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

Voluntary Short Term Disability Employee Enrollment Form

TO BE COMPLETED BY EMPLOYER

Name of Employer (use name from Group Billing Notice) _____

Group Number_____

TO BE COMPLETED BY EMPLOYEE

Name _____ Date of Birth _____

Address _____

Social Security Number _____-_____-_____ Date Employed Full-Time _____

Coverage Effective Date _____ Occupation _____

Annual Earnings $_____ Hours worked per week _____ Sex ☐ Male ☐ Female

Beneficiary _____ Relationship _____

BENEFIT LEVELS

Select the Benefit Level (1-10) that meets your needs from the chart below and enter the Benefit Level number in the box on the right.

Benefit Level	Weekly Benefit	Your Annual Salary Must Be at Least
1	$150	$11,700
2	$200	$15,600
3	$250	$19,500
4	$300	$23,400
5	$350	$27,300
6	$400	$31,200
7	$450	$35,000
8	$500	$39,000
9	$550	$42,900
10	$600	$46,800

BENEFIT LEVEL SELECTED

☐

Weekly Benefits will Equal the Amount Selected, Not to Exceed 66⅔% of your Basic Weekly Earnings at the Time of Benefit Eligibility.

I elect the above Benefit Level for which I am eligible. I authorize my employer to deduct the necessary contribution from my wages to pay the cost of this insurance. I understand that if I select a Benefit Level less than that for which I am eligible, I can apply to increase the Benefit Level, subject to proof of my insurability, and approval of the Company.

Notice: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Date_____ Your Signature _____

If you are refusing coverage, sign below and return this form to your employer.

I acknowledge that I have been offered Voluntary Short Term Disability Insurance by my employer. I hereby wish to waive my right to be insured under this plan. I am aware that I must furnish evidence of insurability satisfactory to Illinois Mutual Life Insurance Company, at my own expense, if I should apply at a later date. The company shall have the right to decline coverage.

Date_____ Signature_____