ILLINOIS MUTUAL®
Life Insurance Company

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_LWL1818APP
- ☐ 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 – 5245
- ☐ 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 Form – 5468 (when applicable)

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

- ☐ Payment Receipt – 5403 (when applicable)
- ☐ MIB Notice, Fair Credit Notice – 2826, 2825 (on one sheet)
- ☐ Description of Information Practices – 2963

Forms not included in this Packet 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: Sales@IllinoisMutual.com
Phone: (800) 437-7355, ext. 775
Fax: (309) 674-7355

LIFE UNDERWRITING CASE STATUS
Email: Underwriting@IllinoisMutual.com
Phone: (800) 437-7355, ext. 768
Fax: (309) 674-2091

Illinois Mutual Life Insurance Company
300 S.W. Adams Street Peoria, IL 61634 Phone (800) 437-7355

Application for Simplified Issue Individual Whole Life Insurance

ILLINOIS MUTUAL®
Life Insurance Company

1. PROPOSED INSURED

a. Name (First, MI, Last) Maiden/Former		b. Gender ☐ Male ☐ Female	c. Marital Status ☐ Single ☐ 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? ☐ 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			

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.

☐ If the Owner(s) die(s) before the Proposed Insured, the Proposed Insured will become the Owner.

☐ 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)	☐ 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)	☐ Primary ☐ Contingent % of Proceeds _____	Date of Birth
Address (Street, City, State, Zip Code)	SSN/Tax ID #	Relationship

Illinois Mutual Life Insurance Company
300 S.W. Adams Street Peoria, IL 61634 Phone (800) 437-7355 Fax (800) 884-7607

4. PLAN AND BILLING INFORMATION

a. Amount of Insurance $	b. Premium Amount Quoted $
c. Effective Date: ☐ Application Date ☐ Issue Date ☐ Other Date _____	
d. Dividend Option: ☐ Accumulate at Interest ☐ Cash	
e. Payment Period: ☐ Continuous Pay ☐ Single Pay	
f. Premium Mode: ☐ Annual ☐ Semi-Annual ☐ Quarterly ☐ Monthly EFT ☐ Special Bill (Indicate billing number if known.) _____	
g. Initial Premium Payment: ☐ Cash with Application $_____ ☐ Cash on Delivery (C.O.D.) ☐ Draft First Month's Premium (Monthly EFT mode only) ☐ At Issue ☐ Other Date _____	
h. Premium Notices: ☐ Insured at residence ☐ Owner at address shown above ☐ Other _____	
i. Mail Policy to: ☐ Agent ☐ 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? ☐ Yes ☐ No If "Yes," list below:

Company Name or Source	Pending (P) or In Force (I)	Face Amount	Will coverage be Replaced?
_____	_____	$_____	☐ Yes ☐ No
_____	_____	$_____	☐ Yes ☐ No
_____	_____	$_____	☐ Yes ☐ No
_____	_____	$_____	☐ Yes ☐ 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? ☐ Yes ☐ 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?	☐ Yes ☐ 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)?	☐ Yes ☐ 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)?	☐ Yes ☐ 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?	☐ Yes ☐ 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)?	☐ Yes ☐ 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?	☐ Yes ☐ No
(2) Systemic lupus, brain tumor, stroke, or aneurysm?	☐ Yes ☐ No
(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?	☐ Yes ☐ No
(4) Cirrhosis, chronic hepatitis, Hepatitis C or other liver disease, kidney failure, chronic glomerulonephritis, polycystic kidney disease, or other kidney disease?	☐ Yes ☐ No
(5 Diabetes, including treatment by oral medication or insulin?	☐ Yes ☐ No
(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?	☐ Yes ☐ 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?	☐ Yes ☐ 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

ILLINOIS MUTUAL®
Life Insurance Company

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.

Illinois Mutual Life Insurance Company
300 S.W. Adams Street Peoria, IL 61634 Phone (800) 437-7355

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)

Illinois Mutual Life Insurance Company
300 S.W. Adams Street Peoria, IL 61634 Phone (800) 437-7355

ILLINOIS MUTUAL®
Life Insurance Company

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.

Illinois Mutual Life Insurance Company
300 S.W. Adams Street Peoria, IL 61634 Phone (800) 437-7355

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)

Illinois Mutual Life Insurance Company
300 S.W. Adams Street Peoria, IL 61634 Phone (800) 437-7355

ILLINOIS MUTUAL®
Life Insurance Company

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.**

Illinois Mutual Life Insurance Company
300 S.W. Adams Street Peoria, IL 61634 Phone (800) 437-7355

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

ILLINOIS MUTUAL®
Life Insurance Company

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

ILLINOIS MUTUAL®
Life Insurance Company

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)

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

NOTICE AND CONSENT FOR TESTING OF BIOLOGICAL SPECIMENS TO INCLUDE HIV (AIDS VIRUS) TESTING

To determine your insurability, the Insurer named above has requested that you provide a biological specimen for testing and analysis. All tests will be performed by a licensed laboratory.

Unless precluded by law, tests may be performed to determine the presence of HIV (the AIDS virus) its component parts, or its antibodies. These tests are extremely reliable. Other tests which may be performed include determinations of blood cholesterol and related lipids (fats), cotinine, cocaine and screening for liver or kidney disorders, diabetes and immune disorders.

All test results will be treated confidentially. They will be reported by the laboratory to the Insurer. When necessary for business reasons in connection with insurance you have or have applied for with the Insurer, the Insurer may disclose test results to others such as its affiliates, reinsurers, employees or contractors. If a biological specimen other than blood is tested to determine the presence of HIV virus, its component parts, or its antibodies, the Insurer may at a later time request a specimen of your blood for further HIV testing. If you choose to decline that request, the results of all testing which has been performed will be provided to the physician which you have designated to receive such results. In addition, if the insurer is a member of the MIB, Inc. and you choose to decline the request that you submit a blood specimen for further HIV testing, the Insurer will report to the MIB, Inc., a generic code which specifies only a non-specific blood test has been ordered and not received. Regardless of the number of tests requested, if the final HIV testing results (including the results of any confirmatory tests dictated by standard medical practice) are other than normal, the Insurer will report to the MIB, Inc. a generic code which signifies only a non-specific test abnormality. If your final HIV testing results are normal, no report will be made about it to the MIB, Inc. Other test results may be reported to the MIB, Inc. in a more specific manner. The organizations described in this paragraph may maintain the test results in a file or data bank. There will be no other disclosure of test results or even that the tests have been done except as may be required or permitted by law or as authorized by you.

If your HIV test results are normal, no routine notification will be sent to you. If the HIV test results are other than normal, the Insurer will contact you. The Insurer may also contact you if there are other abnormal test results which, in the Insurer's opinion, are significant. The Insurer may ask you to confirm the name of a physician to whom you may authorize disclosure and with whom you may wish to discuss the results. If you are a resident of Missouri and your HIV test(s) indicates confirmed infection with HIV and you have not provided the Insurer with the name of a physician to whom you authorize disclosure of test results, the Insurer will disclose test results to the Missouri Department of Health as required by law.

Positive HIV test results or other significant abnormalities detected by additional tests of biological specimens will adversely affect your application for insurance. This means that your application may be declined, that an increased premium may be charged or that other policy changes may be necessary.

Physician: _____

Address: _____

_____

_____

I have read and I understand this Notice of Consent for Testing of biological specimens, which includes HIV testing. I voluntarily consent to provide biological specimens for testing, to the testing of such specimens and the disclosure of the test results as described above.

I understand that I have the right to request and receive a copy of this information. A photocopy of this form will be as valid as the original.

Date: _____ _____

Print Proposed Insured's Name

Date of Birth: _____ _____

Signature of Proposed Insured
or Parent/Guardian

State of Residence: _____

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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.

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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.

ILLINOIS MUTUAL®
Life Insurance Company

IMPORTANT NOTICE

REPLACEMENT OF LIFE INSURANCE OR ANNUITIES

(Note: This document must be signed by the applicant and the producer, if there is one, and a copy left with the applicant.)

You are contemplating the purchase of a life insurance policy or annuity contract. In some cases this purchase may involve discontinuing or changing an existing policy or contract. If so, a replacement is occurring. Financed purchases are also considered replacements.

A replacement occurs when a new policy or contract is purchased and, in connection with the sale, you discontinue making premium payments on an existing policy or contract, or an existing policy or contract is surrendered, forfeited, assigned to the replacing insurer, or otherwise terminated or used in a financed purchase.

A financed purchase occurs when the purchase of a new life insurance policy involves the use of funds obtained by the withdrawal or surrender of or by borrowing some or all of the policy values, including accumulated dividends, of an existing policy to pay all or part of any premium or payment due on the new policy. A financed purchase is a replacement.

You should carefully consider whether a replacement is in your best interest. You will pay acquisition costs and there may be surrender costs deducted from your policy or contract. You may be able to make changes to your existing policy or contract to meet your insurance needs at less cost. A financed purchase will reduce the value of your existing policy and may reduce the amount paid upon the death of the insured.

We want you to understand the effects of replacements before you make your purchase decision and ask that you answer the following questions and consider the questions on Page 2 of this form.

1. Are you considering discontinuing making premium payments, surrendering, forfeiting, assigning to the insurer, or otherwise terminating your existing policy or contract? ☐ Yes ☐ No
2. Are you considering using funds from your existing policies or contracts to pay premiums due on the new policy or contract? ☐ Yes ☐ No

If you answered "yes" to either of the above questions, list each existing policy or contract you are contemplating replacing (include the name of the insurer, the insured or annuitant, and the policy or contract number if available) and whether each policy or contract will be replaced or used as a source of financing:

INSURER NAME	CONTRACT OR POLICY #	INSURED OR ANNUITANT	REPLACED (R) OR FINANCING (F)
1.			
2.			
3.			

Make sure you know the facts. Contact your existing company or its agent for information about the old policy or contract. If you request one, an in force illustration, policy summary or available disclosure documents must be sent to you by the existing insurer. Ask for and retain all sales material used by the agent in the sales presentation. Be sure that you are making an informed decision.

The existing policy or contract is being replaced because _____

_____

_____.

I certify that the responses herein are, to the best of my knowledge, accurate:

_____ _____

Applicant's Signature Date Producer's Signature Date

_____ _____

Applicant's Printed Name Producer's Printed Name

I do not want this notice read aloud to me. _____ (Applicants must initial only if they do not want the notice read aloud.)

Signed Copies to Home Office, Agent, and Applicant

Illinois Mutual Life Insurance Company
300 S.W. Adams Street Peoria, IL 61634 Phone (800) 437-7355

A replacement may not be in your best interest, or your decision could be a good one. You should make a careful comparison of the costs and benefits of your existing policy or contract and the proposed policy or contract. One way to do this is to ask the company or agent that sold you your existing policy or contract to provide you with information concerning your existing policy or contract. This may include an illustration of how your existing policy or contract is working now and how it would perform in the future based on certain assumptions. Illustrations should not, however, be used as a sole basis to compare policies or contracts. You should discuss the following with your agent to determine whether replacement or financing your purchase makes sense:

PREMIUMS:

- Are they affordable?
- Could they change?
- You're older--are premiums higher for the proposed new policy?
- How long will you have to pay premiums on the new policy? On the old policy?

POLICY VALUES:

- New policies usually take longer to build cash values and to pay dividends.
- Acquisition costs for the old policy may have been paid; you will incur costs for the new one.
- What surrender charges do the policies have?
- What expense and sales charges will you pay on the new policy?
- Does the new policy provide more insurance coverage?

INSURABILITY:

- If your health has changed since you bought your old policy, the new one could cost you more, or you could be turned down.
- You may need a medical exam for a new policy.
- Claims on most new policies for up to the first two years can be denied based on inaccurate statements.
- Suicide limitations may begin anew on the new coverage.

IF YOU ARE KEEPING THE OLD POLICY AS WELL AS THE NEW POLICY:

- How are premiums for both policies being paid?
- How will the premiums on your existing policy be affected?
- Will a loan be deducted from death benefits?
- What values from the old policy are being used to pay premiums?

IF YOU ARE SURRENDERING AN ANNUITY OR INTEREST SENSITIVE LIFE PRODUCT:

- Will you pay surrender charges on your old contract?
- What are the interest rate guarantees for the new contract?
- Have you compared the contract charges or other policy expenses?

OTHER ISSUES TO CONSIDER FOR ALL TRANSACTIONS:

- What are the tax consequences of buying the new policy?
- Is this a tax free exchange? (See your tax advisor.)
- Is there a benefit from favorable "grandfathered" treatment of the old policy under the federal tax code?
- Will the existing insurer be willing to modify the old policy?
- How does the quality and financial stability of the new company compare with your existing company?

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ILLINOIS MUTUAL®
Life Insurance Company

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**

Illinois Mutual Life Insurance Company
300 S.W. Adams Street Peoria, IL 61634 Phone (800) 437-7355

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?	We collect your personal information, for example, when you: • apply for a product • make a claim • communicate • transact with us • apply to become an agent 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.
Who does Illinois Mutual share your personal information with?	• Agents • Reinsurers • Medical Professionals • Service Providers who are under contract to not further disclose your information
Why can't I limit all sharing?	Federal law gives you the right to limit only: • 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 State laws and individual companies may give you additional rights to limit sharing.
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.

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