ILLINOIS MUTUAL®
Life Insurance Company
300 S.W. Adams Street Peoria, IL 61634
800.437.7355 Fax 800.884.7607
underwriting@illinoismutual.com

Application for Disability Insurance

PART A

1. Proposed Insured

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

b. Address _____
STREET CITY STATE ZIP CODE

c. Primary Ph._____ Other Ph._____ E-mail_____

d. Social Security Number _____ e. Driver's License Number & State _____

f. Date of Birth _____ g. Place of Birth (State/Country) _____

h. Are you a U.S. Citizen? ☐ Yes ☐ No

(1) If no, have you resided in the U.S. for the past 2 years? ☐ Yes ☐ No

(1a.) If yes, have you been granted permanent resident (green card) status? ☐ Yes ☐ No

i. In the past 12 months, have you used any form of tobacco or nicotine-based product? ☐ Yes ☐ No

j. Occupation and duties: _____

_____

2. Individual Disability Plan Information

Base Monthly Benefit Amount $ _____

Elimination Period: ☐ 30 Day ☐ 60 Day ☐ 90 Day ☐ 180 Day ☐ 1 Year ☐ 2 Year

Benefit Period: ☐ 6 Month ☐ 1 Year ☐ 2 Year ☐ 5 Year ☐ 10 Year ☐ To Age 67

Optional Benefit Riders

☐ Activities of Daily Living (ADL) Monthly Amount $ _____ ☐ 2 Year ☐ 5 Year ☐ To Age 67
☐ Cost of Living Adjustment (COLA)
☐ Extended Own Occupation Period ☐ 5 Year ☐ To Age 67
☐ Guaranteed Insurability Option (GIO) ☐ $100 ☐ $200 ☐ $300 ☐ $400 ☐ $500 ☐ $600
☐ Integrated Monthly Benefit Amount $ _____
☐ Mental/Nervous Benefit
☐ Non-Cancelable
☐ Pure Own Occupation Period ☐ 2 Year ☐ 5 Year
☐ Residual Disability Benefit
☐ Retroactive Injury Benefit
☐ Return of Premium Beneficiary _____ Relationship _____

3. Business Expense Plan Information

Base Monthly Benefit Amount $ _____

Elimination Period: ☐ 30 Day ☐ 60 Day ☐ 90 Day

Benefit Period: ☐ 12 Months ☐ 18 Months ☐ 24 Months

Optional Benefit Riders

☐ Guaranteed Insurability Option (GIO) ☐ $100 ☐ $200 ☐ $300 ☐ $400 ☐ $500 ☐ $600
☐ Mental/Nervous Benefit
☐ Pure 2 Year Own Occupation Period
☐ Retroactive Injury Benefit
☐ Return of Premium Beneficiary _____ Relationship _____

Business Expense Details

Indicate your share of current, ongoing, average monthly fixed business expenses. Include Mortgage and Other Business Interest (but not principal), Rent or Lease, Property and Casualty Insurance, Property and Payroll Taxes, Depreciation, Office Maintenance, Utilities, Periodicals, Magazines and Professional Dues, Professional Services Fees, and Employees' Salaries. Exclude salary, fees or other remuneration received by you, by a partner(s) or by any other member of your profession employed or working with you.

Total Average Monthly Expenses $ _____

4. Accident Plan Information (Only available when applying for Individual Disability coverage)
Plan Levels: ☐ Economy ☐ Standard ☐ Preferred ☐ Premium
Coverage: ☐ Individual ☐ Individual/Spouse ☐ One-Parent Family ☐ Two-Parent Family
Beneficiary _____ Relationship _____

Optional Benefit Riders
☐ Catastrophic Accident
☐ Wellness Benefit Benefit Amount $ _____

Affordable Care Act (Applicable only if applying for Wellness Benefit Rider)

THIS IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. LACK OF MAJOR MEDICAL COVERAGE (OR OTHER MINIMUM ESSENTIAL COVERAGE) MAY RESULT IN AN ADDITIONAL PAYMENT WITH YOUR TAXES.

I hereby attest that the proposed insured(s) named in this application has (have) other insurance that is Minimum Essential Coverage under the Affordable Care Act. ☐ Yes ☐ No*

*If no, the Wellness Benefit Rider may not be selected.

5. Income Information

a. Indicate earned income from primary occupation as reported for federal income tax purposes. If self-employed or owner/employee (more than 20% ownership), indicate share of after-tax net profit (loss) after business expenses.

	Current YTD Income	Income Last Year	Income 2 Years Ago
(1) Owner or Non-owner Employee's salary and bonus (Form W-2)	$ _____	$ _____	$ _____
(2) Sole Proprietor (Form 1040, Sch. C)	$ _____	$ _____	$ _____
(3) S-Corp. (Form 1120S, Sch. K-1 or Form 1040, Sch. E)	$ _____	$ _____	$ _____
(4) C-Corp. (Form 1120)	$ _____	$ _____	$ _____
(5) Partnership or LLC (Form 1065, Sch. K-1 or Form 1040, Sch. E)	$ _____	$ _____	$ _____
(6) Total Earned Income: Sum of a(1) thru a(5) for each year	$ _____	$ _____	$ _____

b. Is unearned income (capital gains, interest, dividends, net rental income, pension, annuities, or alimony) greater than 10% of earned income? ☐ Yes ☐ No If yes, list amounts and sources.

_____

6. Other Disability Insurance

Do you have, are you applying for, or will you become eligible for, any disability insurance plan or benefit? ☐ Yes ☐ No

If yes, list below all: (1) Individual Disability, (2) Group Disability, (3) Sick Leave or Salary Continuation, (4) Disability Retirement/Pension, (5) Business Overhead Expense, or (6) Any other coverage which provides disability benefits.

Company or Source	Pending (P) In Force (I) Eligible (E) Replacing (R)	Type (1 - 6)	Monthly Amt. or Percent of Income	Maximum Benefit Cap	Elim. Period	Benefit Period	Coordinates w/ Soc. Security?	Employer Paid?
_____	_____	_____	_____	_____	_____	_____	☐ Yes ☐ No	☐ Yes ☐ No
_____	_____	_____	_____	_____	_____	_____	☐ Yes ☐ No	☐ Yes ☐ No
_____	_____	_____	_____	_____	_____	_____	☐ Yes ☐ No	☐ Yes ☐ No
_____	_____	_____	_____	_____	_____	_____	☐ Yes ☐ No	☐ Yes ☐ No

7. Owner (If other than the Proposed Insured)

a. Name _____

b. Address _____
STREET CITY STATE ZIP CODE

c. E-mail _____ d. Social Security or Tax ID Number _____

8. Billing and Payment

a. Effective Date: ☐ Application Date ☐ Issue Date ☐ Other _____

b. Premium Notices: ☐ Insured at residence ☐ Owner at address shown above.
☐ Insured at business ☐ Other _____

c. Premium Mode: ☐ Annual ☐ Semi-Annual ☐ Quarterly ☐ Monthly Authorized Check
☐ Special Bill (Indicate billing number if known.) _____

d. Premium Amount Quoted: $ _____ e. Occupation Class Quoted: _____

f. Initial Premium Payment: ☐ Cash with Application $ _____ ☐ Cash on Delivery (C.O.D.)
☐ Draft First Month's Premium (Monthly Authorized Check mode only.)

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

If using the traditional application process, complete Parts B and C.
If using the teleapplication process, complete Part C.

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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.

_____

Proposed Insured _____ **D.O.B.** _____

PART B (continued)

3. Medical Information (If answering yes, please provide full details below.)

a. Have you ever had symptoms, received treatment, or been diagnosed with any injury, disease or disorder of:	Yes	No
(1) The back, neck, knees, shoulders, wrists, hips, joints, bones, muscles, arthritis or fibromyalgia?	☐	☐
(2) High blood pressure, chest pain, heart attack, stroke or any other disease or disorder of the heart, arteries or veins?	☐	☐
(3) Diabetes or borderline diabetes, thyroid, or any other glandular disease or disorder?	☐	☐
(4) Headaches, seizure, paralysis, multiple sclerosis or any other disease or disorder of the brain or nervous system?	☐	☐
(5) Cancer, cyst, polyp or tumor?	☐	☐
(6) Asthma, sleep apnea, chronic bronchitis, emphysema or any other disease or disorder of the lungs or respiratory system?	☐	☐
(7) Anxiety, depression, stress, chronic fatigue or any other mental or nervous disorder?	☐	☐
(8) Irritable bowel, ulcer, colitis, hepatitis or any other disease or disorder of the stomach, intestines, pancreas or liver?	☐	☐
(9) The prostate, kidney, bladder, breast, genital or reproductive organs?	☐	☐
(10) The eyes, ears, nose, throat or skin?	☐	☐

b. Using the list below, provide full details to all "Yes" answers for 3a.(1) thru 3a.(10).

- Question #
- Symptoms, illness, injury or other
- Dates seen (first visit, last visit & how often)
- Type of testing (include dates and results)
- Diagnosis or clinical assessment
- Treatment plan (medication, surgery, other) and follow-up
- Degree of recovery or control
- Length of disability or time off work
- Healthcare provider's name, address & phone

Proposed Insured _____ **D.O.B.** _____

PART B (continued)

3. Medical Information, continued (If answering yes, please provide full details below.)

c. Who is your primary physician? ☐ None

(1) _____
NAME ADDRESS PHONE NUMBER

(2) Date last seen, reason and details _____

	Yes	No
d. Are you currently pregnant? (If yes, due date____/____/____)	☐	☐
e. In the past 10 years, have you had a miscarriage, Cesarean section or other complications of pregnancy?	☐	☐
f. In the past 10 years, have you been diagnosed or treated by a medical practitioner for Acquired Immune Deficiency Syndrome (AIDS), or AIDS related complex (ARC)?	☐	☐
g. In the past 10 years, have you tested positive for antibodies to the AIDS virus?	☐	☐
h. Have you had any natural parent or sibling who was diagnosed with cancer, heart disease, stroke, high blood pressure, diabetes or Huntington's disease prior to the age of 60? (If yes, provide relationship, condition, age diagnosed, current age or age at death.)	☐	☐
i. In the past 5 years, other than previously stated, have you:		
(1) had any medical advice, treatment, diagnostic test, hospitalization, physical exam, illness or injury?	☐	☐
(2) been referred for or advised to undergo treatment, diagnostic test, hospitalization or surgery that was not completed?	☐	☐
(3) consulted any other doctor, chiropractor, psychiatrist, psychologist, counselor, therapist or other healthcare provider?	☐	☐
j. Other than previously stated, are you currently:		
(1) receiving any medical advice or treatment?	☐	☐
(2) taking any medication?	☐	☐

k. Using the list below, provide full details to all "Yes" answers for 3d. thru 3j.

Question #	Treatment plan (medication, surgery, other) and follow-up
Symptoms, illness, injury or other	Degree of recovery or control
Dates seen (first visit, last visit & how often)	Length of disability or time off work
Type of testing (include dates and results)	Healthcare provider's name, address & phone
Diagnosis or clinical assessment	

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.

ILLINOIS MUTUAL®
Life Insurance Company
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. A photographic copy of this authorization shall be as valid as the original.

_____ _____

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.

ILLINOIS MUTUAL®
Life Insurance Company
300 S.W. Adams Street Peoria, IL 61634
800.437.7355

AUTHORIZATION FOR ELECTRONIC FUNDS TRANSFER

Please attach a preprinted voided check or deposit slip to this form
(Alternatively you may submit a letter on financial institution letterhead that includes the routing and account numbers.)

POLICY INFORMATION

Name of Insured: _____

Name of Policyowner (if different): _____

Premium Mode: ☐ Monthly ☐ Quarterly ☐ Semi-Annual ☐ Annual

[**NOTE**: Paying premiums more frequently than annually may affect my cash values and result in higher costs. In addition, for policies with annual, semi-annual or quarterly premium modes, this EFT Authorization is for the initial premium only.]

Initial Premium (all premium modes)

☐ Deduct initial premium upon receipt of properly completed application and Authorization by Illinois Mutual at its Home Office.

☐ Deduct initial premium when the policy has been issued.

Subsequent Premiums (monthly premium mode only)

Indicate premium withdrawal day: _____ (Choose a day between 1 and 28.)

POLICIES

Type_____ Policy Number (If available):_____

Type_____ Policy Number (If available):_____

Type_____ Policy Number (If available):_____

ACCOUNT INFORMATION

☐ Check box if address should be changed

Account Holder Name: _____

Address of Account Holder: _____
City State Zip

☐ Checking Account ☐ Savings Account

Name of Financial Institution: _____

Routing Number: _____ (The 9-digit number at the bottom of your check)

Account Number: _____ Reenter Account Number: _____

NOTE: Unless you are submitting this form through Illinois Mutual's website, we need a preprinted voided check (checking accounts), a voided withdrawal slip (savings accounts) or a letter from the financial institution to allow us to establish your EFT.

AUTHORIZATION

By signing this form, I, the Account Holder, am authorizing Illinois Mutual to initiate withdrawal entries to the deposit account designated on this form at the financial institution named above, using the Automated Clearing House for premium payments in the mode elected and such other withdrawals, e.g., loan repayments, as indicated on this Authorization.

By signing on the next page, I understand and agree as follows:

1. The origination of electronic withdrawals to my account must comply with the provisions of U.S. law;
2. I must give Illinois Mutual written notice of at least 5 business days before a scheduled payment if I want to cancel a payment or terminate this Authorization;
3. **If my financial institution does not honor this withdrawal request, Illinois Mutual will regard (i) my premium as unpaid; (ii) at its sole discretion, Illinois Mutual may resubmit the withdrawal request for collection; and (iii) the coverage is terminated if the premium remains unpaid. Illinois Mutual will charge a fee for withdrawal request that are returned for insufficient funds.**
4. If I change financial institutions or accounts that premiums are withdrawn from and if any premiums are past due at the time of the change, Illinois Mutual will draft my account for any past due premiums upon receipt of the Authorization for the new account so long as coverage has not terminated under the terms of the policy(ies).
5. Illinois Mutual reserves the right to remove any policy from the EFT program.
6. Illinois Mutual does not assume any responsibility for charges by financial institutions related to this Authorization.

By signing below, I further understand (i) that insurance will be effective only as stated in the application/conditional receipt (if any) for insurance (ii) that this Authorization is only for the purpose of effecting electronic fund transfers for the payment of my premium and such other charges as authorized under the coverages or by the financial institution and (iii) I agree to the disclosures below.

Name of Account Holder	Name of Joint Account Holder
Signature of Account Holder	Signature of Joint Account Holder
Date	Date

DISCLOSURE

How can I use this Authorization form? This Authorization can be used to:

- Pay premiums on multiple policies
- Pay additional premiums on universal life policies
- Repay policy loans (a minimum may apply)

Can there be multiple payments withdrawn under this Authorization? Yes, Illinois Mutual will withdraw multiple payments IF:

- More than one policy/contract payment is due or needed to bring your policy/contract up to date.
- You requested a life insurance/individual disability income policy be back-dated resulting in more than one payment due at time of issue.
- The withdrawal date selected is after the contract date for life insurance policies with flexible premiums. Note: Guarantees may be affected if payments are missed or delayed. (See "Can EFT payments affect the guarantees on my policy?")

Can I pay the initial premium with this Authorization Form? Yes, you can pay the initial premium IF:

- You have authorized subsequent premiums by EFT under this form or you have elected to pay the initial premium on the Authorization form.
- All required applications and other forms are completed properly.
- You agree that the initial premium is subject to terms of any conditional receipt.

What if I change financial institutions? You need to give us advance notice of a change in a financial institution. We would like at least 30 days. Just complete another Authorization form and include a voided check (checking account) or withdrawal slip (savings account).

Is it recommended to use savings accounts? You may use a savings account. Many financial institutions impose fees for withdrawals exceeding a maximum number in a given period. You should check with your financial institution to be sure that you are not incurring any fees for using a savings account.

What happens if there are insufficient funds in my account? If there are insufficient funds in your account, you may be charged a fee by your financial institution. In addition, Illinois Mutual will charge a fee for all withdrawal requests returned for insufficient funds. Please be aware that your policy may terminate if the premium remains unpaid. At our option, we may resubmit for payment if there are insufficient funds. You are liable for any charges by your financial institution for the resubmission.

Can EFT payments affect the guarantees on my policy? Yes. For policies with cash values and other guarantees, it is important that the EFT draft (premium pay) date occur at least five (5) days prior to the policy's monthly anniversary (the same day of the month as your policy effective day). If a specific EFT draft date is requested for universal life policies, we will honor your request; however, please be aware that the EFT drafts will take place on the requested date prior to the monthly anniversary of your policy. If no preferred EFT draft date is requested, we will set the EFT draft date for up to 5 days prior to the policy date.

For term life insurance and disability income policies, it is preferred that the EFT draft date is prior to the monthly anniversary. If sufficient funds are unavailable and you have selected a date after the monthly anniversary, then your coverage could terminate before we receive the premium. In such a case we would refund the premium to you. If your policy contains a Grace Period provision and premium is received after the end of the grace period, you would need to have your coverage reinstated if permitted under your policy. This may require new medical underwriting.

When will this Authorization end? This Authorization ends as follows:

- You tell us in writing that you no longer want to use the EFT process. We need at least five (5) days to prevent a scheduled payment.
- We tell you that the EFT is no longer in force.
- The policy (ies) are no longer in force.
- Your account at the financial institution is closed or terminated.

Contact info:

Illinois Mutual Life Insurance Company
300 SW Adams Street
Peoria, IL 61634
(800) 437-7355

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 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-L (11/12)

ILLINOIS MUTUAL®
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300 S.W. Adams Street Peoria, IL 61634
800.437.7355

Payment Receipt

If payment is made, complete this receipt and leave this page with the applicant.

The following payment(s) have been received from _____ on _____, 20 ____ in connection with an application for insurance to Illinois Mutual Life Insurance Company which contains the same date as this receipt.

Please check the applicable policy(s) and fill in premium paid.

☐ **Life Insurance** $ _____ (No payment accepted on face amounts greater than $500,000.)

☐ **Disability Insurance** $ _____

☐ **Critical Illness Insurance** $ _____

☐ **Accident Insurance** $ _____

No coverage will become effective prior to delivery of the policy(s) 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(s) 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 shall not exceed the following limits applicable to each type of insurance policy.

Life Insurance Policy – $100,000 including any accidental death benefit applied for

Disability Insurance Policy – $1,000 per month in total disability benefits payable for no more than 24 months or the benefit period applied for, whichever is less.

Critical Illness Insurance Policy – $10,000

Accident Insurance Policy – units of coverage selected on application

If a policy is offered that is different than applied for, in form, in coverage, or premium amount, the insurance coverage 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 THE CHECK PAYABLE TO THE AGENT OR LEAVE PAYEE BLANK. VOID UNLESS PAYMENT IS MADE AND RECEIPT IS SIGNED BY THE AGENT.

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

LEAVE THIS PAGE WITH THE APPLICANT

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)

HIPAA COMPLIANT 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. A photographic copy of this authorization shall be as valid as the original.

Form 9209 (6/12)

FAIR CREDIT REPORTING ACT NOTICE

The Fair Credit Reporting Act requires that Illinois Mutual Life Insurance Company, 300 S.W. Adams Street, Peoria, Illinois 61634, notify you that, as a regular part of processing your Application for Insurance, investigative consumer reports may be obtained which will include information as to your character, general reputation, personal characteristics, mode of living, health, medical treatment, motor vehicle records, and other applicable information. Such information for said reports will be obtained through personal interviews with your family members, friends, associates, neighbors, financial sources and others. Upon written request to the Home Office, further information will be provided as to how you may obtain a complete and accurate disclosure of the nature and scope of such investigative consumer reports.

Form 2825 (3/13)

ILLINOIS MUTUAL®
Life Insurance Company
300 S.W. Adams Street Peoria, IL 61634
800.437.7355

HIV TEST
INFORMED CONSENT FORM

In order for us to evaluate your eligibility for insurance coverage, we request that you provide a blood sample or other bodily fluid sample for HIV testing and analysis. The test 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 or other bodily fluid sample and that underwriting decisions may be 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.

Human Immunodeficiency Virus (HIV)

The HIV virus causes a life-threatening disorder of the immune system called Acquired Immune Deficiency Syndrome (AIDS). Antibodies to HIV are found in the blood and other bodily fluids of people who have been exposed to the virus. You do not have to have AIDS to have antibodies against HIV. 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 or other bodily fluid 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 (negative), 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 abnormal, a generic code signifying a non-specific blood, oral fluid (saliva) or urine 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 at the MIB that you have some blood, oral fluid or urine 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 greater risk of developing AIDS or AIDS-related conditions if you do not take appropriate medications. If you are infected with HIV, you are 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 HIV or AIDS you may ask a doctor, a nurse, a counselor, or call the Ohio AIDS Hotline at 1-800-332-AIDS (2437). The hotline is a free call.

Consent for HIV Testing

I have read and I understand this HIV Test Informed Consent Form. I voluntarily consent to the withdrawal of blood or to the providing of another bodily fluid sample, the testing of my blood or other bodily fluid for HIV antibodies, and the disclosure of the test results as described above. I will be given a copy of this form. This 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 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 Application

_____
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;

- 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.