notice of any regular or special meeting of the policyholders of the Company, unless further request in writing is made that notice be given to me. This proxy shall remain in force until revoked in writing or superseded by written proxy of later date given to any other policyholder or policyholders of the Company. I agree to notify the Secretary of the Company of such change in proxy, and to abide by the by-laws of the Company governing proxy voting.

Date ________________ Signature ______________________________

Address ______________________________

Form 561-K (1/06)

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

LEAVE THIS PAGE WITH THE APPLICANT.

Disability Income Receipt (Do not complete receipt unless payment is made.)

Received from ______________________________ on ____________________, 20______ the sum of $______________ toward the premium for disability income insurance with the application to Illinois Mutual Life Insurance Company which contains the same date as this receipt. No coverage will become effective prior to delivery of the policy unless and until all the conditions of this receipt have been exactly fulfilled. If the full first premium in accord with the Company's published rates for the policy applied for is paid at the time of application, the policy applied for shall take effect on the date of this receipt, provided:

(1) the application and any medical examinations, tests and personal history interviews required are completed, and
(2) the person to be insured is on this date a risk acceptable to the Company under its rules, limits and standards without modifications, on the plan and in the amount applied for and at the premium declared paid; otherwise the amount shown shall be returned upon surrender of this receipt.

However, the Company's liability hereunder for disability income insurance shall not exceed $1,000 per month in total disability benefits payable for no more than 24 months or the benefit period applied for, whichever is less. If a disability income policy different than applied for, in form, in coverage, amount or premium, is offered, the disability income insurance shall not be effective unless and until the full first premium is paid and the policy is delivered to and accepted by the applicant.

Agent ______________________________

ALL PREMIUM CHECKS MUST BE MADE PAYABLE TO ILLINOIS MUTUAL. DO NOT MAKE CHECK PAYABLE TO THE AGENT OR LEAVE PAYEE BLANK. VOID UNLESS PAYMENT IS MADE AND RECEIPT IS SIGNED BY AGENT.

Form 9163

Medical Information Bureau (MIB, Inc.) Notice

Information regarding your insurability will be treated as confidential. Illinois Mutual Life Insurance Company or its reinsurers may, however, make a brief report thereon to the MIB, Inc., formerly known as Medical Information Bureau, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information about you in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at 866.692.6901 (TTY 866.346.3642). If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.

Illinois Mutual Life Insurance Company, or its reinsurers, may also release information in its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.

Form 2826 (1/10)

Health Information Authorization (Proposed Insured's copy)

I hereby authorize any physician, medical practitioner, hospital, clinic, pharmacy or pharmacy benefit manager, or other medical or medically related facility, MIB, Inc. or insurance company that possesses health information, including prescription history and medications prescribed about me, to furnish all such health information to Illinois Mutual Life Insurance Company, hereinafter called the Company. Health information includes any medical treatment records which includes treatment for drug abuse, alcoholism, AIDS or mental illness but specifically excludes psychotherapy notes. Illinois Mutual Life Insurance Company may specify the name of the practitioner or facility below.

The Company may obtain health information about me in order to evaluate my application for insurance or my eligibility for benefits under an existing policy. Health information obtained by this Authorization will not be re-disclosed by the Company without my authorization except to reinsurers who may be involved with my application for insurance or otherwise permitted or required by law in which case it may not be protected under federal privacy rules. This Authorization is required for the underwriting of an insurance policy and failure to provide a signed Authorization may result in a decline of the coverage applied for.

I acknowledge that I have read this Authorization and I will receive a copy of it. I understand and agree that this Authorization shall be valid for two years from the date of signature below. I may revoke this Authorization by sending written notice to Privacy Officer, Illinois Mutual Life Insurance Company, 300 SW Adams St., Peoria, IL 61634. Action taken in reliance of this Authorization will not be affected until written notice of revocation is received by the Company.

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

NOTICE AND INFORMED CONSENT

NOTICE TO PROPOSED INSUREDS

At this time we are unable to provide insurance at any price to persons who have been exposed to the AIDS virus. Until medical science is able to develop a cure or vaccine, we cannot accept persons who have AIDS Related Complex (ARC) or persons who have progressed to a diagnosis of AIDS itself, or persons who have tested positive for the AIDS virus. We have an obligation to our insureds not to jeopardize the financial stability of Illinois Mutual by accepting uninsurable risks.

To protect our reserves against the potential for persons infected with AIDS obtaining insurance, we are doing two types of screening:

1. The application asks specific questions about ARC and AIDS.

2. As a part of our normal underwriting process, you are being asked to sign the INFORMED CONSENT below. This form will allow us to order blood tests to detect the presence of the AIDS virus.

We have stringent procedures to protect proposed insureds against the improper distribution of AIDS related information. We release that information only to persons or entities authorized by statute or regulations to receive test results.

Thank you for your cooperation in working with us to protect everyone's interest regarding this serious health problem.

INFORMED CONSENT

I (we) understand that, as a part of the underwriting requirements for the insurance for which I (we) have applied to Illinois Mutual Life Insurance Company, I (we) may be required to take ELISA and Western blot assay tests to detect the presence of the HTLV virus, also known as the HIV or Human Immunodeficiency Virus. I (we) do hereby consent to such tests.

I (we) further understand that the results of such tests may be disclosed to Illinois Mutual's reinsurance companies, the Medical Information Bureau, Inc., and as otherwise permitted or required by law. I (we) do hereby consent to such disclosures.

______________________________, 20_____ ______________________________
Signature of Proposed Insured

____
Signature of Other Person Proposed for Insurance

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

**THIS NOTICE IS FOR YOUR INFORMATION.
NO RESPONSE IS REQUIRED.**

DESCRIPTION OF INFORMATION PRACTICES

To Our Applicants:

This description of the information practices of Illinois Mutual Life Insurance Company is being provided in accordance with the requirements of federal and state privacy laws.

Collection of Information

In order to properly underwrite your insurance coverage, we must collect a certain amount of necessary information. The amount and type of information collected may vary depending on the amount and type of coverage applied for, but in general we will be seeking information about your age, occupation income, physical condition, health history, and avocations. In addition, we or your agent may collect information intended to aid in the updating and improvement of your insurance program.

You are our most important source of information, but we may also collect or verify information by contacting medical professionals and institutions which have provided care to you or members of your family proposed for coverage, employers and other insurance companies you have applied to. We may collect information by exchanges of correspondence, by phone or by personal contact.

In some cases, we may ask an insurance support organization with your authorization to collect information and submit an investigative consumer report to us. That organization may retain a copy of the report and may disclose its contents to others for whom it performs such services.

Disclosures by Illinois Mutual

In some circumstances, Illinois Mutual will make disclosures of personal information, without your authorization, to third parties. The following is a brief description of some of the persons or organizations to whom certain items of information might be disclosed.

- Your agent;
- Persons or organizations which perform professional, business or insurance functions for us, such as independent claim examiners or group plan administrators;
- Insurance companies to which you have applied for coverage or benefits;
- Your personal physician or treating medical professional;

- To comply with a properly authorized civil, criminal or regulatory investigation by federal, state and local authorities.

- To comply with a proper subpoena or summons issued under authority of a court of competent jurisdiction.

Please be assured that the above describes some of the disclosures which may be made, not disclosures which are always or even often made. For example, we would ordinarily disclose only information relating to age, amounts of insurance and claims experience to a research organization. Information relating to physical condition or medical history would ordinarily be disclosed only to your personal physician. In any event, the information that may be disclosed without your authorization will be only as much as permitted by law and reasonably necessary to accomplish the intended purpose.

We do not provide personal information about you to affiliated or nonaffiliated third parties for marketing purposes.

Access and Correction

There are procedures by which you can obtain access to personal information about you appearing in our policy files, including information contained in investigative consumer reports. We have also established procedures by which you may request correction, amendment or deletion of any information in our files which you believe to be inaccurate. If you notify us that the information is incorrect, we will review it. If we agree, we will correct our records. If we do not agree, you may submit a short statement of dispute, which will be included in our files and in any future disclosure of the disputed information.

Confidentiality and Security

Your personal information is restricted to employees who need to know the information to provide our products and services to you. Our employees are trained to understand the importance of customer privacy. Appropriate disciplinary measures are applied to employees who violate our privacy policy. We maintain physical, electronic, and procedural safeguards that comply with all applicable laws.

Obtaining Additional Information

We at Illinois Mutual hope that you find this description of our information practices helpful. We take our responsibilities, and your rights, very seriously. If you have any further questions about the items just discussed, please contact us at Illinois Mutual Life Insurance Company, 300 S.W. Adams Street, Peoria, IL 61634.

Thank You!

Thank you for your recent insurance application. We appreciate your business and want to make the application process as fast and easy as possible for you. That's why we created this confidential, accurate and professional process. This brochure gives you a preview of the remaining steps to help you know what to expect next.

Questions?
Contact Illinois Mutual.

(800) 437-7355, ext. 750

300 S.W. Adams Street Peoria, IL 61634
800.437.7355
www.IllinoisMutual.com

Form 9239 (9/09)

Teleunderwriting: What to Expect Next

Consumer Guide

The Process

You and your agent have just taken the first step toward putting your insurance plan in place by completing a short application (Teleapp Part A). In most cases, just two steps remain:

Telephone Interview

Your agent can connect you with a customer service representative now, or if you prefer, a customer service representative will contact you to complete a fact-finding interview (Teleapp Part B). It's up to you! To complete the interview as quickly as possible, please have the following information available:

- Medical history
- Names, addresses and phone numbers of consulting physicians
- Names of prescription medications used
- Occupational duties
- Employment history
- Participation in various hobbies
- Driving record
- Financial information, including your income, and other insurance you have

Please be assured that keeping client information secure and private is one of our top priorities. All answers given to the customer service representative are used solely for the consideration of your application and will remain confidential in accordance with our privacy procedures.

The information provided during the telephone interview will become part of your policy. Therefore, you will be asked to verify the accuracy of the telephone interview by providing a voice signature at the end of the interview.

For the convenience of our Spanish-speaking clients, we offer the option of having the interview conducted in Spanish.

The Examination

Routine examination requirements may be necessary depending on your age, medical history or amount of coverage applied for. During the interview, the customer service representative may schedule a time for you to meet with a trained examiner. Please have your calendar with you so you are prepared to schedule the exam at this time. This exam can occur at the location of your choosing, but keep in mind, it will require privacy. The exam may include the following:

- Measurement of height, weight, blood pressure and pulse
- Blood sample
- Urine sample
- Electrocardiogram (EKG)

To obtain the most favorable and accurate test results, you should not eat or drink for 12 hours prior to the exam.

Your completed telephone interview and any exam information will be forwarded to our Home Office for review and consideration.

For point of sale interviews only, call ExamOne at (866) 433-7376.

Call Hours (central time):
7 a.m. to 11 p.m. Monday through Thursday
7 a.m. to 5 p.m. Friday
10 a.m. to 2 p.m. Saturday

For Your Information

The coverage you applied for is very valuable and may not be available as requested. In fairness to our policyowners, a professional underwriter will review your application and any exam findings to determine your eligibility. Additional information, such as medical records, which we will obtain from your doctor, may be necessary to properly evaluate your request for coverage.

Depending on your individual circumstances, the underwriter may approve your application as applied for, make a counter offer with coverage or premium modifications or deny your request for coverage.

With application approval, an insurance policy will be sent to your agent for delivery. At this time we ask that you carefully review your policy and discuss any questions you may have with your agent.