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

Employer Participation Application For The Employer Group Insurance Trust

1. Employer Information

a. Full Legal Name of Employer _____

b. Telephone Number (_____)_____ **c.** Employer's Federal Tax ID Number _____

d. Type of Business _____

e. Address _____
STREET CITY STATE ZIP CODE

f. Administrative Correspondence with the employer should be addressed to:

_____
NAME TITLE

g. Nature of Business _____

h. Requested Effective Date (12:01 a.m.):_____, 20_____ **i.** Premiums are to be paid monthly.

j. Are there subsidiary or affiliate businesses covered under this plan? ☐ Yes ☐ No
If Yes, please state name and nature of each subsidiary or affiliate _____

_____

k. Are separate billings required? ☐ Yes ☐ No If Yes, please provide billing instructions_____

_____

l. Will the requested insurance replace existing insurance? ☐ Yes ☐ No If Yes, give coverage, name of existing carrier, and proposed termination date_____

2. Employee Eligibility

a. The normal work week for full-time employees is _____ hours.
Eligibility: All regular full-time employees working a minimum of 30 hours per week.

b. Number of Eligible Employees _____ **c.** Number of Enrolled Employees _____

d. Are there any ineligible classes or divisions? ☐ Yes ☐ No If Yes, please describe: _____

_____

e. Are any eligible employees disabled at this time? ☐ Yes ☐ No If Yes, please describe: _____

_____

f. Is a Section 125 Plan in effect? ☐ Yes ☐ No **g.** Will this Plan be subject to the Section 125 Plan? ☐ Yes ☐ No

3. Voluntary Short Term Disability Benefit Level

(**a**) Employer's Plan Selected _____

Qualifying Period 90 Days of Continuous Full-time Employment

Plan	Elimination Period Accident	Elimination Period Sickness	Maximum Total Disability Benefit Period
A	0 Days	7 Days	13 Weeks
B	7 Days	7 Days	13 Weeks
C	14 Days	14 Days	13 Weeks
D	0 Days	7 Days	26 Weeks
E	7 Days	7 Days	26 Weeks
F	14 Days	14 Days	26 Weeks

4. Employer's Signature

PLEASE READ CAREFULLY

On behalf of the employer listed above, I hereby agree to participate in the Employer Group Insurance Trust and subscribe to the Agreement and Declaration of Trust. I understand that the insurance benefits resulting from this application will be provided by Illinois Mutual Life Insurance Company under a group policy issued to the Trust and that any claims will be handled by the insurer and are not the responsibility of the Trust.

Quotations were based on the proposal data submitted to Illinois Mutual Life Insurance Company. Final premium rates will be determined on the basis of the actual composition of the group of persons who become insured.

If the initial deposit is at least equal to the first month's premium, and if the requested insurance is acceptable under Illinois Mutual's current rules and practices, insurance under the terms of the policy shall be effective on the effective date requested. In the interim, liability is limited to a return of the original deposit. Only Illinois Mutual's home office has the authority to guarantee the acceptability of the requested insurance.

Dated at _____ this _____, 20_____
CITY/STATE DATE

_____ _____ _____
SIGNATURE OF EMPLOYER TITLE WITNESS

5. Agent's Report

a. Initial Deposit (Minimum first month's premium is required.): $_____

b. Are all the employees to be insured for Disability Income covered by Workers' Compensation? ☐ Yes ☐ No
If No, explain: _____

c. Have you explained to the employer that an employee not actively at work on the policy effective date will not be covered until such employee returns to active work full-time? ☐ Yes ☐ No
Remarks: _____

d. Is there another group insurance plan(s) which duplicates any of the benefits applied for with this application that will remain in force or be placed concurrently with this plan(s)? ☐ Yes ☐ No If Yes, please describe the benefit amounts and purpose(s) of this plan(s):_____

_____

_____

e. Is Agent or Broker licensed in the State of this group for the types of insurance solicited? ☐ Yes ☐ No

f. To the best of the Agent's or Broker's knowledge, replacement ☐ is ☐ is not involved with this transaction.

g. Print name of Agent/Broker_____

h. Signature of Agent/Broker _____ Date _____