

Application for Workplace Voluntary Disability Income Insurance

1. Employee Information (Complete All)

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

b. Address _____
STREET CITY STATE ZIP CODE

c. Home Ph. (_____) _____ d. E-mail Address _____

e. Soc. Sec. # _____ f. Date of Birth _____ g. State of Birth _____

h. Employer's Name _____

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

l. Occupation _____

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

2. Policy Information (Complete All)

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

d. Benefit Period for Accident and Sickness _____ Months

e. Coverage Selected:

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

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

TOTAL PAYROLL PREMIUM DEDUCTED: \$ _____

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

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

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

Agreement

I represent and agree that: (1) all statements and information found in the application are deemed representations and not warranties; (2) all statements and answers herein are true and correctly recorded to the best of my knowledge and belief; (3) this application will be a part of any contract issued; (4) no policy issued on this application shall be effective until the 1st day of the month in which payroll deductions or authorized check deductions begin; and (5) I have received a Medical Information Bureau Notice.

Authorization: I hereby authorize my employer, Medical Information Bureau, Inc., or any consumer reporting agency who possess information on me, to furnish such information to Illinois Mutual Life Insurance Company, hereinafter called the Company, or its legal representative upon presenting this Authorization or a photocopy. The Company or its authorized representatives may obtain information, in order to evaluate my application for insurance.

I have read this Authorization and understand that I may receive a copy upon request. I understand and agree that this Authorization shall be valid for two years from the date signed below.

Signed at _____
CITY AND STATE SIGNATURE OF EMPLOYEE

Date _____

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

Agent's Certification

I certify that I asked the above questions of the Employee in person and have recorded the information correctly. An Outline of Coverage was given to the Applicant. I do do not have knowledge that the insurance applied for will replace any existing disability income insurance.

PRINT WRITING AGENT NAME AGENT'S SIGNATURE

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

Form WSD-APP07

Proxy (Do not use in IA, 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, 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

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 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.

**Authorization To Honor Checks Drawn by Illinois Mutual Life Insurance Company
for Premiums Due on Insurance Policies**

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		
<input type="checkbox"/> Checking		<input type="checkbox"/> Savings		Account Title, if applicable		
Account Number		Draft premium on day ____ of each month. (Only days 1 thru 28 are valid due to February)				
Financial Institution Routing No.		Today's Date		Your Signature		

Form 2534-D (3/08)

ATTACH VOID CHECK
Return to: 300 SW Adams St., Peoria, IL 61634