



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

Application for Disability Income Insurance

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

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. ( ) Best time to call AM PM
d. E-mail address (optional) Best place to call Home Work
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.?

2. Owner (if other than Proposed Insured)

a. Name b. Soc. Sec. or Tax I.D.#
c. Address STREET CITY STATE ZIP CODE

3. Employment Information

a. Primary Occupation b. How long in occupation?
c. Employer's Name d. Current Employment Date
e. Employer's Address f. No. of Employees
g. Describe exact duties of occupation.
h. Indicate percentage of time spent: Performing professional, managerial or administrative duties %
Performing trade, services or labor %
i. Number of hours currently working per week in primary occupation?
j. Other employment currently or in past 5 years, full or part time? Yes No If yes, give details

4. Income Information

If Proposed Insured is employed in his/her primary occupation for wage or salary, complete a. and b. as reported for federal tax purposes.
a. Wage/Salary Income \$ Hourly Weekly Monthly Annually b. Prior year's taxable income \$
If Proposed Insured is self-employed or an owner of a corporation, complete c.(1), (2), (3) and (4).
c. Net earned income after business expenses from primary occupation as reported for federal income tax purposes:
(1) Average monthly income for current tax year \$ (2) Actual annual income for prior tax year \$
(3) Actual annual income for tax year 2 years ago \$
(4) Sole Proprietor Partner C Corporation S Corporation Other

5. 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

**6. 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 \_\_\_\_\_

**7. Business Expense Plan Information**

Base Monthly Benefit \$ \_\_\_\_\_

Plan  BE21 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**

Retroactive Injury  
 Surrender Value SVR Beneficiary \_\_\_\_\_ Relationship \_\_\_\_\_  
 Guaranteed Insurability  \$100  \$200  \$300  \$400  \$500  \$600

**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 \$ \_\_\_\_\_

**8. 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 \_\_\_\_\_%

**9. Other Disability Coverage**

a. Do you have or are you applying for other disability income coverage, such as: (1) Individual Disability Income; (2) Sick Pay Plan, Group Short Term or Long Term Disability, excluding Worker's Compensation; or (3) Business Expense Insurance?  Yes  No

Company or Source	Pending or In Force (P/I)	Type (1,2,3)	Monthly Amount	Elim. Period	Benefit Period	% of Premium Paid by Employer	Will coverage be replaced?
_____	_____	_____	\$ _____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	_____	\$ _____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	_____	\$ _____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No



**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 and the first full premium 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 any physician, medical practitioner, hospital, clinic, other medical or medically related facility, Veteran's Administration, Medical Information Bureau, Inc., Social Security Administration, my employer, consumer reporting agency, insurance or reinsuring company, or insurance support organization, who possess medical or other 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, its reinsurers, insurance support organizations and their authorized representatives may obtain medical and other information, in order to evaluate my application for insurance or my eligibility for benefits under an existing policy. This Authorization shall include information concerning drugs, alcoholism, AIDS or mental illness. I understand that the Company or its reinsurers may make a brief report concerning me to other insurance companies to whom I have applied or may apply for coverage.

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 APP21

**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**

- Paramedical Exam (Urinalysis required.)  Blood Profile (Informed Consent must be signed.)  EKG
- Agent will schedule.  Home Office will schedule.

**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 \_\_\_\_\_  
STREET CITY STATE ZIP CODE

Checking Account Number \_\_\_\_\_

Financial Institution Routing Number \_\_\_\_\_

Account Title, if applicable \_\_\_\_\_

Account Holder's Signature \_\_\_\_\_ Date \_\_\_\_\_

Form 2534-C 9/97

**Proxy** (Do not use in OK or SC.)

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, R. M. Groom, R. A. McCord, V. J. McCord, M. Metternich, J. K. McCord, and K. M. 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-J (7/98)



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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 Bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the Bureau, upon request, will supply such company with the information in its file.

Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the Bureau's information office is Post Office Box 105, Essex Station, Boston, Massachusetts 02112, telephone number 617.426.3660.

Illinois Mutual Life Insurance Company or its reinsurers may also release information in their files to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

Form 2826