Personal Paycheck Power℠

ESPECIALLY DESIGNED FOR:
Amit Fishler
8/19/2020

PRESENTED BY:
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Underwritten by:

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

Paycheck Power℠ Series Illustration

Designed for: Amit Fishler, Male, Age 34, Class 5 Upgrade, Non-Tobacco User

Your Paycheck is Worth Protecting

Your Current Annual Income: $54,985

Your Current Age: 34

Your Earning Potential To Age 67: $1,814,505*

*assumes no salary increases

Your Most Valuable Asset

You probably already insure valuable assets like your home and car. But do you have the protection you need to continue paying for these and other expenses, like your mortgage, utilities and groceries, if you should become sick or hurt and are unable to work?

Disability Income Insurance is designed to help you offset the loss of your income in the event of an injury or illness. Protecting your Income now could mean the difference between a secure future for you and your family and a devastating financial nightmare. This illustration shows how Illinois Mutual's Personal Paycheck Power℠ plan provides coverage to meet your needs.

"It won't happen to me."

Many 34-year-olds think "it won't happen to me". But, the reality is anyone can become disabled and unable to work. At age 34, your chance of suffering a long-term disability (90 days or longer) prior to age 65 is approximately 42%*.

Did you know?

A disabling injury happens every second, that's 25,700,000 disabling injuries per year.
(National Safety Council, Injury Facts, 2010 Edition)

Approximately 90% of disabilities are caused by illnesses rather than accidents.
(Council for Disability Awareness, May 2011)

Your Maximum Potential Base Benefit: $628,452

This demonstrates how your disability income insurance plan can close the financial gap in the event of a total disability.

$628,452 is the total potential benefit that could be reimbursed after satisfying your elimination period assuming all policy conditions are met and you remain totally disabled until 100% of the total potential benefit has been reimbursed.

What if I Don't Become Disabled?

When you add Illinois Mutual's optional Return of Premium Rider to your disability income insurance policy, at age 67, 100% of the premiums you paid will be returned to you, less any benefits you received**.

*Disability based on 1985 CIDA, 90-day elimination period class 5. Statistics vary by class. The 1985 CIDA is the most current morbidity table for individual disability claim incidents adopted by most State Departments of Insurance.

**Return of Premium Rider available for issue ages 18-55.

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Policy Information

	Amount	Modal Premium
Mode: Monthly		
Elimination Period: 90 Days		
Benefit Period: To Age 67		
Total Disability Monthly Benefit	$1,587	$30.53
Integrated Monthly Benefit Rider	$1,700	$22.37
	$3,287	**$52.90**

Base Policy Features

Partial Disability Monthly Benefit	$794	
Recurrent Disability		
Presumed Total Disability		
Total Loss of Sight & Double Dismemberment Benefit		
Retraining & Home Modification Benefit		
Organ Donor Benefit		
Survivor Benefit	$6,348	
Waiver of Premium Provision		
Suspension of Policy During Unemployment		

Options Selected

Future Purchase Option Rider (FPO)	$600	$1.16
Two Year Pure Own Occupation Rider		$2.29
Residual Disability Benefit Rider		$8.61
Cost of Living Adjustment Rider (COLA)		$12.54
Automatic Increase Benefit		No charge
Option Total		$24.60

Total Modal Premium

$77.50

Annual	$880.64
Semi-Annual	$453.53
Quarterly	$233.37

Business Owner Occupation Class Upgrade has been selected for this illustration. The rates shown for this occupation are one occupation class higher for the business owner. To be eligible for this better premium rating the business owner must have at least 20% ownership in the business and can demonstrate 2 consecutive years of financially successful business operation immediately preceding the application completion. The occupation class upgrade can be denied at the underwriter's discretion on above average risk cases.

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Base Policy Features

Thank you for considering Illinois Mutual for your disability income insurance needs. There is no better way to protect you and your family against the financial devastation an illness or injury could cause. To help you better understand how your Illinois Mutual disability income insurance policy can work for you, we have described its key features and options below. If you have questions about what these mean, please contact your agent or call our home office toll-free at (800) 437-7355.

Definition of Total Disability: Total Disability for any one period of disability starting while this policy is in force means:

1. During the first 24 months, your inability to perform the substantial and material duties of your occupation and you are not engaged in any occupation for wage or profit.
2. After 24 months, your inability to perform the substantial and material duties of any occupation for wage or profit in which you might be expected to be engaged, with due regard to your education, training, experience and you are not engaged in any occupation for wage or profit.

To be totally disabled, you must be under the Regular Care of a Physician. Only one total disability benefit will be payable at any one time even if you are totally disabled because of multiple causes. You cannot receive a Total Disability Monthly Benefit and a Partial Disability Monthly Benefit at the same time.

Renewability: This Policy is issued for the term for which premium is paid starting on the Date of Issue. You may renew it by paying the current premium rate for like policies written or renewed by us until the renewal date that follows your Renewal Age birthday. Then, we have the option of renewing the Policy annually at the current rates for your attained age. This Policy may not be renewed after the renewal date that follows your 75th birthday.

Total Disability Monthly Benefit: ($1,587) If injury or sickness in and of itself causes your total disability, we will pay you the Total Disability Monthly Benefit shown in the Schedule. This Benefit shall be paid to you after the Elimination Period shown in the Schedule has been satisfied. This Benefit shall be paid to you for as long as you are totally disabled up to the Maximum Total Disability Benefit Period shown in the Schedule for any one period of total disability. If we renew this Policy after your Renewal Age birthday and you become totally disabled on or after the first renewal date following your Renewal Age birthday, we will pay you this Benefit. However, the Benefit will be payable for up to 24 months or for up to the Maximum Total Disability Benefit Period, whichever is less.

Partial Disability Monthly Benefit: Partial Disability for any one period of disability starting while this Policy is in force means: (1) your inability to perform one or more of the substantial and material duties of your occupation; or (2) the necessary loss of one-half or more of the time spent by you in the usual daily performance of the duties of your occupation. To be partially disabled, you must be under the Regular Care of a Physician. Only one partial disability benefit will be paid at any one time even if you are partially disabled because of multiple causes. You cannot receive a Partial Disability Monthly Benefit and a Total Disability Monthly Benefit at the same time.

Recurrent Disability: A recurrence of your disability from the same or related causes will be considered a continuation of the prior period unless you have been engaged in any gainful occupation for more than 6 continuous months. You must be reasonably fitted and have been performing all of the substantial and material duties of that occupation. If your disability is treated as a recurrent disability of the prior period, it will not be subject to a new Elimination Period or a new Maximum Total or Partial Disability Benefit Period.

Presumed Total Disability: You will be deemed to be totally disabled if, while this Policy is in force, injury or sickness shall result in the total and irrecoverable loss of: (1) sight in both eyes; or (2) hearing of both ears; or (3) speech; or (4) use of both hands; or (5) use of both feet; or (6) use of a hand and a foot. As long as such loss continues during your life you will be considered totally disabled up to the Maximum Total Disability Benefit Period. Such total disability will be presumed regardless of your ability to work and regardless of your being under the Regular Care of a Physician. Your presumed total disability will start on the day of such loss. The Elimination Period will apply.

Base Policy Features – continued on next page.

Base Policy Features - Continued

Total Loss of Sight and Double Dismemberment Monthly Benefit: If, while this Policy is in force, injury or sickness shall result in your total and irrecoverable loss of: (1) sight in both eyes; or (2) both hands by complete severance through or above the wrist; or (3) both feet by complete severance through or above the ankle joints; or (4) a hand and a foot by complete severance through or above the wrist and the ankle joint. We will pay you the Total Loss of Sight and Double Dismemberment Monthly Benefit shown. This Benefit starts with the day of such loss. We will pay this Benefit to you as long as such loss continues during your life, up to 24 months for any such loss or the Maximum Total Disability Benefit Period, whichever is less. This Benefit will be paid in addition to any other benefits in the Policy.

Retraining and Home Modification Benefit: If benefits have been paid to you under this Policy for 6 months of continuous total disability and if your total disability continues past the 6th month, we will pay you for: (1) your actual costs of tuition, books and equipment that are required for a formal retraining program. Such a program must be at a licensed college, vocational or business school. (2) your actual costs to modify your home to accommodate your disabling condition. You must be totally disabled and be receiving total disability benefits under this Policy when you start a retraining program or make modifications to your home. The total amount we will pay for such costs shall not exceed 6 times the Total Disability Monthly Benefit. This Benefit will not be paid unless the Maximum Total Disability Benefit Period is 12 months or more.

Organ Donor Benefit: After this Policy has been in force 6 months or more, if you become totally disabled as a result of giving one of your organs for use as a transplant, including bone marrow donations, benefits will be payable as for any other total disability. The Elimination Period will not apply to the payment of this Benefit.

Survivor Benefit: If you die during a current period of total disability and have been receiving a Total Disability Monthly Benefit for 6 continuous months, we will pay 4 times the amount of the Total Disability Monthly Benefit to your spouse, if living, otherwise to your estate.

Waiver of Premium: If injury or sickness causes your total disability for 90 continuous days, we will waive the payment of any premiums which become due. We will refund any premiums which you paid during such 90-day period and which became due after your total disability started. This Policy will stay in force at the end of a period of total disability until the next premium due date. We will then notify you when the next premium payment is due. You have the right to resume payment of premiums for this Policy at that time.

Suspension of Policy during Unemployment: After this Policy has been in force for at least one year, you may temporarily suspend this Policy if you become unemployed and have received 8 weeks of government unemployment benefits. The suspension will begin when we receive your written request to suspend this Policy and you certify that you are unemployed and that you have received 8 weeks of government unemployment benefits. This Policy will not be in force while it is suspended and we will not accept premiums for the period of suspension. No benefits or options under this Policy or any attached riders may be exercised during the period of suspension. We will refund the pro rata portion of any premiums paid for a period beyond the date that the suspension begins. Premiums must be paid to the date of suspension. After the end of a period of suspension, this Policy may not be suspended again until 24 months have elapsed from the end of the period of suspension.

Designed for: Amit Fishler, Male, Age 34, Class 5 Upgrade, Non-Tobacco User

Options

Two Year Pure Own Occupation Rider
This Rider changes the definition of Total Disability to be defined as during the first 24 months, your inability to perform the substantial and material duties of your occupation. After 24 months, your inability to perform the substantial and material duties of any occupation for wage or profit in which you might be expected to be engaged, with due regard to your education, training, experience and you are not engaged in any occupation for wage or profit.

Integrated Monthly Benefit Rider
This Rider provides a monthly benefit that is paid in addition to the Total Disability Monthly Benefit after the Elimination Period has been satisfied. The amount of this Benefit will be reduced by any benefits you receive from:

1. Federal Social Security Act (primary or family benefits) and Social Security retirement benefits.
2. Worker's Compensation Act or Law or Occupational Disease Law.
3. The Railroad Retirement Act (primary or family benefits) and retirement benefits.
4. Federal, State, County, Municipal or other government subdivision retirement and disability fund.

This Benefit will continue to be paid for as long as your total disability continues, but not beyond the Maximum Total Disability Benefit Period.

Future Purchase Option Rider
This Rider affords you 5 options to buy more coverage prior to your 55th birthday. Your health status will not be considered. You may choose to exercise your options at any time after 24 months from the Date of Issue. But, each such purchase must be at least 24 months apart. In the event of a life change, which is defined as a marriage, death of a spouse, divorce or birth or adoption of a child, you may accelerate a purchase but the next purchase will follow upon the normal 24 month sequence. Each purchase is subject to earnings qualifications, our issue and participation limits and any impairment rating or exclusion of coverage that had been applied to the Policy and is still in effect at the time of such purchase. Each purchase may be for no more than the purchase amount selected.

Cost of Living Adjustment Rider
This Rider provides that an increase in Total Disability Monthly Benefit will start on the second year of your continuous total disability. The Adjusted Total Disability Monthly Benefit (after COLA) can be increased each year up to 6% compounded annually, based upon the Consumer Price Index for All Urban Consumers, until the date the Maximum Total Disability benefit is reached, your Renewal Age (usually age 67), or the date your total disability ends, whichever occurs first. Please Note: your total disability must be continuous. The Adjusted Benefit provided by this Rider will not be paid if you are working for pay. If your COLA can no longer be adjusted because your total disability has ended or you have reached your Maximum Total Disability benefit, you will no longer receive the COLA benefit for any subsequent periods of disability. If your COLA can no longer be adjusted because you have reached the Renewal Age, you may receive a limited COLA adjustment for a later period of disability, if any.

Residual Disability Benefit Rider
This Rider provides a monthly benefit if you return to your regular job and suffer a loss of 20% or more of your prior monthly income. We will pay the Residual Disability Monthly Benefit during your residual disability as follows: (1) The Residual Disability Monthly Benefit starts after the Elimination Period is satisfied as shown. The Elimination Period can be satisfied by any continuous period of total and/or residual disability. (2) Benefits are not payable for any period when a Total Disability Monthly Benefit is payable. (3) Benefits are payable until the earliest of the following: (a) the date your residual disability ends; (b) the date the Maximum Total Disability Benefit Period, as shown in the Schedule, has been reached; or (c) the date of your Renewal Age birthday. But, if you are age 55 or older when a period of residual disability starts and it is not preceded by at least 180 days of total disability due to the same or related cause, the Residual Disability Monthly Benefit is payable for no longer than 24 months or to Renewal Age, if earlier. (4) For each of the first 6 months of residual disability your benefit will be the greater of: (a) 50% of the Total Disability Monthly Benefit; or (b) the Residual Disability Monthly Benefit.

Options – continued on next page.

Options - Continued

Automatic Increase Benefit Rider

Your Total Disability Monthly Benefit will increase automatically on the first premium due date on or after each of the first five policy anniversaries. The amount of the increase will be 3% times the Total Disability Monthly Benefit at policy issue. Increases will not be offered on any policy anniversary on which you are disabled or your amount of total coverage would exceed our issue and participation limits. You may decline to accept an increase, but if you decline, you forfeit your right to further increases. There are no premiums charged for this Rider, however when an automatic benefit increase takes place, the Policy premium will increase in accordance with the increase in benefits. The additional benefit premium will be based upon your classification at policy issue and your attained age at the time of the increase. This rider ends on the earliest of these occurrences: your 56th birthday, you refuse an automatic increase, you decrease your Total Monthly Disability benefit amount, the Policy or this rider ends, or the date of your final increase.

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Premium Alternatives

	Benefit Periods					
	6 mos.	1 Year	2 Year	5 Year	10 Year	To Age 67
30-Day Elimination Period						
Base Policy	$20.56	$23.09	$26.55	$38.99	$48.11	$53.63
Integrated Monthly Benefit Rider (IBR)	$0.00	$0.00	$22.71	$29.85	$36.80	$44.69
Future Purchase Option Rider (FPO)	$0.78	$0.87	$1.00	$1.47	$1.82	$2.03
Two Year Pure Own Occupation Rider	$1.64	$1.85	$3.94	$3.56	$3.64	$3.88
Residual Disability Benefit Rider	$0.00	$0.00	$5.31	$8.28	$10.84	$13.23
Cost of Living Adjustment Rider (COLA)	$0.00	$0.00	$0.00	$2.40	$6.09	$12.54
60-Day Elimination Period						
Base Policy	$15.81	$17.76	$20.40	$29.73	$37.69	$41.69
Integrated Monthly Benefit Rider (IBR)	$0.00	$0.00	$17.01	$22.31	$28.29	$33.45
Future Purchase Option Rider (FPO)	$0.60	$0.67	$0.77	$1.12	$1.43	$1.58
Two Year Pure Own Occupation Rider	$1.26	$1.42	$2.99	$2.72	$2.88	$3.07
Residual Disability Benefit Rider	$0.00	$0.00	$4.08	$6.43	$8.76	$10.85
Cost of Living Adjustment Rider (COLA)	$0.00	$0.00	$0.00	$2.40	$6.09	$12.54
90-Day Elimination Period						
Base Policy	$13.42	$15.08	$17.35	$21.80	$28.38	**$30.53**
Integrated Monthly Benefit Rider (IBR)	$0.00	$0.00	$13.69	$15.68	$20.30	**$22.37**
Future Purchase Option Rider (FPO)	$0.51	$0.57	$0.65	$0.82	$1.07	**$1.16**
Two Year Pure Own Occupation Rider	$1.07	$1.21	$2.48	$1.99	$2.19	**$2.29**
Residual Disability Benefit Rider	$0.00	$0.00	$3.47	$4.84	$6.89	**$8.61**
Cost of Living Adjustment Rider (COLA)	$0.00	$0.00	$0.00	$2.40	$6.09	**$12.54**
180-Day Elimination Period						
Base Policy	$0.00	$11.95	$13.73	$18.80	$24.87	$27.08
Integrated Monthly Benefit Rider (IBR)	$0.00	$0.00	$10.82	$13.48	$17.80	$19.81
Future Purchase Option Rider (FPO)	$0.00	$0.45	$0.52	$0.71	$0.94	$1.02
Two Year Pure Own Occupation Rider	$0.00	$0.96	$1.96	$1.73	$1.95	$2.08
Residual Disability Benefit Rider	$0.00	$0.00	$2.75	$4.24	$6.19	$7.92
Cost of Living Adjustment Rider (COLA)	$0.00	$0.00	$0.00	$2.40	$6.09	$12.54

Certain elimination and benefit period combinations may cause the Monthly Total Disability Benefit, options and riders to vary from the quoted plan design.

Exceptions and Reductions

A. We will not pay benefits for disability that results (a) from normal pregnancy or childbirth; (b) from intentionally self-inflicted injury or sickness; (c) from your commission or attempted commission of a felony; (d) from war, declared or not; (e) from any military service, except during active duty for training of less than 60 days. The pro rata premium will be refunded for a period during which you are not covered for such military reason; or (f) we will not pay benefits while you are incarcerated in any penal or correctional institution.

B. Total Disability benefits caused or contributed to by a mental or nervous disorder or alcohol or drug abuse will be limited to a cumulative lifetime maximum of 24 months. This limitation will not apply to any period during which you are confined to a Hospital for one of these conditions. If the Optional Full Benefits for Mental or Nervous Disorders, Alcoholism or Drug Abuse is purchased this limitation will not apply.

C. If you become Totally Disabled due to an injury or sickness sustained or continued while you are outside of the United States, Canada or Mexico your Total Disability Benefit Period will be limited to 90 days. After the 90 day period, benefits will not be paid until you return to the United States, Canada or Mexico. The Maximum Total Disability Period will be reduced by the benefits paid while you were out of the country.

D. During the first 2 years after the Date of Issue, this Policy will not pay benefits for any condition diagnosed or treated by a physician within 2 years prior to the Date of Issue. However, if you fully disclose such condition in the application for this Policy, benefits will be payable unless a Rider excludes such condition by name.

This is only a summary of premiums, benefits and limitations. Premiums and benefits are not guaranteed. This is NOT a contract and only the contract provisions in the policy, if one is issued, will control. Any coverage issued is subject to the terms and conditions of the policy. All policy applications are subject to Illinois Mutual's underwriting requirements and guidelines. A medical exam may be required. Not all riders and policy benefits are available in all states. The addition of optional policy riders may increase premiums.

Paycheck Power℠ Series Illustration

Designed for: Amit Fishler, Male, Age 34, Class 5 Upgrade, Non-Tobacco User

Underwriting Requirements

To expedite the underwriting process, please submit an illustration of the desired plan design with the application.

Medical Requirements

- Abrv. Paramed, Blood Profile, Urinalysis
- Regular benefit period limitations selected.
- The medical requirements shown are for the benefits illustrated. If multiple Illinois Mutual policies are applied for, the medical requirements must be based on the combined monthly benefits.

Financial Requirements

- If the monthly benefit is more than $5,000 a copy of your federal income tax return or other proof of income must be submitted.
- For all self-employed individuals with a monthly benefit over $3,000, the past 2 years federal income tax returns with supporting forms and schedules are required.

Application Process

Choose the application option according to your preference from the following:
1. Web based application (WebApp)
2. Fillable PDF application
3. Paper application

Each application includes the following:
- Part A - Demographics, Plan Information and Details
- Part B - Employment, General and Medical Information
- Part C - Signature and Legal Forms

Traditional Application/Telephone Interview
Agent completes **Parts A, B and C**
- A customer service representative may contact you to confirm or clarify application information.
- See *Your Guide to the Underwriting Process* (Form C7012)

Teleunderwriting Application/Telephone Interview
- Agent completes **Parts A and C**
- A customer service representative will complete **Part B** with you by phone.
- See *Teleunderwriting: What to Expect Next-Consumer Guide* (Form C7018)

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Personal Paycheck Power℠ Waiver of Coverage

I have been advised of the potential loss of earned income that I may suffer in the event of total disability. It has been recommended that I purchase disability income insurance from Illinois Mutual.

After careful consideration and a clear understanding of the basic and optional benefits recommended, I elect not to apply for any disability income insurance coverage at this time.

I understand the coverage that may be available to me today, may not be available in the future due to changes in my health, age, occupation or earned income.

I understand that this is not an application for insurance.

_____

Signature

_____

Date

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

Application for Disability Insurance

PART A

1. Proposed Insured

a. Name Fishler (LAST) | Amit (FIRST) | (MI) | (MAIDEN/FORMER) | Married (MARITAL STATUS) | M (GENDER)

b. Address 9621 Triton Ct (STREET) | Boca Raton (CITY) | FL (STATE) | 33434 (ZIP CODE)

c. Primary Ph. 561-526-6027 Other Ph. ——— E-mail maayand320@gmail.com

d. Social Security Number 653-62-2845 e. Driver's License Number & State F246000860650, FL

f. Date of Birth 2/25/1986 g. Place of Birth (State/Country) Israel

h. Are you a U.S. Citizen? ☑ Yes ☐ No

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

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

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

j. Occupation and duties: Business owner ; Locksmith, Locksmith 50% Sliding Door 50%, Performing trade/service/manual labor: 100%

2. Individual Disability Plan Information

Base Monthly Benefit Amount $ 1,587

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

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

Required Benefit Riders

You must elect one of the following options to meet state requirements:

☑ 2 Year Pure Own Occupation Period ☐ 5 Year Pure Own Occupation Period + one of the following:

Extended Own Occupation Period ☐ 5 Year ☐ To Age 67

Optional Benefits

☐ Activities of Daily Living (ADL) Monthly Amount $——— ☐ 2 Year ☐ 5 Year ☐ To Age 67

☑ Cost of Living Adjustment (COLA)

☑ Guaranteed Insurability Option (GIO) ☐ $100 ☐ $200 ☐ $300 ☐ $400 ☐ $500 ☑ $600

☑ Integrated Monthly Benefit Amount $ 1,700

☐ Mental/Nervous Benefit

☐ Non-Cancelable

☑ Residual Disability Benefit

☐ Retroactive Injury Benefit

☐ Return of Premium Beneficiary——— Relationship——— SSN/Tax ID#———

3. Business Expense Plan Information

Base Monthly Benefit Amount $———

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

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

Required Benefit Riders

You must elect one of the following options to meet state requirements:

☐ 2 Year Pure Own Occupation Period

Optional Benefit Riders

☐ Guaranteed Insurability Option (GIO) ☐ $100 ☐ $200 ☐ $300 ☐ $400 ☐ $500 ☐ $600

☐ Mental/Nervous Benefit

☐ Retroactive Injury Benefit

☐ Return of Premium Beneficiary——— Relationship——— SSN/Tax ID#———

Business Expense Details

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

Total Average Monthly Expenses $ ———

4. Accident Plan Information (Only available when applying for Individual Disability coverage)
Plan Levels: ☐ Economy ☐ Standard ☐ Preferred ☐ Premium
Coverage: ☐ Individual ☐ Individual/Spouse ☐ One-Parent Family ☐ Two-Parent Family
Beneficiary _____ Relationship _____ SSN/Tax ID# _____
Optional Benefit Riders
☐ Catastrophic Accident
☐ Wellness Benefit Benefit Amount: $ _____

The following notice is applicable if applying for the Wellness Benefit Rider

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

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

	Current YTD Income	Income Last Year	Income 2 Years Ago
(1) Owner or Non-owner Employee's salary and bonus (Form W-2)	$	$	$
(2) Sole Proprietor (Form 1040, Sch. C)	$	$	$
(3) S-Corp. (Form 1120S, Sch. K-1 or Form 1040, Sch. E)	$	$	$
(4) C-Corp. (Form 1120)	$	$	$
(5) Partnership or LLC (Form 1065, Sch. K-1 or Form 1040, Sch. E)	$ 38,000	$ 54,985	$ 50,107
(6) Total Earned Income: Sum of a(1) thru a(5) for each year	$ **38,000**	$ **54,985**	$ **50,107**

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

6. Other Disability Insurance
Do you have, are you applying for, or will you become eligible for, any disability insurance plan or benefit? ☐ Yes ☑ No
If yes, list below all: (1) Individual Disability, (2) Group Disability, (3) Sick Leave or Salary Continuation, (4) Disability Retirement/Pension, (5) Business Overhead Expense, or (6) Any other coverage which provides disability benefits.

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

7. Owner (If other than the Proposed Insured)
a. Name _____
b. Address _____ (STREET) _____ (CITY) _____ (STATE) _____ (ZIP CODE)
c. E-mail _____ d. Social Security or Tax ID Number _____

8. Billing and Payment

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

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

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

d. Premium Amount Quoted: $ 77.50 e. Occupation Class Quoted: Class 3

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

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

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

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

Application for Insurance

Proposed Insured Amit Fishler **D.O.B.** 2/25/1986

PART B (All references to "you" mean the Proposed Insured.)

1. Employment Information (For DI, complete questions 1a thru 1l. For Life, complete questions 1a thru 1c.)

a. Primary Occupation: Business owner ; Locksmith
b. Years of experience: 4
c. Employer's name: Fishler Locksmith, 9621 Triton Court, Boca Raton, FL, 33434
d. Date employed with current employer: 2017
e. No. of employees: 1
f. Describe exact duties of occupation and percentage of time spent in each.
Locksmith 50% Sliding Door 50%; Performing trade/service/manual labor : 100%
g. How many hours are you currently working per week in your primary occupation?
50
h. Are you self-employed or an owner of a corporation or partnership? ☑ Yes ☐ No
If yes, indicate percentage of ownership and type of business entity.
Limited Liability Corporation (LLC) : 100%
i. Do you work from your home? ☐ Yes ☑ No If yes, specify number of hours per week.
j. Do you intend to change occupation, employer or employment status in the next 6 months? ☐ Yes ☑ No
If yes, provide details.
k. Do you have other employment currently, full or part-time? ☐ Yes ☑ No
If yes, specify number of hours per week, dates employed and occupational duties performed.
l. Did you have other employment within the past 5 years, full or part-time? ☐ Yes ☑ No
If yes, specify number of hours per week, dates employed and occupational duties performed.

2. General Information

a. What is your current: (1) Height: 5 feet 11 inches (2) Weight: 154 pounds
b. Have you lost more than 10 pounds in the past 12 months? ☐ Yes ☑ No
If yes, specify number of pounds lost and reason.
c. In the past 10 years, have you consumed alcoholic beverages? ☐ Yes ☑ No If yes, specify type, amount and frequency, and date of last use.
d. In the past 10 years, have you used heroin, cocaine, marijuana, barbiturates or any other controlled substance not prescribed by a physician? ☐ Yes ☑ No If yes, specify type, frequency and date of last use.
e. Have you ever been advised to limit or discontinue the use of alcohol or drugs, or received counseling or treatment recommended by a licensed physician or licensed medical professional because of alcohol or drug use? ☐ Yes ☑ No If yes, provide dates and details.
f. In the past 10 years, have you been convicted of a felony? ☐ Yes ☑ No If yes, provide dates and details.
g. In the past 5 years, have you been charged with driving while intoxicated, had more than 3 moving violations, or had your driver's license suspended or revoked? ☐ Yes ☑ No If yes, provide dates and details.
h. Do you engage in piloting personal aircraft, mountain or rock climbing, motor-powered racing, scuba or sky diving, or hang gliding? ☐ Yes ☑ No If yes, provide details.
i. In the past 5 years, have you had any insurance application modified or declined? ☐ Yes ☑ No
If yes, provide details.

j. In the past 5 years, have you requested or received any disability benefits? ☐ Yes ☑ No If yes, provide details.

_____

Proposed Insured Amit Fishler **D.O.B.** 2/25/1986

PART B(continued)

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

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

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

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

Proposed Insured Amit Fishler **D.O.B.** 2/25/1986

PART B(continued)

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

c. Do you have a primary physician? ☐ None

(1) Paul Murry

NAME ADDRESS PHONE NUMBER

(2) Date last seen, reason and details. New PCP has not seen yet

	Yes	No
d. Are you currently pregnant, to the best of your knowledge and belief? (If yes, due date ___ / ___ / _____)	☐	☑
e . In the past 10 years, have you had a miscarriage, Cesarean section or other complications of pregnancy as diagnosed or treated by a licensed member of the medical profession?	☐	☑
f. In the past 10 years, have you tested positive for exposure to the HIV infection or been diagnosed, by a physician, as having ARC or AIDS caused by the HIV infection or other sickness or condition derived from such infection?	☐	☑
g. To the best of your knowledge and belief, have you had any natural parent or sibling who was diagnosed with cancer, heart disease, stroke, high blood pressure, diabetes or Huntington's disease prior to the age of 60? (If yes, provide relationship, condition, age diagnosed, current age or age at death.)	☐	☑
h. In the past 5 years, other than previously stated, have you:		
(1) had any medical advice, diagnosis or treatment by a licensed physician or licensed medical professional, diagnostic test, hospitalization, physical exam?	☐	☑
(2) Been referred for or advised by a licensed member of the medical profession to undergo treatment, diagnostic test, hospitalization or surgery that was not completed?	☐	☑
(3) Consulted any other doctor, chiropractor, psychiatrist, psychologist, counselor, therapist or other healthcare provider?	☐	☑
i. Other than previously stated, are you currently:		
(1) Receiving any medical advice, diagnosis or treatment by a licensed physician or licensed medical professional?	☐	☑
(2) Taking any medication?	☐	☑

j. Using the list below, provide full details to all "Yes" answers for 3d. thru 3i , excluding treatment information related to HIV/AIDS.

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

PART C

Home Office Endorsement Only. Question No. _____ corrected to read as follows:

Agreement and Declaration

I represent and agree that all statements and information found in the application are deemed representations and not warranties. I further represent and agree that all statements and answers recorded in this application are true, complete and correctly recorded to the best of my knowledge and belief. I understand that this application and any medical examination which may be required will become a part of any policy issued. I understand that acceptance of any policy issued on this application indicates my agreement to any amendments made by the Company in the "Home Office Endorsement Only" space except changes in the amounts of insurance or premium, classification of risk, and plan of insurance shall require my written acceptance. I understand and agree that no policy issued on this application shall become effective until I have received and accepted it and the first full premium paid. However, if a Receipt has been delivered, then liability of the Company shall be as stated in the Receipt. I have received a MIB Notice, Fair Credit Reporting Act Notice and an Outline of Coverage if applying for disability insurance or critical illness insurance.

I declare that I paid to Illinois Mutual Life Insurance Company the sum of $ 0.00 and that I hold a Receipt for same. I agree to the terms of such Receipt.

Authorization: I hereby authorize any licensed physician, medical practitioner, hospital, clinic, or other medical or medically related facility, pharmacy benefit manager, insurance company, MIB, Inc. or other organization, institution or person, that has any records or knowledge of me or my health, to give to Illinois Mutual Life Insurance Company, or its reinsurers, any such information. I authorize Illinois Mutual Life Insurance Company, or its reinsurers, to make a brief report of my personal health information to MIB.

I have read this Authorization and understand that I may receive a copy upon request. I understand and agree that this Authorization shall be valid for 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.

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 Amit Fishler

NOTICE: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

When completed electronically, I verify that the unique identifier used to sign this application is mine and that by clicking the "Submit" button, I am signing the application electronically.

Signed at Boca Raton, FL
CITY & STATE

Date 08/19/2020 09:51:08 CST

Amit Fishler
SIGNATURE OF PROPOSED INSURED
(OR PARENT IF PROPOSED INSURED UNDER AGE 18)

SIGNATURE OF OWNER/APPLICANT, IF OTHER THAN PROPOSED INSURED
(If business insurance, show title of person signing for insurance.)

SIGNATURE OF PROPOSED RIDER INSURED

Agent's Certification: An Outline of Coverage was given to the Proposed Insured for disability insurance. I, ☐ do ☑ do not, have knowledge that the insurance applied for will replace any existing disability insurance and/or life insurance.

Joseph Corozza	w113685	Joseph Corozza 08/19/2020 09:46:03 CST
PRINT WRITING AGENT NAME	FLORIDA LICENSE #	WRITING AGENT'S SIGNATURE

Agent's Code # 75962 Agent's Phone # 561-241-3121

Agent's NPN # 16793833 Agent's E-mail jcorozza@seemanholtz.com

Is Proposed Insured/Owner related to Agent? ☐ Yes ☑ No Relationship

Does the Proposed Insured prefer to receive future correspondence in Spanish? ☐ Yes ☑ No

Split Commission Information

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

Name	Joseph Corozza	Code #	75962	% of Commission	100
Name		Code #		% of Commission	

Examination Requirements

☐ Non-Medical ☑ Abbreviated Paramedical Exam (Urinalysis required.)
☐ Full Paramedical Exam (Urinalysis required.)
☑ Blood Profile (Informed Consent must be signed.) ☐ EKG
☐ Agent will schedule. ☐ Exam completed on _____ ☑ Home Office will schedule.

ILLINOIS MUTUAL®
Life Insurance Company
300 S.W. Adams Street Peoria, IL 61634
Phone 309.674.8255

GLB Authorization

I hereby authorize the application, as completed, to be electronically transmitted to the Policyowner(s) for signature and review. I acknowledge that (i) I may revoke this authorization at any time in writing and that such a revocation will have no effect on any actions taken by the Company prior to receipt of the revocation and (ii) any information disclosed pursuant to this authorization may be re-disclosed and may no longer be protected by the state or federal privacy laws.

Amit Fishler 08/19/2020 09:51:08 CST

Signature of Proposed Insured
(or Parent/Legal Guardian if Proposed Insured is Under 18)

3196 (3/19)

ILLINOIS MUTUAL®
Life Insurance Company
300 S.W. Adams Street Peoria, IL 61634
Phone 309.674.8255

Consent to Electronic Delivery

By selecting the "By clicking this checkbox, I am electronically signing this document" checkbox, you are consenting to the electronic delivery of all the required notices. You have the right to withdraw your consent at any time. If you wish to withdraw your consent or to request a paper version of an electronic communication, contact us at 1-800-437-7355. In order to receive electronically delivered documents you must have an active email account and access to the internet. Immediately notify us of any change in your email address. You represent that you have the equipment and access to receive documents electronically.

Amit Fishler

Signature of Proposed Insured
(or Parent/Legal Guardian if Proposed Insured is Under 18)

3197 (3/19)

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

HIPAA COMPLIANT
HEALTH INFORMATION AUTHORIZATION

I hereby authorize any physician, medical practitioner, hospital, clinic, pharmacy or pharmacy benefit manager, or other medical or medically related facility, MIB, Inc. or insurance company that possesses health information, including prescription history and medications prescribed about me, to furnish all such health information to Illinois Mutual Life Insurance Company, hereinafter called the Company. Health information includes any medical treatment records which includes treatment for drug abuse, alcoholism, AIDS or mental illness but specifically excludes psychotherapy notes. Illinois Mutual Life Insurance Company may specify the name of the practitioner or facility below.

The Company may obtain health information about me in order to evaluate my application for insurance or my eligibility for benefits under an existing policy. Health information obtained by this Authorization will not be re-disclosed by the Company without my authorization except to reinsurers who may be involved with my application for insurance or otherwise permitted or required by law in which case it may not be protected under federal privacy rules. This Authorization is required for the underwriting of an insurance policy and failure to provide a signed Authorization may result in a decline of the coverage applied for.

I acknowledge that I have read this Authorization and I will receive a copy of it. I understand and agree that this Authorization shall be valid for two years from the date of signature below. I may revoke this Authorization by sending written notice to Privacy Officer, Illinois Mutual Life Insurance Company, 300 SW Adams St., Peoria, IL 61634. Action taken in reliance of this Authorization will not be affected until written notice of revocation is received by the Company. A photographic copy of this authorization shall be as valid as the original.

08/19/2020 09:51:08 CST
Date

Amit Fishler
Signature of Proposed Insured or Parent if Proposed Insured under 18

Amit Fishler
Print Name of Proposed Insured

February 25,1986
Date of Birth

653-62-2845
Social Security Number

Application Number, if known

Home Office Use Only:

Practitioner or Facility

NOTE TO MEDICAL PROVIDERS: This Authorization is designed to comply with the requirements of the Health Insurance Portability and Accountability Act of 1996 also known as HIPAA.

Return original to Home Office, leave a copy with Proposed Insured

ILLINOIS MUTUAL®
Life Insurance Company
300 S.W. Adams Street Peoria, IL 61634
Phone 309.674.8255

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: Amit Fishler
Name of Policyowner (if different): _____
Premium Mode: ☑ Monthly ☐ Quarterly ☐ Semi-Annual ☐ Annual

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

Initial Premium (all premium modes)

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

☑ Deduct initial premium when the policy has been issued.

Subsequent Premiums (monthly premium mode only)
Indicate premium withdrawal day: 1 (Choose a day between 1 and 28.)

POLICIES

Type Disability Income Insurance 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: Amit Fishler
Address of Account Holder: 9621 Triton Ct Boca Raton FL 33434
City State ZIP

☐ Checking Account ☐ Savings Account
Name of Financial Institution: _____
Routing Number: _____ (The 9-digit number at the bottom of your check)
Account Number: _____ Reenter Account Number: _____

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

AUTHORIZATION

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

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

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

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

Amit Fishler
Name of Account Holder

Amit Fishler
Signature of Account Holder

08/19/2020 09:51:08 CST
Date

Name of Joint Account Holder

Signature of Joint Account Holder

Date

DISCLOSURE

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

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

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

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

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

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

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

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

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

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

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

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

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

Contact info:

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

ILLINOIS MUTUAL®
Life Insurance Company
300 S.W. Adams Street Peoria, IL 61634
Phone 309.674.8255

LEAVE THIS PAGE WITH THE APPLICANT

Medical Information Bureau (MIB, Inc.) Notice
Information regarding your insurability will be treated as confidential. Illinois Mutual Life Insurance Company or its reinsurers may, however, make a brief report thereon to the MIB, Inc., formerly known as Medical Information Bureau, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information about you in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at 866.692.6901 (TTY 866.346.3642). If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.

Illinois Mutual Life Insurance Company, or its reinsurers, may also release information in its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.
Form 2826 (1/10)

HIPAA COMPLIANT HEALTH INFORMATION AUTHORIZATION (Proposed Insured's copy)
I hereby authorize any physician, medical practitioner, hospital, clinic, pharmacy or pharmacy benefit manager, or other medical or medically related facility, MIB, Inc. or insurance company that possesses health information, including prescription history and medications prescribed about me, to furnish all such health information to Illinois Mutual Life Insurance Company, hereinafter called the Company. Health information includes any medical treatment records which includes treatment for drug abuse, alcoholism, AIDS or mental illness but specifically excludes psychotherapy notes. Illinois Mutual Life Insurance Company may specify the name of the practitioner or facility below.

The Company may obtain health information about me in order to evaluate my application for insurance or my eligibility for benefits under an existing policy. Health information obtained by this Authorization will not be re-disclosed by the Company without my authorization except to reinsurers who may be involved with my application for insurance or otherwise permitted or required by law in which case it may not be protected under federal privacy rules. This Authorization is required for the underwriting of an insurance policy and failure to provide a signed Authorization may result in a decline of the coverage applied for.

I acknowledge that I have read this Authorization and I will receive a copy of it. I understand and agree that this Authorization shall be valid for two years from the date of signature below. I may revoke this Authorization by sending written notice to Privacy Officer, Illinois Mutual Life Insurance Company, 300 SW Adams St., Peoria, IL 61634. Action taken in reliance of this Authorization will not be affected until written notice of revocation is received by the Company.
Form 9209 (6/12)

FAIR CREDIT REPORTING ACT NOTICE
The Fair Credit Reporting Act requires that Illinois Mutual Life Insurance Company, 300 S.W. Adams Street, Peoria, Illinois 61634, notify you that, as a regular part of processing your Application for Insurance, investigative consumer reports may be obtained which will include information as to your character, general reputation, personal characteristics, mode of living, health, medical treatment, motor vehicle records, and other applicable information. Such information for said reports will be obtained through personal interviews with your family members, friends, associates, neighbors, financial sources and others. Upon written request to the Home Office, further information will be provided as to how you may obtain a complete and accurate disclosure of the nature and scope of such investigative consumer reports.
Form 2825 (3/13)

ILLINOIS MUTUAL®
Life Insurance Company
300 S.W. Adams Street Peoria, IL 61634
Phone 309.674.8255

NOTICE AND CONSENT FOR AIDS-RELATED BLOOD TESTING

To evaluate your insurability, the Insurer named above has requested that you provide a sample of your blood for testing and analysis to determine the presence of human immunodeficiency virus (HIV) antibodies. By signing and dating this form you agree that this test may be done and that underwriting decisions will be based on the test result.

TESTING

The tests must be performed by a laboratory certified by the United States Department of Health and Human Services under the Clinical Laboratory Improvement Act of 1967, permitting testing of specimens obtained in interstate commerce, of American Pathologists, the American Association of Bio Analysis, or an equivalent program approved by the Centers for Disease Control of the United States Department of Health and Human Services.

MEANING OF POSITIVE TEST RESULTS

The test is not a test for AIDS. It is a test for antibodies to the HIV virus, the causative agent for AIDS, and shows whether you have been exposed to the virus. A positive test result does not mean that you have AIDS but that you are at significantly increased risk of developing problems with your immune system. The test for HIV antibodies is very sensitive. Errors are rare, but they do occur. Your private physician, a public health clinic, or an AIDS information organization in your city might provide you with further information on the medical implications of a positive test.

Positive HIV antibody test results 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.

NOTIFICATION OF TEST RESULTS

If your test results are negative, no routine notification will be sent to you. If your test results are reported by the laboratory to the Insurer as being positive, a trained person should deliver that information so that you can understand clearly what the test result means.

The Company will provide results of positive tests to a physician or to the Florida Department of Health, as selected by you, who will, in turn, report the positive result to you in the manner required by law.

Positive Test results are to be provided to:

☐ Physician

Name _____
Address _____

☑ Florida Department of Health

CONFIDENTIALITY OF TEST RESULTS

All test results are required to be treated confidentially. They will be reported by the laboratory to the Insurer. The test results may be disclosed as required by law or may be disclosed to employees of the Insurer who have the responsibility to make underwriting decisions on behalf of the Insurer or to outside legal counsel who needs such information to effectively represent the Insurer in regard to your application. The results may be disclosed to a reinsurer, if the reinsurer is involved in the underwriting process. The test may be released to an insurance medical information exchange under procedures that are designed to assure confidentiality, including the use of general codes that also cover results of tests for other diseases or conditions not related to AIDS, or for the preparation of statistical reports that do not disclose the identity of any particular person.

CONSENT

I have read and I understand this Notice and Consent for AIDS-Related Blood Testing. I voluntarily consent to the withdrawal of blood from me, the testing of that blood, and the disclosure of the test results as described above. I have read the information on this form about what a test result means and understand that I should contact a local AIDS service group or my private physician for further information and counseling if the test result is positive.

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

Amit Fishler
Signature of Proposed Insured or Parent/Guardian

Date Signed: 08/19/2020

Amit Fishler
Name of Proposed Insured

9621 Triton Ct, Boca Raton, FL, 33434
Address

ILLINOIS MUTUAL®
Life Insurance Company
300 S.W. Adams Street Peoria, IL 61634
Phone 309.674.8255

NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS INSURANCE

THIS NOTICE IS FOR YOUR BENEFIT AND IS REQUIRED BY REGULATION OF YOUR DEPARTMENT OF INSURANCE

According to your application and/or information you have furnished, you intend to lapse or otherwise terminate existing accident and sickness insurance policy _____ (Number) you have with _____ (Company) and replace it with a policy to be issued by Illinois Mutual Life Insurance Company. For your information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

1. Health conditions which you may presently have (pre-existing conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.

2. You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.

3. If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain that all questions on the application concerning your medical/health history are truthfully and completely answered.

4. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed it should be carefully reviewed before being signed to be certain that all information has been properly recorded.

5. New policies may be issued at an older age than that used for issuance of your present policy; therefore, the cost of the new policy, depending upon the benefits, may be higher than you are paying for your present policy.

6. The renewal provisions of the new policy should be reviewed so as to make sure of your rights to periodically renew the policy.

The above "Notice to Applicant" was delivered to me on _____

_____ Agent

_____ Applicant

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

**THIS NOTICE IS FOR YOUR INFORMATION.
NO RESPONSE IS REQUIRED.**

DESCRIPTION OF INFORMATION PRACTICES

To Our Applicants:

This description of the information practices of Illinois Mutual Life Insurance Company is being provided in accordance with the requirements of federal and state privacy laws.

Collection of Information

In order to properly underwrite your insurance coverage, we must collect a certain amount of necessary information. The amount and type of information collected may vary depending on the amount and type of coverage applied for, but in general we will be seeking information about your age, occupation income, physical condition, health history, and avocations. In addition, we or your agent may collect information intended to aid in the updating and improvement of your insurance program.

You are our most important source of information, but we may also collect or verify information by contacting medical professionals and institutions which have provided care to you or members of your family proposed for coverage, employers and other insurance companies you have applied to. We may collect information by exchanges of correspondence, by phone or by personal contact.

In some cases, we may ask an insurance support organization with your authorization to collect information and submit an investigative consumer report to us. That organization may retain a copy of the report and may disclose its contents to others for whom it performs such services.

Disclosures by Illinois Mutual

In some circumstances, Illinois Mutual will make disclosures of personal information, without your authorization, to third parties. The following is a brief description of some of the persons or organizations to whom certain items of information might be disclosed.

- Your agent;
- Persons or organizations which perform professional, business or insurance functions for us, such as independent claim examiners or group plan administrators;
- Insurance companies to which you have applied for coverage or benefits;
- Your personal physician or treating medical professional;
- To comply with a properly authorized civil, criminal or regulatory investigation by federal, state and local authorities.
- To comply with a proper subpoena or summons issued under authority of a court of competent jurisdiction.

Please be assured that the above describes some of the disclosures which may be made, not

disclosures which are always or even often made. For example, we would ordinarily disclose only information relating to age, amounts of insurance and claims experience to a research organization. Information relating to physical condition or medical history would ordinarily be disclosed only to your personal physician. In any event, the information that may be disclosed without your authorization will be only as much as permitted by law and reasonably necessary to accomplish the intended purpose.

We do not provide personal information about you to affiliated or nonaffiliated third parties for marketing purposes.

Access and Correction

There are procedures by which you can obtain access to personal information about you appearing in our policy files, including information contained in investigative consumer reports. We have also established procedures by which you may request correction, amendment or deletion of any information in our files which you believe to be inaccurate. If you notify us that the information is incorrect, we will review it. If we agree, we will correct our records. If we do not agree, you may submit a short statement of dispute, which will be included in our files and in any future disclosure of the disputed information.

Confidentiality and Security

Your personal information is restricted to employees who need to know the information to provide our products and services to you. Our employees are trained to understand the importance of customer privacy. Appropriate disciplinary measures are applied to employees who violate our privacy policy. We maintain physical, electronic, and procedural safeguards that comply with all applicable laws.

Obtaining Additional Information

We at Illinois Mutual hope that you find this description of our information practices helpful. We take our responsibilities, and your rights, very seriously. If you have any further questions about the items just discussed, please contact us at Illinois Mutual Life Insurance Company, 300 S.W. Adams Street, Peoria, IL 61634.

ILLINOIS MUTUAL®
Life Insurance Company
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POLICY FORM DI105

DISABILITY INCOME PROTECTION COVERAGE
REQUIRED OUTLINE OF COVERAGE

1. **READ YOUR POLICY CAREFULLY.** This Outline of Coverage gives a very brief description of the features of your Policy. This is not the insurance contract. Only the actual Policy provisions will control. The Policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is important that you READ YOUR POLICY CAREFULLY!
2. **DISABILITY INCOME PROTECTION COVERAGE** is designed to provide you with coverage for disabilities resulting from a covered injury or sickness. Coverage is provided by the benefits described in Paragraph (3). The benefits described in Paragraph (3) may be limited by Paragraph (4). Coverage is not provided for basic hospital, basic medical-surgical or major medical expenses.

3. **BENEFITS –**

A. Total Disability Monthly Benefit ..... $ 1,587 /mo. ☑ Included

If an injury or a sickness causes you to be totally disabled, we will pay this Benefit to you. Payment to you shall start after the 90 Day Elimination Period has been satisfied. We will pay you for up to To Age 67. But, if this Policy is renewed on or after the renewal date next after your 67th birthday and you become totally disabled after that date, this Benefit will only be paid for a total of 24 months.

B. Partial Disability Monthly Benefit ..... $ 794 /mo. ☑ Included

This Benefit will be paid to you if injury or sickness causes your partial disability. It will be paid for up to 6 months. Payment to you shall start after the 90 Day Elimination Period has been satisfied.

C. Presumed Total Disability ..... ☑ Included

If an injury or a sickness causes the total and irrecoverable loss of sight in both eyes, hearing of both ears, or speech, or in the total and irrecoverable loss of the use of both hands, both feet or a hand and a foot, you will be presumed to be totally disabled. Such disability shall start with the date of your loss. It shall continue up to the longest length of time that benefits can be paid. Such disability shall continue whether or not you are under the care of a physician. It shall continue whether or not you are able to work.

D. Total Loss of Sight and Double Dismemberment Monthly Benefit ..... $ 1,587 ☑ Included

If an injury or a sickness shall cause the loss, by actual severance, of both hands, or both feet, or a hand and a foot, or irrecoverable loss of sight of both eyes, this Benefit will be paid. Payment shall be equal to Benefit A, above. Payment of this Benefit shall start with the day of such loss. It shall be paid up to your maximum benefit period or 24 months, whichever is less. It shall be paid in addition to any other benefits.

E. Retraining and Home Modification Benefit ..... $ 9,522 — ☑ Included

If benefits have been paid to you for at least 6 months in a row for total disability and you continue to be totally disabled, up to the amount of this Benefit will be payable. This Benefit provides for the actual expense of tuition, books and equipment at a licensed college, vocational or business school for a formal retraining program. It also provides for the actual costs to modify your home to accommodate your disabling condition. The amount of this Benefit is up to 6 times Benefit A above.

Not Included if Maximum Benefit Period is less than 12 months.

F. Organ Donor Benefit ..... ☑ Included

If you become totally disabled as a result of giving one of your organs Benefit A will be paid to you. Your Policy must have been in force at least 6 months for Benefit A to be payable for this reason. No Elimination Period will apply to this Benefit.

G. Survivor Benefit ..... ☑ Included

If you die during a current period of total disability and have been receiving Benefit A for 6 continuous months, we will pay 4 times the amount of Benefit A to your spouse, if living, otherwise to your estate.

Not Included if Maximum Benefit Period is 6 months.

H. Waiver of Premium ..... ☑ Included

When you have been totally disabled for 3 consecutive months, we will waive the premiums that follow. We will continue to waive them for as long as your total disability continues. All premiums paid in the first 3 months of your total disability will be returned to you.

I. Automatic Increase Benefit Rider, Form 9252 ..... ☑ Included

Your Total Disability Monthly Benefit will increase automatically on the first premium due date on or after each of the first five policy anniversaries. The amount of the increase will be 3% times the Total Disability Monthly Benefits at policy issue. Increases will not be offered on any policy anniversary on which you are disabled or your amount of total coverage would exceed our issue and participation limits. You may decline to accept an increase, but if you decline, you forfeit your right to further increases. There are no premiums charged for this Rider, however when an automatic benefit increase takes place, the Policy premium will increase in accordance with the increase in benefits. The additional benefit premium will be based upon your classification at policy issue and your attained age at the time of the increase.

Not Included if the monthly benefit is less than $1,000 or the insured is over age 50.

J. Optional Non-Cancelable Policy Rider, Form 9251 ..... ☐ Included ☑ Not Included

This Rider provides that as long as the premium is paid by the end of the grace period until the renewal date that follows your 67th birthday, we can not change the premium for this Policy. This would not apply to benefit changes or the addition or termination of Riders after the Date of Issue.

Premium: $ _____ Per

K. Optional Retroactive Injury Rider, Form 9253 ..... ☐ Included ☑ Not Included

If injury causes your total disability within 30 days of your injury, Benefit A will be paid from the 1st day of total disability. You must have been continuously totally disabled from your injury for the entire Elimination Period before benefits will be payable.

Premium: $ _____ Per

L. Optional Five Year Own Occupation Extension Rider, Form 9257 ..... ☐ Included ☑ Not Included

This Rider changes the definition of Total Disability for your own occupation from 24 months to 60 months.

Premium: $ _____ Per

M. Optional Own Occupation Extension To Your Renewal Age Rider, Form 9258

☐ Included
☑ Not Included
Premium:
$ _____ Per

This Rider changes the definition of Total Disability for your own occupation from 24 months to your age 67.

N. Optional Two Year Pure Own Occupation Rider, Form 9255

☑ Included
☐ Not Included
Premium:
$ 5.09 Per Monthly

This Rider changes the definition of Total Disability during the first 24 months to your inability to perform the substantial and material duties of your occupation only.

O. Optional Five Year Pure Own Occupation Rider, Form 9256

☐ Included
☑ Not Included
Premium:
$ _____ Per

This Rider changes the definition of Total Disability during the first 60 months to your inability to perform the substantial and material duties of your occupation only.

P. Optional Return of Premium Rider, Form 9266

☐ Included
☑ Not Included
Premium:
$ _____ Per

This Rider provides a return of premium payment. This payment, if any, is the amount by which (a) the total of all premiums paid times the proper percentage is greater than (b) the total of all the benefits paid. The proper percentage is determined by how long the policy is in force. The return of premium payment, if any, is payable (1) upon your request in writing, (2) upon lapse, (3) upon your death, or (4) when you reach age 67. The surrender of the Policy is required in each case.

Q. Optional Guaranteed Insurability Options Rider, Form 9267

☑ Included
☐ Not Included
Premium:
$ 1.16 Per Monthly

This Rider affords you 5 options to buy more coverage prior to your 55th birthday. Your health status will not be considered. You may choose to exercise your options at any time after 24 months from the Date of Issue. But, each such purchase must be at least 24 months apart. In the event of a life change which is defined as a marriage, death of a spouse, divorce or birth or adoption of a child, you may accelerate a purchase but the next purchase will follow upon the normal 24 month sequence. Each purchase is subject to our issue and participation limits. Each purchase may be for no more than $ 600 per month.

R. Optional Integrated Monthly Benefit Rider, Form 9264 up to $ 1,700 /mo.

☑ Included
☐ Not Included
Premium:
$ 22.37 Per Monthly

This Rider provides a monthly benefit that is paid in addition to Benefit A after the Elimination Period has been satisfied. The amount of this Benefit will be reduced by any benefits you receive from:

a. Federal Social Security Act (primary or family benefits) and Social Security retirement benefits.

b. Worker's Compensation Act or Law or Occupational Disease Law.

c. The Railroad Retirement Act (primary or family benefits) and retirement benefits.

d. Federal, State, County, Municipal or other government subdivision retirement and disability fund.

This Benefit will continue to be paid for as long as your total disability continues, but not beyond the Maximum Total Disability Benefit Period.

S. Optional Activities of Daily Living Rider, Form 9259 ..... $_____/mo.

☐ Included
☑ Not Included
Premium:
$ _____ Per

This Benefit will be paid to you up to _____ if you are unable to perform 2 or more Activities of Daily Living (ADLs) without stand-by assistance or you are cognitively impaired. Activities of Daily Living are bathing, continence, dressing, eating, toileting, or transferring. You must first satisfy the ADL Elimination Period of _____.

T. Optional Cost of Living Adjustment Rider, Form 9260 .....

☑ Included
☐ Not Included
Premium:
$ 12.54 Per
Monthly

This Rider provides that an increase in Benefit A, above, will start on the second year of your continuous total disability. Benefit A, above, can be increased each year up to 6% compounded annually, based upon the Consumer Price Index for All Urban Consumers, until the benefit doubles, until you reach age 67 or until the end of the benefit period, whichever occurs first; but, your total disability must be continuous. The Adjusted Benefit provided by this Rider will not be paid if you are working for pay.

U. Optional Residual Disability Benefit Rider .....

☑ Included
☐ Not Included
Premium:
$ 8.61 Per
Monthly
☐ Form 9261 without COLA
☐ Form 9263 with COLA

This Rider provides a monthly benefit if you return to your regular job and suffer a loss of 20% or more of your prior monthly income. Your Benefit is based on your percent of income lost as a result of sickness or injury. We will pay this Benefit to you starting on the 90 Day of continuous total and/or residual disability. This Rider is available with a Cost of Living Adjustment Benefit. But, it is available with this Rider only if you have also chosen Benefit T.

V. Optional Full Benefits for Mental or Nervous Disorders, Alcoholism or Drug Abuse Rider, Form 9265 .....

☐ Included
☑ Not Included
Premium:
$ _____ Per

This Rider amends the Policy to eliminate the limitations for total disability caused or contributed to by mental or nervous disorder or alcoholism or drug abuse to a lifetime benefit maximum of 24 months so that these conditions will be treated as any other sickness.

4. **EXCEPTIONS AND REDUCTIONS –**

   A. We will pay no benefits for disability that results (a) from normal pregnancy or childbirth; (b) from intentionally self-inflicted injury or sickness; (c) from your commission or attempted commission of a felony; (d) from war, declared or not; (e) from any military service, except during active duty for training of less than 60 days. The pro rata premium will be refunded for a period during which you are not covered for such military reason; or (f) We will not pay disability benefits while you are incarcerated in any penal or correctional institution.

   B. Total Disability benefits caused or contributed to by a mental or nervous disorder or alcohol or drug abuse will be limited to a cumulative lifetime maximum of 24 months. This limitation will not apply to any period during which you are confined to a Hospital for one of these conditions. If the Optional Full Benefits for Mental or Nervous Disorders, Alcoholism or Drug Abuse is purchased this limitation will not apply.

   C. If you become Totally Disabled due to an injury or sickness sustained or continued while you are outside of the United States, Canada or Mexico your Total Disability Benefit Period will be limited to 90 days. After the 90 day period, benefits will not be paid until you return to the United States, Canada or Mexico.

   D. In the first 2 years that this Policy is in force, we will not pay benefits:
      1. for a condition which was diagnosed or treated by a physician in the 2 years prior to the Date of Issue; or
      2. for a condition which caused symptoms in the 2 years prior to the Date of Issue if it would have caused an ordinarily prudent person to seek medical care.

      However, if you fully disclosed such a condition in your application, we will pay benefits unless a Rider excludes such condition by name.

5. **RENEWABILITY –** This Policy is guaranteed to be renewed until the renewal date that follows your 67th birthday. We have the right to increase the premiums by class unless you purchase the Optional Non-Cancelable Rider. After the renewal date that follows your 67th birthday, it is renewable annually at our option.

6. **PREMIUM –**

Proposed
Insured: Amit Fishler

Total Premium: $ 77.50 Per Monthly .

Total Premium: $ 880.64 Per Year.

The premiums that you pay may change by class unless you purchase the Optional Non-Cancelable Rider. Each Policy has a 31 day grace period.

08-19-2020	Joseph Corozza
Date	Signature of Agent

RETAIN FOR YOUR RECORDS