



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

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
<input type="checkbox"/> GR21	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	<input type="checkbox"/> 30 Day <input type="checkbox"/> 60 Day <input type="checkbox"/> 90 Day <input type="checkbox"/> 180 Day	<input type="checkbox"/> 6 Month <input type="checkbox"/> 1 Year <input type="checkbox"/> 2 Year
<input type="checkbox"/> NC21	<input type="checkbox"/> 4 <input type="checkbox"/> 5	<input type="checkbox"/> 1 Year <input type="checkbox"/> 2 Year	<input type="checkbox"/> 5 Year <input type="checkbox"/> 10 Year <input type="checkbox"/> 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) | Property and Casualty Insurance |
| Mortgage and Other Business Interest (but not principal) | Rent/Lease |
| Office Maintenance | Taxes (property and payroll) |
| Periodicals, Magazines & Professional Dues | Utilities |
| Professional Services Fees | 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 Medical Information Bureau 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, Medical Information Bureau, Inc., my employer, 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 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

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

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-F

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 _____



ILLINOIS MUTUAL®
Life Insurance Company

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

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, Medical Information Bureau, Inc. or insurance company that possess 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. If any of the above items be dishonored, either with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results 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 (3/08)

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 _____



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

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 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 Medical Information Bureau, a non-profit membership organization of life 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 in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have 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 Post Office Box 105, Essex Station, Boston, Massachusetts 02112.

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.

Form 2826

(11/04)

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, Medical Information Bureau, Inc. or insurance company that possess 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.

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.

Form 9209 (7/07)



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

HIV TEST INFORMED CONSENT FORM

In order for us to evaluate your eligibility for insurance coverage, we request that you provide a blood sample for testing and analysis. One of the tests that will be performed will determine the presence of antibodies to the HIV virus. By signing and dating this form, you agree that the HIV antibody test may be performed on your blood sample and that underwriting decisions may be based on the test results. A positive test result will adversely affect your insurance application. It also may result in uninsurability for life, health, or disability insurance for which you may apply in the future.

The HIV Virus

The HIV virus causes a life-threatening disorder of the immune system called Acquired Immune Deficiency Syndrome (AIDS). Antibodies to the HIV virus are found in the blood of most people with AIDS and AIDS-Related Complex (ARC), and can be found in people who do not have AIDS or ARC but have been exposed to the virus. The virus is spread by sexual contact with an infected person, by exposure to infected blood (as in needle sharing during intravenous drug use or, rarely, as a result of a blood transfusion), or from an infected mother to her new-born infant.

The HIV antibody test is actually a series of tests performed upon your blood sample by a medically accepted procedure which is extremely reliable. The testing will be performed by a licensed laboratory.

Pre-Testing Consideration

Many public health organizations have recommended that before taking an HIV virus antibody test a person seek counseling to become informed about the implications of such tests. You may wish to consider counseling, at your expense, prior to being tested.

Disclosure of Test Results

All test results are confidential, except as provided by law. State law requires that the laboratory notify the Ohio Department of Health of positive test results.

The results of the test will be reported to the insurance company named on your application for insurance. The insurer may not by law, release positive test results except as provided below:

If your HIV antibody test result is normal, you will not be notified. You will be notified of an abnormal (positive) test result if you indicate that you desire a positive result be made known to you. You may also identify another person to whom you want the positive results released.

If you want a physician or other health care provider to be notified of an abnormal HIV antibody test result, you must indicate the name and address of that physician or provider.

Abnormal test results may be disclosed to persons hired by the insurer who participate in medical underwriting decisions of the insurer. Abnormal test results may also be disclosed to affiliates of the insurer who require the results for medical underwriting purposes.

In addition, if your HIV antibody test is normal, a generic code signifying a non-specific blood abnormality may be made known to the Medical Information Bureau, Inc. (MIB). The MIB is an organization of life and health insurance companies which operates as an information exchange on behalf of its members. There will be no record with the MIB that you had a positive HIV antibody test; however, there will be a record that you have some blood abnormality. If you apply to another MIB member company for life or health insurance coverage, the MIB, upon request, will supply the information on you in its file to that member.

Test Results

While a positive test result does not necessarily mean that you have AIDS, it does mean that you are at serious risk of developing AIDS or AIDS-related conditions. You may be infected with the HIV virus and infectious to others. You should seek medical follow-up care with your personal health care provider.

HIV test results are highly reliable but not 100% accurate. If the test gives a positive result you should consider retesting in order to confirm the result. If the test gives a negative result, there is still a small possibility you may be infected with HIV. This is most likely to happen in recently infected person. It takes at least 4 to 12 weeks for a positive test result to develop after a person is infected, and may take as long as 6 to 12 months.

Other Sources of Information

For more information about AIDS you may call the Columbus AIDS Hotline at 1-800-332-2437.

Consent for HIV Testing

I have read and I understand this HIV Test Informed Consent Form. I voluntarily consent to the withdrawal of blood, the testing of my blood for HIV antibodies, and the disclosure of the test results as described above. I will be given a copy of this form. The CONSENT is valid for ninety (90) days from the date of my signature below. Insurer agrees to complete testing and provide the authorized notifications, as appropriate, within this 90 (ninety) day period.

Notification of Positive Test Result

In the event of a positive test result:

_____ Send the result to me at:

_____ Address

_____ I authorize Illinois Mutual Life Insurance Company to send the result to another person:

_____ Name

_____ Address

_____ I authorize Illinois Mutual Life Insurance Company to send the result to the following physician or health care provider:

_____ Physician's Name

_____ Address

Authorization

_____ Name of Applicant

_____ Signature of Applicant

_____ Date

_____ Signature of Legal Guardian, if any

_____ Date

_____ Signature of Person Obtaining consent

_____ Date



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**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;
- Persons or organizations conducting bona fide actuarial or scientific research studies, audits or evaluations;

- 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.

TELEUNDERWRITING: WHAT TO EXPECT NEXT

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.

ANY QUESTIONS?
CONTACT ILLINOIS MUTUAL.

1.800.437.7355 ext. 750



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



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

A customer service representative will contact you to complete a short 15-20 minute interview (Teleapp Part B). It can take place at a time and location of your choosing. 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 has always been 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.

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. 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 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, 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. Discuss any questions you may have with your agent.

