ILLINOIS MUTUAL®
Life Insurance Company

# WORKSITE INSURANCE PROPOSAL REQUEST

Agent name: _____ Agent Code:_____ Phone: _____

Employer Name and Address (for proposal): _____

_____

Type of Business or SIC: _____ Years in Business: _____ Avg. Annual Employee Turnover: _____

Number of Eligible W-2 employees: _____ Number of Eligible 1099 Contract Workers:_____

Number of Locations: _____ State(s) of locations to be enrolled:_____ Pay Frequency: _____

**PRODUCT DESIGN INFORMATION** Check all that apply:

☐ **TERM LIFE INSURANCE** ☐ 10-Year Term ☐ 20-Year Term

Face Amounts: ☐ $25,000 ☐ $35,000 ☐ $50,000 ☐ $75,000 ☐ $100,000

- ☐ Accidental Death Benefit Rider
- ☐ Child Insurance Rider
- ☐ Payor Waiver of Premium

☐ **WORKSITE SHORT TERM DISABILITY INSURANCE** ☐ Off-the-job Only ☐ 24-Hour Coverage

Please indicate below the specific benefit/elimination period combination requested.

| Benefit Period* | Accident Elimination Period/Sickness Elimination Period** | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| ☐ 3 Months – | ☐ 0/7 | ☐ 7/7 | ☐ 0/14 | ☐ 14/14 | | | | | |
| ☐ 6 Months – | ☐ 0/7 | ☐ 7/7 | ☐ 0/14 | ☐ 14/14 | ☐ 0/30 | ☐ 30/30 | | | |
| ☐ 12 Months – | ☐ 0/7 | ☐ 7/7 | ☐ 0/14 | ☐ 14/14 | ☐ 0/30 | ☐ 30/30 | ☐ 60/60 | ☐ 90/90 | |
| ☐ 24 Months – | ☐ 0/7 | ☐ 7/7 | ☐ 0/14 | ☐ 14/14 | ☐ 0/30 | ☐ 30/30 | ☐ 60/60 | ☐ 90/90 | ☐ 180/180 |
| ☐ 60 Months – | ☐ 14/14 | ☐ 30/30 | ☐ 60/60 | ☐ 90/90 | ☐ 180/180 | | | | |

Is this a Replacement of existing coverage? ☐ Yes ☐ No If yes, is this a Takeover†? ☐ Yes ☐ No

* 3-month benefit period not available in VA. 60-month benefit period not available in OR. 24-month & 60-month benefit period not available in UT.
** RI and NJ: minimum 180-day EP or maximum 40% issue if shorter EP offered.

☐ **ACCIDENT INSURANCE** ☐ Off-the-job Only ☐ 24-Hour Coverage

- ☐ Off Job Accident Disability Rider
- ☐ Sickness Hospital Confinement Rider*
- ☐ Wellness Benefit Rider**
- ☐ Catastrophic Accident Rider

* Not guaranteed issue. Additional health questions apply.
** If the Worksite Accident and Worksite Critical Illness are both offered, the Wellness Benefit Rider can only be made available on one.

☐ **CRITICAL ILLNESS INSURANCE** ☐ Base Plan Only ☐ Base Plan Plus Cancer*

- ☐ Recurrence Benefit Rider
- ☐ Wellness Benefit Rider**

Is this a Replacement of existing coverage? ☐ Yes ☐ No If yes, is this a Takeover†? ☐ Yes ☐ No

*Not available in ME or WY.
** If the Worksite Accident and Worksite Critical Illness are both offered, the Wellness Benefit Rider can only be made available on one.



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

☐ **VOLUNTARY SHORT TERM DISABILITY (VSTD11)*** (employer may select one plan to offer employees)

☐ Plan A 0/7-13 weeks ☐ Plan B 7/7-13 weeks ☐ Plan C 14/14-13 weeks

☐ Plan D 0/7-26 weeks ☐ Plan E 7/7-26 weeks ☐ Plan F 14/14-26 weeks

Is this a Replacement of existing coverage? ☐ Yes ☐ No If yes, is this a Takeover†? ☐ Yes ☐ No

*Only plans D, E and F are available in Vermont.

**ENROLLMENT STRATEGY** Check all that apply:

Proposed Enrollment Date(s)*: _____

Enrollment Expectations: ☐ Mandatory ☐ Voluntary

Enrollment Method: ☐ Paper ☐ Electronic

Employer Utilizes Shift Work: ☐ Yes ☐ No

* Enrollment window is assumed to be 30 days unless otherwise specified. Enrollment window cannot exceed 30 days without prior underwriting approval.

**APPROVAL SECTION** To be completed by Home Office:

Case Decision Date: _____

Decision: ☐ Approved ☐ Approved (conditional) ☐ Not Approved

Comments: _____

_____

_____

_____

By: _____

* Groups with conditional approval will need to satisfy the conditions as outlined. Should these conditions not be met an additional review and approval will be required.
* Groups seeking pre-enrollment guaranteed issue, or approved groups with 10 or more eligible lives, will require a completed Employer Agreement (Form 8031) or an Employer-furnished census file prior to issue.

† Takeover: all existing insureds are moving to Illinois Mutual coverage. Submit census and/or list bills with prior coverage effective dates and insurance carrier information.

**Return to: Illinois Mutual Fax – (309) 636-0363 Email – Worksite@IllinoisMutual.com**



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