



SIMPLIFIED ISSUE WHOLE LIFE APPLICATION SUBMISSION CHECKLIST

Thank you for considering Illinois Mutual

Please review this checklist to avoid unnecessary delays in the processing of your life application submission.

Forms to send back to Illinois Mutual:

- Application – ICC18_LWLSI18APP
- Signed HIPAA – Authorization For Release of Personal Health Information – 9209 (1/22)
- Signed HIPAA – Consent For Disclosure of Substance Use Disorder Patient Records – 9209-PT2 (1/22)
- Informed Consent – 5191-A
- Authorization for Electronic Funds Transfer – 3176 (when applicable)
- Customer Source of Funds – 5753 (when applicable)
- Single Premium Whole Life Insurance Disclosure – 5752 (when applicable)
- Replacement Forms – 5125, 5126 (when applicable)

Forms to complete, keep with agent file and/or leave behind with client:

- Payment Receipt – 5403 (when applicable)
- Notice Regarding Illinois Religious Freedom Protection and Civil Union Act – 3174
- MIB Notice, Fair Credit Notice – 2826, 2825 (on one sheet)
- Description of Information Practices – 2963
- Buyer's Guide – C5050

Additional forms not included in this Packet that can be downloaded from the Resource Library when needed:

- Supplement to Application, Additional Beneficiaries – ICC17_17SAPP-B
- 1035 Exchange Authorization – 1035EXCH
- Military Sale Presentation Disclosure – 5608
- Foreign National United States Immigrant Questionnaire – 7016

Please make copies of any pieces you want for your records before sending to Home Office.

QUESTIONS?

LIFE SALES SUPPORT TEAM

Email: LifeSalesSupport@IllinoisMutual.com

Phone: (800) 437-7355, ext. 775

Fax: (309) 636-0363

LIFE UNDERWRITING CASE STATUS

Email: Underwriting@IllinoisMutual.com

Phone: (800) 437-7355, ext. 768

Fax: (309) 674-2091

Application for Simplified Issue Individual Whole Life Insurance



1. PROPOSED INSURED

a. Name (First, MI, Last)		Maiden/Former	b. Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	c. Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married
d. Address (Street, City, State, Zip Code)				
e. Primary Phone	f. Alternate Phone		g. Email	
h. Social Security Number			i. Driver's License Number and State	
j. Date of Birth	k. Place of Birth (State/Country)		l. Occupation	
m. Employer's Name and Address				
n. Are you a U.S. Citizen? <input type="checkbox"/> Yes <input type="checkbox"/> No (1) If "No," have you resided in the U.S. for the past 2 years? <input type="checkbox"/> Yes <input type="checkbox"/> No (1a) If "Yes," have you been granted permanent resident (green card) status? <input type="checkbox"/> Yes <input type="checkbox"/> No				

2. OWNER INFORMATION (if other than Proposed Insured)

a. Name (First, MI, Last)	b. Date of Birth	c. SSN/Tax ID#
d. Address (Street, City, State, Zip Code)		e. Relationship to Proposed Insured
f. Primary Phone	g. Alternate Phone	h. Email
i. Contingent Owner Information (recommended if Owner is not Proposed Insured). If no box is checked, the Owner's estate will become the Owner. <input type="checkbox"/> If the Owner(s) die(s) before the Proposed Insured, the Proposed Insured will become the Owner. <input type="checkbox"/> If the Owner(s) die(s) before the Proposed Insured, the individual or entity named below will become the Owner. Name _____ Date of Birth _____ SSN/Tax ID# _____ Address _____ Relationship to Proposed Insured _____		

3. BENEFICIARY DESIGNATION

Unless you state otherwise, if more than one primary Beneficiary is named, each primary Beneficiary will share equally with other surviving primary Beneficiaries. If no primary Beneficiary(ies) survive(s), each contingent Beneficiary will share equally with other surviving contingent Beneficiaries. Please list in whole percentages only; percentages in each Beneficiary class (primary or contingent) must total 100%.

a. Name (First, MI, Last or Entity Name if Non-Natural Person)	<input type="checkbox"/> Primary % of Proceeds _____	Date of Birth
Address (Street, City, State, Zip Code)	SSN/Tax ID #	Relationship
b. Name (First, MI, Last or Entity Name if Non-Natural Person)	<input type="checkbox"/> Primary <input type="checkbox"/> Contingent % of Proceeds _____	Date of Birth
Address (Street, City, State, Zip Code)	SSN/Tax ID #	Relationship

4. PLAN AND BILLING INFORMATION

a. Amount of Insurance \$	b. Premium Amount Quoted \$
c. Effective Date: <input type="checkbox"/> Application Date <input type="checkbox"/> Issue Date <input type="checkbox"/> Other Date _____	
d. Dividend Option: <input type="checkbox"/> Accumulate at Interest <input type="checkbox"/> Cash	
e. Payment Period: <input type="checkbox"/> Continuous Pay <input type="checkbox"/> Single Pay	
f. Premium Mode: <input type="checkbox"/> Annual <input type="checkbox"/> Semi-Annual <input type="checkbox"/> Quarterly <input type="checkbox"/> Monthly EFT <input type="checkbox"/> Special Bill (Indicate billing number if known.) _____	
g. Initial Premium Payment: <input type="checkbox"/> Cash with Application \$ _____ <input type="checkbox"/> Cash on Delivery (C.O.D.) <input type="checkbox"/> Draft First Month's Premium (Monthly EFT mode only) <input type="checkbox"/> At Issue <input type="checkbox"/> Other Date _____	
h. Premium Notices: <input type="checkbox"/> Insured at residence <input type="checkbox"/> Owner at address shown above <input type="checkbox"/> Other _____	
i. Mail Policy to: <input type="checkbox"/> Agent <input type="checkbox"/> Owner (Policy will be mailed to Agent if no box is checked.)	
j. Secondary Addressee to receive notice of policy lapse due to nonpayment of premium (optional)*: Name _____ Phone _____ Address (Street, City, State, Zip Code) _____ *If you decline to name a secondary addressee at this time, you may still designate someone at a later date.	

5. OTHER LIFE COVERAGE

a. Do you have any in-force life insurance or annuities, or pending applications? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," list below:			
Company Name or Source	Pending (P) or In Force (I)	Face Amount	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
_____	_____	\$ _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
b. If replacement is indicated, provide company address and policy number. Forward replacement forms, if required. _____			
c. In connection with this application, has there been, or will there be, with this or any other company, any: surrender transaction; loan; withdrawal; lapse; reduction or redirection of premium/consideration; or change transaction (except conversions) involving an annuity or other life insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No			

6. UNDERWRITING INFORMATION (All references to “you” in this section mean the Proposed Insured.)

a. What is your current: (1) Height: _____ feet _____ inches (2) Weight: _____ pounds	
b. Do you require personal assistance to perform the normal activities of daily living such as bathing, dressing, eating, toileting, or moving about; or are you confined at home, in a hospital or nursing facility, or receiving hospice care?	<input type="checkbox"/> Yes <input type="checkbox"/> No
c. Have you ever tested positive for, or been diagnosed by a medical professional with, Human Immunodeficiency Virus (AIDS virus) or Acquired Immune Deficiency Syndrome (AIDS)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
d. In the past 5 years, have you been diagnosed, treated or given advice by a medical professional for cancer, leukemia, or malignant melanoma (excluding Basal or Squamous cell skin cancer)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
e. In the past 5 years, have you had or been advised by a medical professional to have kidney dialysis or an organ transplant?	<input type="checkbox"/> Yes <input type="checkbox"/> No
f. In the past 5 years, have you been advised by a medical professional to get specified medical care which was not completed or for which results have not been received, such as hospitalization, surgery, biopsy, or diagnostic tests, excluding those tests related to the Human Immunodeficiency Virus (AIDS virus)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
g. In the past 2 years, have you been diagnosed, treated, or given advice by a medical professional for: (1) Pacemaker, heart attack, heart surgery, congestive heart failure, angina (chest pain), or other circulatory disease or disorder? (2) Systemic lupus, brain tumor, stroke, or aneurysm? (3) Alzheimer’s disease, Parkinson’s disease, dementia, cerebral palsy, epilepsy (seizures, convulsions), Huntington’s disease, muscular dystrophy, multiple sclerosis, amyotrophic lateral sclerosis (ALS), or schizophrenia? (4) Cirrhosis, chronic hepatitis, Hepatitis C or other liver disease, kidney failure, chronic glomerulonephritis, polycystic kidney disease, or other kidney disease? (5) Diabetes, including treatment by oral medication or insulin? (6) Chronic obstructive pulmonary disease (COPD), emphysema, chronic bronchitis that is not seasonal, or other chronic respiratory disorder, excluding allergies or asthma, or have you used oxygen therapy to assist with breathing?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
h. In the past 2 years, have you received medical treatment or counseling for, or been advised by a medical professional to limit or discontinue, the use of alcohol or prescribed or non-prescribed drugs?	<input type="checkbox"/> Yes <input type="checkbox"/> No

7. HOME OFFICE ENDORSEMENT ONLY

Question # _____ corrected to read as follows: _____

8. AGREEMENT AND AUTHORIZATION

Agreement: I represent and agree that: (1) all statements and information found in the application are deemed representations and not warranties and are part of and the basis of any policy issued; (2) I have read, or had read to me, the information on this application, and my answers are, to the best of my knowledge and belief, true and correctly recorded; (3) this application shall be attached to and become a part of any contract issued; (4) no information will have been deemed to have been given to the Company unless it is stated in this application, including any amendments and supplements; (5) my 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; (6) no policy issued on this application shall become effective until received and accepted by me and the full premium paid while the Proposed Insured is alive. However, if a premium has been paid, then liability of the Company shall be as stated in the Receipt; (7) I have received a MIB Notice and Fair Credit Reporting Act Notice.

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 medical or medically related facility, pharmacy or 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 for the purpose of evaluating my eligibility for insurance. Health information obtained will not be re-disclosed without my authorization unless permitted by law, in which case I may not be protected under federal privacy rules. I authorize Illinois Mutual Life Insurance Company, or its reinsurers, to make a brief report of my personal health information to MIB.

8. AGREEMENT AND AUTHORIZATION (cont.)

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 such time limit, if any, permitted by applicable law in the state where the policy is delivered or issued for delivery. A copy of this Authorization is as valid as the original. I may revoke this Authorization at any time by providing written notification of its termination to Illinois Mutual Life Insurance Company at its Home Office.

I understand that paying my insurance premiums more frequently than annually may result in a higher yearly out-of-pocket cost.

If I intend to replace existing insurance or annuities, I have so indicated in the appropriate section of the application.

By signing the application, I agree that I have read the application and agree to the Agreement and Authorization.

Illinois Mutual Life Insurance Company Proxy

Proxy 561-M (3/18)

(Do not complete if contract state is IA, MD, OK, SC or TN):

Do you hereby constitute and appoint K.M. Jenkins and T.P. Jenkins, or any one of them in attendance, as your proxy for you, and in your name, place and stead hereby authorize and empower them to cast your vote or votes to which you may be entitled at any special or regular policyowner meeting of Illinois Mutual on any election or question requiring your proxy? I hereby authorize such proxies, either individually or collectively, to have the full power to name, substitute and appoint any other person to act for and on his or her behalf and to act in my name, place, stead and behalf in the event my named proxies are unable to attend any meeting requiring my proxy. I hereby waive notice of all policyowner meetings. This proxy shall continue in force until the earlier of the date I am no longer a policyowner of this insurance coverage or the date my written notice of revocation has been on file with the Secretary of the Company for at least 60 days. I agree to notify the Secretary of Illinois Mutual of such change in proxy, and to abide by the Company's bylaws governing proxy voting.

⚠ I appoint and agree to this proxy: Yes No Signature of Owner _____

Fraud Notice: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and may be subject to penalties under state law.

I verify, when completing electronically, the unique identifier used to sign the application is mine and I am signing the application electronically.

Signed at (City, State)	Date
Signature of Proposed Insured _____	
Signature of Owner/Applicant if other than Proposed Insured _____	

Agent's Certification: I certify that I asked the application questions and have recorded the information correctly. I do do not have knowledge that the insurance applied for will replace any existing life insurance or annuities.

Print Writing Agent's Name	Writing Agent's Signature
Agent's Phone Number	Agent's Email
Agent's NPN	Agent's Code Number

Is the Proposed Insured/Owner related to Agent? Yes No If "Yes," relationship _____

Does the Proposed Insured/Owner prefer to receive future correspondence in Spanish? Yes No

Split Commission Information:

For proper recording of split commission business, complete the following (print all names):

Name	_____% of Commission	NPN	Code Number
Name	_____% of Commission	NPN	Code Number

Personal History Interview Completed:

Yes Reference # _____ No



**AUTHORIZATION FOR RELEASE OF
PERSONAL HEALTH INFORMATION**

This Authorization is intended to comply with the
HIPAA Privacy Rule (45 C.F.R. Part 164, Subpart E).

Proposed Insured or Claimant: _____ Date of Birth: _____

Address: _____ Policy/Claim Number: _____

PURPOSE

Providing this Authorization enables Illinois Mutual Life Insurance Company and its agents, employees, and representatives (collectively, "Illinois Mutual") to underwrite your application and determine your eligibility for coverage, obtain reinsurance, administer coverage issued to or claims made by you, and conduct other legally permitted activities relating to the coverage for which you have applied or that is issued to you. Providing this Authorization is voluntary, but if you decline to provide this Authorization, Illinois Mutual may deny your application for coverage or your claim for benefits.

AUTHORIZATION

I authorize and request:

any health plan, physician, other health care professional or practitioner, clinic, hospital, psychiatric facility or mental health institution, other health care facility or health care provider, laboratory, pharmacy, pharmacy benefit manager, insurance or reinsurance company, viatical broker, provider or company, healthcare clearinghouse, ambulance or other healthcare transport service, MIB LLC, government agency, consumer reporting agency, insurance support organization, third party administrator, and any other organization, institution, or person that has screening, diagnosis, treatment, prescription, or other health or health payment information about me (each, an "Information Source"), to release and disclose to Illinois Mutual, all such screening, diagnosis, treatment, prescription, or other health or health payment information about me, including (a) my entire medical and health care claims records; and (b) any information relating to mental health (other than psychotherapy notes), drug, alcohol or other substance misuse, Human Immunodeficiency Virus ("HIV") infection and other sexually transmitted diseases, and dental and vision health (collectively, my "Personal Health Information"). My Personal Health Information includes any protected health information subject to the HIPAA Privacy Rule.

This Authorization overrides any agreement I may have made with any Information Source to restrict use or disclosure of my Personal Health Information. I instruct Information Sources to release and disclose my Personal Health Information to Illinois Mutual, or its reinsurers, without restriction.

I authorize Illinois Mutual to use and to re-disclose my Personal Health Information for the purpose stated above, including to make a brief report to MIB LLC and to other parties providing services to Illinois Mutual who may be involved with my claim. I understand that Illinois Mutual will not otherwise use or re-disclose my Personal Health Information, except as further authorized by me or as permitted or required by law. I further understand that once my Personal Health Information is redisclosed by Illinois Mutual, it may no longer be protected by Federal or other laws.

EXPIRATION AND REVOCATION

Unless I earlier revoke this Authorization by written notice to Illinois Mutual, this Authorization will expire 24 months following the date I enter below (except that it shall remain in force for the duration of the policy in Minnesota; 30 months in Arizona, California, Connecticut, Delaware, Georgia, Illinois, Maine, Massachusetts, Nevada, New Jersey, North Carolina, Ohio and Virginia; 1 year for mental health records in Maine; 1 year for substance abuse records in Alabama; 90 days for Iowa HIV infection and sexually transmitted diseases records; and 180 days for Arizona HIV infection and sexually transmitted diseases records). I understand I may revoke this Authorization at any time by written notice of revocation to Compliance Officer, Illinois Mutual Life Insurance Company, 300 SW Adams St., Peoria, Illinois 61634. I understand that a revocation is not effective to the extent that Illinois Mutual or any Information Source has relied on this Authorization before receiving notice of my revocation, or to the extent Illinois Mutual has a legal right to contest a claim under an insurance policy or to contest the policy itself.

ACKNOWLEDGEMENT AND SIGNATURE

I have read this Authorization. I understand that, upon request of Illinois Mutual, I am entitled to a copy of this Authorization bearing my signature or the signature of my personal representative below. I agree that a photocopy or facsimile of this signed Authorization is as valid as the original.

Date

Signature of Proposed Insured or Claimant

Printed Name of Proposed Insured or Claimant

Signature of Personal Representative authorized
by law to give this Authorization

Personal Representative's authority or relationship to Proposed
Insured or Claimant

Practitioner or Facility (Home Office Use Only)



CONSENT FOR DISCLOSURE OF SUBSTANCE USE DISORDER PATIENT RECORDS

This Consent is intended to comply with the Federal Confidentiality
of Substance Use Disorder Patient Records Rule
(42 C.F.R. Part 2).

Proposed Insured or Claimant: _____ Date of Birth: _____

Address: _____ Policy/Claim Number: _____

PURPOSE

Your provision of this Consent enables Illinois Mutual Life Insurance Company and its agents, employees, and representatives (collectively, "Illinois Mutual") to underwrite your application and determine your eligibility for coverage, obtain reinsurance, administer coverage issued to or claims made by you, and conduct other legally permitted activities relating to the coverage for which you have applied or that is issued to you. Your provision of this Consent is voluntary, but if you decline to provide this Consent, Illinois Mutual may deny your application for coverage or your claim for benefits.

CONSENT

I consent to any substance use disorder program subject to 42 C.F.R. Part 2 that has patient records about me to disclose to Illinois Mutual and its Vice President of Underwriting and/or Vice President of Claims all such patient records, inclusive of any screening, diagnosis, treatment, prescription, or other information, reports and histories about me (collectively, my "Substance Use Disorder Patient Records"). I further consent to any other organization, institution or person that holds my Substance Use Disorder Patient Records to disclose those patient records to Illinois Mutual and its Vice President of Underwriting and/or Vice President of Claims.

I consent to use and re-disclosure of my Substance Use Disorder Patient Records by Illinois Mutual, its reinsurers, and its Vice President of Underwriting and/or Vice President of Claims for the purpose stated above, including making a brief report to MIB LLC, or its reinsurers, with each re-disclosure accompanied by the following notice: "42 CFR part 2 prohibits unauthorized disclosure of these records."

EXPIRATION AND REVOCATION

Unless I earlier revoke this Consent by notice to Illinois Mutual, this Consent will expire 24 months following the date I enter below (1 year for substance abuse records in Alabama). I understand I may revoke this Consent at any time by notice of revocation to Compliance Officer, Illinois Mutual Life Insurance Company, 300 SW Adams St., Peoria, Illinois 61634. I understand that a revocation is not effective to the extent that Illinois Mutual or any lawful holder of my Substance Use Disorder Patient Records has relied on this Consent before receiving notice of my revocation, or to the extent Illinois Mutual has a legal right to contest a claim under an insurance policy or to contest the policy itself.

ACKNOWLEDGEMENT AND SIGNATURE

I have read this Consent. I understand that, upon request of Illinois Mutual, I am entitled to a copy of this Consent bearing my signature or the signature of other authorized person identified below. I agree that a photocopy or facsimile of this signed Consent is as valid as the original.

Date

Signature of Proposed Insured or Claimant

Printed Name of Proposed Insured or Claimant

Signature of other person authorized by law to give this Consent

Other person's authority or relationship to Proposed Insured or Claimant

Practitioner or Facility (Home Office Use Only)



PAYOR INFORMATION AND 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): _____

Payor (Third Party): _____ Payor Relationship: _____

Payor SSN/Tax ID #: _____ Payor Date of Birth: _____

Payor Email: _____ Payor Phone: _____

COMPLETE BELOW FOR ELECTRONIC FUNDS TRANSFER

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 at other date _____.

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

Check 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 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

Signature of Account Holder

Date

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

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.

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 notice 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



LIFE RECEIPT

LIFE RECEIPT (Do not complete receipt unless payment is made. No payments accepted on face amounts greater than \$500,000.)

Received from _____ on _____, 20 ____ the

sum of \$ _____ toward the premium for life 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 accordance 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 required medical examinations, tests and personal history interviews 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 life insurance, including any accidental death benefit applied for, shall not exceed \$100,000. If a life policy different than applied for, in coverage, amount or premium, is offered, the life 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.

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



LEAVE THIS PAGE WITH THE APPLICANT

MIB, LLC 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 MIB, LLC, which operates an information exchange on behalf of insurance companies that are members of MIB Group Inc. 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 or go to its website at www.mib.com to request disclosure online. 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.

2826 (1/22)

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.

2825 (3/13)



NOTICE AND INFORMED CONSENT

NOTICE TO PROPOSED INSUREDS

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

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

- 1. The application asks specific questions about ARC and AIDS.
2. As a part of our normal underwriting process, you are being asked to sign the INFORMED CONSENT below. This form will allow us to order tests to detect the presence of the AIDS virus.

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

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

INFORMED CONSENT

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

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

Date

Printed Name of Proposed Insured

Signature of Proposed Insured

Printed Name of Other Person Proposed for Insurance

Signature of Other Person Proposed for Insurance



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

CUSTOMER SOURCE OF FUNDS

Agents must complete when total annual premium is \$5,000 or more to help with anti-money laundering (AML) compliance.

1. Source of Funds for Premium Payment (check all that apply):

- Cash/Checking/Savings/CDs
- Stocks/Bonds/Mutual Funds (U.S. only)
- Personal or Equity Loan
- Sale of Property
- Inheritance/Death Benefit Proceeds
- Reverse Mortgage
- Another Person (if so, identify) _____
- Other (please specify) _____
- 401k/Pension
- Existing Life Insurance Cash Value
- Proceeds of Canceled Life Insurance Policy
- Existing Annuity

Explanation (Must complete if Proposed Owner/Payor has possessed funds for less than 60 days): _____

Agent Must Verify Source of Funds

List documents reviewed, e.g., bank statement, 401k distribution statement, etc.: _____

Agent's Relationship with Proposed Owner (or Payor if Proposed Owner not paying):

How Known _____ Length of Time Known (in years) _____

Nature of Relationship _____

- 2. Source of Information:** Proposed Owner Insured (if different than Owner) Payor
 Other (please specify) _____

- 3. Acknowledgement and Signatures:** I have reviewed the questions on this form, and the information provided is true and accurate to the best of my knowledge and belief.

Print Name of Proposed Insured

Print Name of Proposed Owner

Signature of Proposed Owner

Date

Print Name of Payor
(if not Proposed Owner)

Signature of Payor
(if not Proposed Owner)

Date

Print Name of Writing Agent

Signature of Agent

Date

AGENT: Please submit this completed and signed form to the Home Office along with the application.



300 S.W. Adams Street Peoria, IL 61634
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**SINGLE PREMIUM WHOLE LIFE INSURANCE
DISCLOSURE**

I understand and agree that:

1. I am purchasing a *life insurance policy* called "Single Premium Whole Life" insurance. It is not an annuity, investment, savings or retirement product.
2. The purchase of this product may affect my future eligibility for need-based governmental benefits such as Medicaid or Supplemental Security Income (SSI). Eligibility for Social Security retirement benefits or Social Security Disability Insurance (SSDI) should not be affected since, under current law, these programs are not need-based.
3. I do not need the funds used as the premium for my current or future living expenses or other financial obligations.
4. If, in the future, I need to access the funds that were used to purchase this life insurance, the funds available (cash value) will be less than the premium paid and I will need to take a loan, at interest, to withdraw the funds. Any loans and any accrued interest not repaid will reduce the death benefit.
5. It is not recommended that I surrender an annuity, cash out investments, or take a loan to fund the premium payment for this life insurance.
6. If the premium used to pay for this life insurance is a withdrawal or surrender of certain investments or savings, e.g., certificates of deposit, money market funds, mutual funds, or annuities, there may be income tax consequences, including tax penalties, and penalties or charges assessed by the issuer on the withdrawal or surrender.

MODIFIED ENDOWMENT CONTRACT DISCLOSURE

I understand that the Single Premium Whole Life insurance policy for which I am applying is a Modified Endowment Contract (MEC) under federal tax law and in particular Section 7702A. This SPWL policy is not a MEC if all of the premium applied to this policy is transferred from another life insurance contract that is not a Modified Endowment Contract. MECs are life insurance policies in which the premium paid fails the "7 pay" test stated in the law.

MECs differ from non-MEC life insurance in that, with a MEC, certain pre-death distributions are taxed to the extent of any gain at the time of the distribution. In addition to the current income taxation, a penalty tax of 10% is assessed unless the owner is 59-1/2 or disabled at the time of the distribution or if the distribution is a life annuity. Pre-death distributions include but are not limited to surrenders of the policy, loans, dividends paid as cash or withdrawn, or any assignment or pledge of the policy.

It is important to note that while pre-death distributions are taxable, the tax advantages on payments due to the death of the insured (the death benefit) are the same for MECs and non-MECs. That is, the death benefit payment (excluding any interest on the death benefit) is not subject to income tax. Depending upon the estate of an owner-insured, there may be estate taxes.

I UNDERSTAND AND ACKNOWLEDGE THAT:

- **THESE DISCLOSURES ARE BASED ON TAX LAWS THAT ARE COMPLEX AND SUBJECT TO CHANGE;**
- **ILLINOIS MUTUAL AND ITS AGENT MAY NOT OFFER ANY TAX OR LEGAL ADVICE; AND**
- **IT IS MY RESPONSIBILITY TO SEEK INDEPENDENT TAX OR LEGAL ADVICE, IF SO DESIRED.**

Print Name of Proposed Insured

Print Name of Proposed Owner

Signature of Proposed Owner

Date

Print Name of Writing Agent

Signature of Writing Agent

Date

AGENT: Please submit this completed and signed form to the Home Office along with the application.

**NOTICE REGARDING REPLACEMENT
REPLACING YOUR LIFE INSURANCE POLICY OR ANNUITY**

Are you thinking about buying a new Life insurance policy or annuity and discontinuing or changing an existing one? If you are, your decision could be a good one – or a mistake. You will not know for sure unless you make a careful comparison of your existing benefits and the proposed benefits.

Make sure you understand the facts. You should ask the company or agent that sold you your existing policy to give you information about it.

Hear both sides before you decide. This way you can be sure you are making a decision that is in your best interest.

We are required by law to notify your existing company that you may be replacing their policy.

List below the identification of policies which are involved in the replacement transaction.

_____	_____
	Applicant's Signature
Contract No. _____	_____
Contract No. _____	Agent's Signature
Contract No. _____	_____
Contract No. _____	Date



ILLINOIS MUTUAL®

Life Insurance Company

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

NOTICE REGARDING PROPOSED REPLACEMENT OF LIFE INSURANCE OR ANNUITY

Dear Sir:

You are herewith given notice that we are in receipt of application(s) for life insurance or annuity(ies) for an individual presently insured with your company.

Identification

Name of Insured _____

Address _____

Contract Numbers

_____	_____
_____	_____
_____	_____
_____	_____

This notice is given pursuant to 50 Ill. Adm. Code 917.70(c).

Sincerely,

Christopher A. Connor
Vice President, Underwriting

(Agent's Signature)



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

NOTICE REGARDING ILLINOIS RELIGIOUS FREEDOM PROTECTION AND CIVIL UNION ACT

What is the Illinois Religious Freedom Protection & Civil Union Act? The Illinois Religious Freedom & Civil Union Act (the “Civil Union law”), among other items, authorizes same sex or heterosexual couples to enter into a formal civil union which has the same rights and privileges as married couples.

How does this affect insurance? The Civil Union law provides that the same legal obligations, responsibilities, protections and benefits afforded to married persons under insurance policies, contracts, certificates and/or riders and endorsements be made available to parties to a civil union and their families.

How does this affect my coverage with Illinois Mutual? The Illinois Civil Union law affects your Illinois Mutual policies in several ways.

- The word “spouse” now includes a civil union partner.
- Terms that mean or refer to a marital or family relationship or that may be construed to mean or refer to a marital or family relationship: such as “marriage”, “spouse”, “husband”, “wife”, “dependent”, “next of kin”, “relative”, “beneficiary”, “survivor”, “family”, “immediate family” and any other such terms include the relationship created by a civil union.
- Children now include children of a civil union. For instance, if the definition of “child” in your policy includes “step-children”, then the child(ren) of a civil union partner from a legally recognized prior civil union which was dissolved (similar to divorce) or a prior marriage are now included in the definition of “child.”
- Terms that mean or refer to the inception or dissolution of a marriage, such as “date of marriage”, “divorce decree”, “termination of marriage” and any other such terms include the inception or dissolution of a civil union.
- Benefits, Policyowner Services and Underwriting will follow the Illinois Civil Union law.

What if I entered into a domestic partnership or civil union in a state other than Illinois? To the extent that Illinois will recognize domestic partnerships or civil unions formalized in another state, Illinois Mutual will apply the same rules as to civil unions entered into Illinois.

Does this new law mean that my domestic partner and I are now automatically in a civil union? No. The Illinois law provides that, unless recognized by another state, persons in a domestic partnership must formalize their relationship with a civil union in accordance with Illinois law. This generally includes obtaining a civil union license from your local governmental authority. Once the civil union is legally formalized, then the rights and privileges described above are effective. Until then insurance companies are not obligated to treat domestic partnerships similarly to marriages.

Do I need to change my beneficiary designation if I am in a civil union? We always recommend periodic review of beneficiary designations upon the occurrence of life events such as marriage, birth/adoption of a child, death of a beneficiary. If you enter into a civil union, we would recommend that you review your beneficiary designation.

Do all states and the federal government also recognize a civil union entered into under Illinois law? No. A few states may recognize the Illinois civil union but most states will not. The federal law expressly does not recognize civil unions or domestic partnerships. Under the federal Defense of Marriage Act (“DOMA”), only traditional marriages between a man and a woman are recognized. Therefore, issues regarding taxation of insurance and use of insurance for estate planning should be directed to your tax consultant.

Where can I obtain additional information regarding the Illinois Civil Union law? Information regarding how to enter into a civil union, recognition of civil unions entered into in other states and other rights afforded partners in civil unions can be found at <http://insurance.illinois.gov>. Information regarding your coverage at Illinois Mutual can be directed to your Illinois Mutual producer or to Illinois Mutual at 1-800-437-7355.



FACTS **WHAT DOES ILLINOIS MUTUAL LIFE INSURANCE COMPANY DO WITH YOUR PERSONAL INFORMATION?**

Why? Financial companies choose how they share your personal information. Federal law and state law give consumers the right to limit some but not all sharing. Federal law also requires us to tell you how we collect, share, and protect your personal information. Please read this notice carefully to understand what we do.

What? The types of personal information we collect and share depend on the product or service you have with us. This information can include:

- Personal Information, such as name, address and Social Security number
- Demographic Information
- Employment Information, such as employment history
- Medical Information, such as medical history and records
- Financial Information, such as account numbers
- Internet or Other Electronic Network Activity Information, such as browsing history or IP address
- Insurance Product Information, such as policy numbers and policy values

When you are no longer our customer, we continue to share your information as described in this notice.

How? All financial companies need to share customer personal information to run their everyday business. In the section below, we list the reasons financial companies can share their customer personal information; the reasons Illinois Mutual Life Insurance Company chooses to share; and whether you can limit this sharing.

Reasons we can share your personal information	Does Illinois Mutual share?	Can you limit this sharing?
For our everyday business purposes — such as to process your transactions, maintain your account(s), respond to court orders and legal investigations, or report to credit bureaus	Yes	No
For our marketing purposes — to offer our products and services to you	Yes	No
For joint marketing with other financial companies	No	No
For our affiliates' everyday business purposes — information about your transactions and experiences	No	No
For our affiliates' everyday business purposes — information about your creditworthiness	No	No
For nonaffiliates to market to you	No	No

Questions? Call 1-800-437-7355, ext. 436 or send email to Privacy@IllinoisMutual.com

Who we are	
Who is providing this notice?	Illinois Mutual Life Insurance Company, 300 SW Adams Street, Peoria, IL 61634

What we do	
How does Illinois Mutual protect my personal information?	To protect your personal information from unauthorized access and use, we use security measures that comply with state and federal law. These measures include computer safeguards, access limitations, and secured files and building.
How does Illinois Mutual collect my personal information?	<p>We collect your personal information, for example, when you:</p> <ul style="list-style-type: none"> • apply for a product • make a claim • communicate • transact with us • apply to become an agent <p>We also obtain information from your healthcare providers, employers, and other insurance companies. With your authorization, we may use insurance support organizations to collect information and provide an investigative consumer report to us. That organization may keep the report and disclose its contents to other companies.</p>
Who does Illinois Mutual share your personal information with?	<ul style="list-style-type: none"> • Agents • Reinsurers • Medical Professionals • Service Providers who are under contract to not further disclose your information
Why can't I limit all sharing?	<p>Federal law gives you the right to limit only:</p> <ul style="list-style-type: none"> • sharing for affiliates' everyday business purposes – information about your creditworthiness • affiliates from using your information to market to you • sharing for nonaffiliates to market to you <p>State laws and individual companies may give you additional rights to limit sharing.</p>
Access and Correction	Illinois Mutual has procedures by which you can obtain access to personal information about you appearing in our policy files and by which you may request a correction, amendment or deletion of information you believe is inaccurate. Please notify us if you think any information is incorrect, and we will review it. If we agree, we will correct our files. If we do not agree, you may submit a statement which we will keep in your file and provide with any future disclosure of the disputed information.

Definitions	
Affiliates	Companies related by common ownership or control. They can be financial and nonfinancial companies. Illinois Mutual does not have any affiliates.
Nonaffiliates	Companies not related by common ownership or control. They can be financial and nonfinancial companies. These are service providers that perform business functions.
Joint marketing	A formal agreement between nonaffiliated financial companies that together market financial products or services to you. Illinois Mutual does not joint market.

Prepared by the National Association of Insurance Commissioners

The National Association of Insurance Commissioners is an association of state insurance regulatory officials. This association helps the various insurance departments to coordinate insurance laws for the benefit of all consumers.

This guide does not endorse any company or policy

BEFORE YOU BUY LIFE INSURANCE

Understand What Life Insurance Is

Life insurance pays a death benefit if you die while the policy is in effect, in exchange for premiums you pay before your death. You can use the death benefit to protect against financial hardships such as loss of your income, funeral expenses, medical or nursing care expenses, debt repayments, and child care costs after your death. You can get information from the NAIC website – www.naic.org.

If You Need Life Insurance, Decide How Much Coverage to Buy

How much life insurance to buy depends on the financial needs that will continue after your death. Examples include supporting your family, paying for child(ren)'s education, and paying off a mortgage. Some questions you may want to ask about your own needs include:

- Does anyone depend on me financially?
- How much of the family income do I provide?
- How will my family pay my final expenses and repay debts after my death?
- Do I want to leave money to charity or family?
- If I have life insurance through my employer, is it enough to meet my financial obligations?

The answers to these questions can help you decide how much coverage you need. An insurance agent, financial advisor, or insurance company representative can help you evaluate your insurance needs and give you information about available policies.

If You Already Have Life Insurance, Assess Your Current Life Insurance Policy

It's important to compare your current policy with any new policy you might buy. Keep in mind that you may be able to change your current policy to get benefits you want. Also, know that any changes in your health may impact your ability to get a new policy or the premium you'll pay. Don't cancel your current policy until you get the new one.

Also, while you may have free or low-cost life insurance through your employer, the death benefit usually is less than you need. And if you leave the employer, you may not be able to take this coverage with you.

Compare the Different Types of Insurance Policies

There are many types of life insurance policies. You should choose a policy with features that fit your individual needs. Some things to consider are:

Term Insurance vs. Cash Value Insurance. Term insurance is intended to provide lower-cost coverage for a specific period of time (“a term”). If you want coverage for a longer period of time, such as for your lifetime, cash value insurance may be more cost effective. Most term policies don’t build up cash values that you can use in the future.

Renewable Term vs. Non-renewable Term. Most term life insurance coverage can be continued (“renewed”) at the end of the term, even if your health has changed. If you renew a term policy, the new premiums are higher. Ask what the premiums will be before you renew the policy. Also ask if you’ll lose the right to renew the policy at a certain age. A Non-renewable term policy can’t be continued. You’ll have to apply for a new policy if you still want coverage.

Whole Life vs. Universal Life. Whole life and universal life insurance are two types of cash value insurance. A key difference between the two is how you pay for the coverage. You typically pay premiums for whole life insurance according to a set schedule. In a universal life policy, you can choose a flexible premium payment pattern as long as you pay enough to keep your policy in force.

Variable Life vs. Non-variable Life. The investments you will choose (such as stock and bond funds) in a variable life policy directly impact your cash value. These policies have the greatest potential to build cash value but also the greatest risk of losing cash value. Non-variable life policies often have guaranteed minimums for some features (interest or cash value, for example) but not all. Non-variable life policies also have less potential to build cash value than variable life policies.

Be Sure You Can Afford the Premium

Before you buy a life insurance policy, be sure you can pay the premiums. Can you afford the initial premium? If the premium increases later, will you still be able to afford it? The premiums for many life insurance policies are sensitive to changes in the company’s investment earnings, claims costs, and other expenses. If those are worse than expected, you may have to pay a much higher premium. Ask what might be the highest premium you’d have to pay to keep your coverage.

Understand the Application Process

You can apply for life insurance through life insurance agents, the mail, and online. In addition to basic information, such as your name, address, employer, job title, and date of birth, you’ll be asked for more personal information. Depending on the type of policy, the insurer may require you to see a doctor, answer health-related questions, or have a medical professional come to your home or office to assess your health. Usually a policy that doesn’t require detailed health information will cost more and provide less coverage than one that does.

It’s important to tell the truth on the application. The insurance company will check your answers so review the application before you sign. If the insurance company discovers false statements on your application after it issues your policy, it could reduce or cancel your coverage.

Choose a Beneficiary

A beneficiary is the person(s) or organization(s) you name to receive your life insurance policy’s death benefit. You’ll need to know the Social Security or tax identification number for all beneficiaries. Experts advise you not to name a minor child as a beneficiary. Insurance companies won’t pay a minor. Instead, consider leaving the money to your estate or trust.

Evaluate the Future of Your Policy

Does your policy have a cash value? In some cash value policies, the values are low in the early years but build later on. In other policies the values build up gradually over the years. Most term policies have no cash value. Ask your insurance agent, financial advisor, or an insurance company representative for an illustration showing future values and benefits.

AFTER YOU BUY LIFE INSURANCE

Read Your Policy Carefully

After you carefully read your policy, you should be able to answer the following important questions:

- Is your personal information correct?
- Do premiums or policy values vary from year to year?
- What part of the premium or policy value isn't guaranteed?
- How will the timing of money paid and received affect any interest the policy might earn?

Your insurance agent, financial advisor, or an insurance company representative can help you understand anything that isn't clear.

If you're not satisfied with your new policy, you can return it for a full refund within a certain period, usually 10 days after you receive it. The review period usually is stated on the first page of the policy.

Review Your Life Insurance Program Every Few Years

Review your policy with your insurance agent, financial advisor, or an insurance company representative every few years to keep up with changes in your policy and your needs.

- Have the premiums or benefits changed since your policy was issued?
- Do the death benefits still meet your needs?
- Do you need more or less coverage after life events, such as birth, adoption, marriage, job change, death, or divorce?

The insurance company can provide policy statements and illustrations to help with this review. As the policy owner, you can change beneficiaries at no cost. Be sure to review your beneficiaries every few years, especially after major life events that affect your life insurance needs.