KANSAS CITY LIFE

GROUP BENEFITS

Kansas City Life Insurance Company
3520 Broadway, Kansas City, MO 64111

GRP # _____

Group Insurance Enrollment Form

COMPLETED BY EMPLOYER

1. Employer		2. Location	
3. Full-time employment date	4. Occupation	5. Hours worked/week	6. Annual earnings
7. Coverage class	8. Rehire date	9. This enrollment is: (check all that apply) ☐Initial enrollment ☐Late entrant ☐New hire ☐Change ☐Other _____	

COMPLETED BY EMPLOYEE

10. Last Name, First Name, Middle Initial		11. E-mail	
12. Home Address, City, State and Zip			
13. Social Security Number	14. ☐Male ☐Female	15. Date of Birth (M/D/Y) / /	16. ☐Single ☐Married

To apply for coverage(s), complete the following section and sign below. Indicate only those products available through your employer/plan sponsor.

17. Coverage(s) for Employee and/or Dependents (Employee coverage required)
☐Basic Life & AD&D ☐ Voluntary Life Amount: _____
☐Dental If Applicable: ☐Low Plan ☐High Plan
☐Short-Term Disability ☐ Voluntary STD If Applicable: Amount: _____
☐Long-Term Disability ☐ Voluntary LTD If Applicable: Amount: _____
☐Vision If Applicable: ☐Low Plan ☐High Plan
☐Accident If Applicable: ☐Low Plan ☐Medium Plan ☐High Plan

18. Coverage(s) for Dependents (Employee coverage required)
For Dependent Life and/or Voluntary Life, the Spouse must be under age 70 to be eligible for Spouse coverage.
☐ Dependent Life Spouse Date of Birth (M/D/Y): _____
☐ Spouse Voluntary Life Amount: _____
☐ Child/ren Voluntary Life Amount: _____
Dental: ☐Spouse ☐Child/ren
Vision: ☐Spouse ☐Child/ren
Accident: ☐Spouse ☐Child/ren

19. If COBRA continuee, please supply qualifying event and date:

20. Full Name of Primary Beneficiary and Relationship to you:	21. Full Name of Contingent Beneficiary and Relationship to you:

For Dependent Coverage: List each dependent you wish to insure.

22. Name (show last name if different from employee)		Gender	Relationship	Date of Birth
Spouse			N/A	/ /
Child				/ /
Child				/ /
Child				/ /
Child				/ /

By signing below, I acknowledge I have read and I agree to the terms of the Provisions of Coverage as follows:

I hereby apply to Kansas City Life Insurance Company for Group Insurance as presented to me and authorize my employer to make any necessary deduction from my wages to pay the premium when my insurance becomes effective.

I represent I am not presently disabled and I am performing the material and substantial duties of my occupation for at least the number of hours as shown in box 5.

I understand any material misstatement on this enrollment form may result in a denial of a claim and/or discontinuance of coverage.

I have made a copy of this application for my records.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

23. Signature of Employee: _____ **Date:** _____

(To decline any coverages, complete "Declination of Coverage" on page 3.)

NOTICE TO ARIZONA APPLICANTS:
Any life insurance producer, examining physician or other person who knowingly makes a false or fraudulent statement or representation in or relative to an application for life or disability insurance, or who makes any such statement to obtain a fee, commission, money or benefit is guilty of a class 2 misdemeanor.

NOTICES TO COLORADO APPLICANTS:
It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

THIS POLICY DOES NOT INCLUDE COVERAGE OF PEDIATRIC DENTAL SERVICES AS REQUIRED UNDER FEDERAL LAW. COVERAGE OF PEDIATRIC DENTAL SERVICES IS AVAILABLE FOR PURCHASE IN THE STATE OF COLORADO, AND CAN BE PURCHASED AS A STAND-ALONE PLAN, OR AS A COVERED BENEFIT IN ANOTHER HEALTH PLAN. PLEASE CONTACT YOUR INSURANCE CARRIER, AGENT, OR CONNECT FOR HEALTH COLORADO TO PURCHASE EITHER A PLAN THAT INCLUDES PEDIATRIC DENTAL COVERAGE, OR AN EXCHANGE-QUALIFIED STAND-ALONE DENTAL PLAN THAT INCLUDES PEDIATRIC DENTAL COVERAGE.

NOTICE TO FLORIDA APPLICANTS:
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.

NOTICE TO GEORGIA APPLICANTS:
Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance may be subject to fines and confinement in prison.

NOTICE TO ILLINOIS APPLICANTS:
NOTICE TO POLICYHOLDER – ILLINOIS RELIGIOUS FREEDOM PROTECTION AND CIVIL UNION ACT
The Illinois Department of Insurance requires that we inform you of Kansas City Life Insurance Company's compliance with the Illinois Religious Freedom Protection and Civil Union Act (the Act). The Act provides that the parties to a civil union are entitled to the same legal obligations, responsibilities, protections, and benefits that are afforded or recognized by the laws of Illinois to spouses. Therefore, Kansas City Life Insurance Company will administer both existing and newly issued policies and use processes and systems to ensure that parties to a civil union and a marriage are provided identical benefits, protections, and financial security.
Please contact your agent or the Home Office of Kansas City Life Insurance Company if you have questions regarding this notice

NOTICE TO KANSAS APPLICANTS:
Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance may be guilty of insurance fraud as determined by a court of law.

NOTICE TO KENTUCKY APPLICANTS:
Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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.

NOTICE TO MAINE, TENNESSEE, AND WASHINGTON APPLICANTS:
It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

NOTICE TO MARYLAND APPLICANTS:
Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

NOTICE TO OKLAHOMA APPLICANTS:
WARNING: Any person who knowingly, and with intent to injure, defraud, or deceive any insurer makes any claim for the proceeds of an insurance policy containing any false, incomplete, or misleading information is guilty of a felony.

NOTICE TO OREGON APPLICANTS:
It may be a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties could include imprisonment and fines, and may result in a denial of insurance benefits.

NOTICE TO PENNSYLVANIA APPLICANTS:
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.

NOTICE TO UTAH APPLICANTS IF DENTAL AND/OR VISION COVERAGE IS APPLIED FOR:
The policy provides dental / vision benefits only. Review your policy carefully.

NOTICE TO VIRGINIA APPLICANTS:
Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated the state law.

DECLINATION OF COVERAGE

To refuse coverage(s) for which you are required to pay a portion of the premium, please complete the following section:

Last Name, First Name, Middle Initial	Employer

Indicate Coverage(s) Declined Below:

Coverage(s) for Employee:

- ☐ Basic Life & AD&D
- ☐ Dental
- ☐ Short-Term Disability
- ☐ Long-Term Disability
- ☐ Accident
- ☐ Voluntary/Supplemental Life
- ☐ Voluntary STD
- ☐ Voluntary LTD
- ☐ Vision

Coverage(s) for Dependents (Employee coverage required):

Life:	☐ Spouse	☐ Children
Dental:	☐ Spouse	☐ Children
Vision:	☐ Spouse	☐ Children
Accident:	☐ Spouse	☐ Children

Reason for refusing coverage: _____

I have been given an opportunity to participate in the group insurance plan offered by my employer. I am refusing the coverage indicated. I fully understand by this refusal, I and/or my dependents will not be entitled to any benefits under these coverages marked. If I and/or my Spouse or Child(ren) desire to participate at a later date, coverage(s) may be limited and proof of insurability may be required at my own expense.

Signature: _____ Date: _____

KANSAS CITY LIFE
GROUP BENEFITS

Group Number _____

Policyholder _____

Health Statement

Print full names of all to be insured.	Relationship to Primary Insured	Birthdate					Build			*Weight Change in past year	
		Month	Day	Year	Age	Sex	Ft.	In.	Lb.	Gain	Loss
1.											
2.											
3.											
4.											
5.											
6.											

Questions apply to all Proposed Insureds*

*__Give DETAILS__ to __Yes__ answers. Identify Proposed Insured(s), question, specify conditions, severity, dates, duration, after-effects, weight gain or loss, and names and addresses of all attending physicians and medical facilities.

	Yes	No
1. Do you take prescription medicine?	☐	☐
2. Are you currently pregnant? Due Date?_____	☐	☐
3. Have you ever used or received treatment or counseling for the use of marijuana, heroin, cocaine, amphetamines, barbiturates, hallucinogenic agents or opium or its derivatives?	☐	☐
4. Have any of the Proposed Insureds used any form of nicotine/tobacco in the last 12 months? (i.e., cigar, pipe, smokeless tobacco, cigarettes, etc.) If cigarettes, how many packs per day?_____	☐	☐
5. Have you sought advice, been treated or arrested for the use of alcohol?	☐	☐
During the **last 5 years** have you:		
6. been hospitalized or had medical advice, diagnostic tests recommended, or treatment by a physician or other medical practitioner?	☐	☐
During the **last 10 years** have you been diagnosed or treated for any disease or disorder of:		
7. brain and nervous system - mental illness, epilepsy, seizures, stroke, paralysis?	☐	☐
8. sight or hearing?	☐	☐
9. blood - anemia or leukemia?	☐	☐
10. tumor or cancer?	☐	☐
11. heart/blood vessels - murmur, chest pain or pressure, palpitations, heart attack?	☐	☐
12. blood pressure?	☐	☐
13. thyroid or glandular trouble?	☐	☐
14. lungs - asthma, emphysema, tuberculosis?	☐	☐
15. digestive system - ulcer, intestines or rectum, polyps, colitis?	☐	☐
16. liver - elevated enzymes, cirrhosis, hepatitis?	☐	☐
17. diabetes - sugar in urine?	☐	☐
18. kidney/bladder or prostate - albumin, blood or pus in urine?	☐	☐
19. bone, joint, muscles, back or spine - arthritis?	☐	☐
20. breasts, uterus, ovaries?	☐	☐
21. menstruation or pregnancy?	☐	☐
Have you ever been diagnosed or treated for:		
22. a sexually transmitted disease?	☐	☐
23. Acquired Immune Deficiency Syndrome (AIDS) or tested positive for the Human Immunodeficiency Virus?	☐	☐
24. In the **past 3 years,** have you applied for life or health insurance or reinstatement thereof, without receiving it exactly as requested?	☐	☐

Names, addresses and phone numbers of personal or family physicians. (If none, list last physician, clinic or hospital consulted.)

Date and Reason:_____ Clinic or VA last consulted: _____

_____ Claim Number: _____

Agreement and Signatures

It is understood and agreed as follows:

1. The statements and answers recorded in all parts of this application are true and complete.
2. No information regarding any Proposed Insured(s) will be considered known by the Company unless explicitly set out in writing on this application.
3. This application, and the answers to any required medical exam, will become a part of any insurance issued on it.
4. No agent has the authority to waive any of the Company's rights or rules, or to make or change any contract.
5. I (We) have received the Notice of Information Practices which explains my (our) rights under the Fair Credit Reporting Act.

AUTHORIZATION: I (We) authorize the following to give information (defined below) to Kansas City Life or any person or group acting on the part of Kansas City Life: any medical professional, medical care institution, the Medical Information Bureau, Inc., insurer, reinsurer, government agency, consumer reporting agency or employer. I authorize Kansas City Life Insurance Company, or its reinsurers, to make a brief report of my personal health information to MIB. "Information" means facts of: a medical nature in regard to my (our) physical or mental condition; employment; other insurance coverage; or any other non-medical facts.

I (We) understand that this information will be used by Kansas City Life to determine eligibility for insurance. I (We) agree this Authorization is valid for two and one-half years from the date signed.

I (We) know that I (we) have a right to receive a copy of this Authorization upon request.

I (We) agree that a photographic copy of this Authorization is as valid as the original.

Dated at _____ this _____ day of _____ , _____.
(City, State) (Day) (Month) (Year)

_____ _____
Employee's Signature **Spouse's Signature** (if coverage applied for)

EMPLOYER SECTION:

Reason for Submitting Health Statement:

☐ Late Applicant ☐ Adding Coverage ☐ Other _____
☐ Late Dependent ☐ Increasing Coverage _____

Coverage Type and Amount Applying For:

☐ Life $_____ ☐ WDI $ _____
☐ Supplemental Life $_____ ☐ LTD $ _____
☐ Dependent Life: Spouse _____ Child _____

_____ _____ _____
Information Provided By Phone # Date

HOME OFFICE USE ONLY:

Basic Max._____ EOI _____
Supp. Max _____ EOI _____
Combined Max. _____ EOI _____
WDI Max. _____
LTD Max. _____
Notes: _____

Amount to be Approved
Basic _____
Supp. _____
Total _____

Underwriting Action:

Approved ☐
Declined ☐
Withdrawn ☐

UND. | Decision Date

Notes:

KANSAS CITY LIFE

GROUP BENEFITS

To obtain further information contact:
New Business Department
Kansas City Life Insurance Company
PO Box 219371
Kansas City, MO 64121-9371

NOTICE OF INFORMATION PRACTICES

Including Fair Credit Reporting Act Notice and MIB, Inc. Notice

Thank you for your application. It is the major source of information about you which we use in evaluating your application and issuing your contract. However, we wish to inform you that an investigative consumer report may be ordered as to your insurability. If an investigative consumer report is prepared in connection with this application, you may request to be interviewed in connection with the preparation of this report. This report may include, if applicable, information as to your character, general reputation, personal characteristics and mode of living (except as may be related directly or indirectly to your sexual orientation) as may be obtained through interviews with family members, friends, neighbors and associates. If you would like to know whether such a report was ordered and, if so, receive additional information as to its nature and scope, including the name, address and phone number of the reporting agency, we will be pleased to furnish this information upon your written request to our Home Office at the address above. You may receive a copy of such report by contacting the reporting agency. Our experience shows that information from investigative reports usually does not have any adverse effect on our underwriting decision. However, if it should, we will notify you in writing of this fact as well as provide you the identity by name and address of the reporting agency. You may then wish to discuss the matter with that agency.

We are committed to protecting the privacy of our customer's nonpublic personal information. We will only disclose our customer's nonpublic personal information: among the affiliated companies of the Kansas City Life Group; to provide services to our customers and administer our business; to market products; and as otherwise permitted by law. We may disclose our customer's nonpublic personal information to our agents and representatives to provide services to our customers and for marketing purposes. When we contract with other entities to provide support or marketing services, we will require them to adhere to our privacy standards.

Sometimes we acquire medical information about our customers, for instance, to underwrite an insurance contract or to process an insurance claim. We will keep our customer's medical information confidential. We will not share our customer's medical information even among the affiliated companies of the Kansas City Life Group without the customer's consent. We will only use or disclose our customer's medical information to underwrite insurance, process claims, administer our business, to comply with laws and regulations or as otherwise authorized by our customers.

You have the right to obtain access to certain items of information we have collected about you, and you have the further right to request correction of information if you feel it is inaccurate.

If you wish to have a more detailed description of our information practices, we will be pleased to furnish this information upon your written request to our New Business Department, Kansas City Life Insurance Company, PO Box 219371, Kansas City, MO 64121-9371.

MIB, Inc. Notice

While the information you provide to us regarding you insurability is treated as confidential, Kansas City Life or its reinsurers may make a brief report thereon to the Medical Information Bureau, a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. Should you apply for life or health insurance, or submit a claim for benefits to another member company, the Medical Information Bureau, upon request from that member company, will supply the information in its file.

Upon written request from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of the information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedure set forth in the Federal Fair Credit Reporting Act. The address of the Bureau's information office is PO Box 105, Essex Station, Boston, MA 02112. Telephone (617) 426-3660.

We or our reinsurers may also release information in our file to other life insurance companies to whom you apply for life or health insurance, or to whom a claim for benefits may be submitted.

K·C·L GROUP BENEFITS

Kansas City Life Insurance Company
PO Box 219425
Kansas City, MO 64121-9425

APPLICATION FOR CONVERSION OF GROUP LIFE INSURANCE

1 PROPOSED INSURED

Print full first name, middle initial, last name | Social Security Number

☐ MALE ☐ FEMALE | Birthdate (Month/Day/Year) | Age | Birthplace (State)

Address | City | State | Zip Code

2 LIFE INSURANCE

Basic Plan | Face Amount $_____ | Annual Premium $_____ | Automatic Premium Loan ☐ Yes ☐ No

3 PREMIUMS

Payment Frequency: ☐ Ann ☐ SA ☐ Qlty ☐ Mo

Payment Method: ☐ PAC ☐ GA ☐ CB ☐ Other

Notices to: ☐ Proposed Insured ☐ Owner ☐ Other — If other, give name and address below.

4 BENEFICIARY with right to change

Primary (Name, Address, and Social Security Number) | Relationship to Proposed Insured | Equally to the survivors, or to the survivor

Contingent (Name, Address, and Social Security Number) | Relationship to Proposed Insured

5 OWNER if other than Proposed Insured

Print full first name, middle initial, last name | Relationship to Proposed Insured

Number Street or Route | City | State | Zip Code | ☐ Male ☐ Female

☐ Social Security Number ☐ Taxpayer I.D. Number _____ | Birthdate (Month/Day/Year) | Age | Birthplace (State)

Successor Owner (If applicable) | Relationship to Proposed Insured | (If multiple successor owners, show order and distribution in "6" below.)

6 SPECIAL REQUESTS

Home Office Endorsements

7 AGREEMENT AND SIGNATURES

It is understood and agreed as follows:

1. I have carefully read the statements and answers recorded in this application; they are, to the best of my knowledge and belief, true and complete, they will become a part of this application and the policy issued on it;
2. No agent has the authority to waive any of the Company's rights or requirements or to make or alter any contract or policy;
3. The effective date of the policy and insurance applied for will be the 31st day after the termination of insurance described in the Conversion Provisions of the Group Master Policy; however, no insurance will be effective if the Proposed Insured is not then living or if the policy applied for is not available under the Conversion Provisions of the Group Master Policy;
4. This application must be accompanied by the first premium; I agree there will be no liability on the part of the Company prior to the effective date and until the first premium has been paid;
5. Any provision in this application contrary to the laws of the state in which this policy is applied for and issued will be null and void.

Dated at _____ this _____ day of _____, 20_____.

In payment of the first full premium, $f_____ accompanies this application.

_____ _____

Witness Signature | Proposed Insured's Signature (if under 15, parent/guardian signature)

CERTIFICATION OF ELIGIBILITY FOR CONVERSION

To be completed by Policyholder

The following information is to be completed by the Policyholder of Group Master Policy Number_____ under which the Proposed Insured's Insurance is being converted.

Proposed Insured	☐ Insured Individual ☐ Dependent of _____ Insured Individual	Certificate Number
Date coverage began	Date coverage ceases	Amount of terminating life insurance

Reason for converting group insurance:

Individual:

☐ Termination of employment or membership with Policyholder organization.

☐ Transfer to class of individuals not eligible for life insurance.

☐ Termination of life insurance on class of individuals to which Proposed Insured belongs.

☐ Other

Dependent:

☐ Death of Insured Individual

☐ Dependent ceases to qualify as defined by the Dependents Rider.

☐ Other. _____

I certify that, according to our records, the information recorded above is true and complete.

Dated at _____ this _____ day of _____, 20 _____.

_____

Policyholder

By _____/ _____

Signature *Title*

For Home Office use only:

_____/ _____ _____/ _____

Agent *Code* *Agency* *Code*

Kansas City Life Insurance Company
PO Box 219425
Kansas City, MO 64121-9425

BENEFICIARY FORM

EMPLOYEE (INSURED'S) NAME	SOCIAL SECURITY NO.

EMPLOYER NAME

POLICY NO.

TO KANSAS CITY LIFE INSURANCE COMPANY, KANSAS CITY, MISSOURI. It is hereby requested that the beneficiary under the policy numbered as above be changed to:

PRIMARY: (Include Full Name, Relationship to the Insured, Address, Social Security No. and Date of Birth for each beneficiary)

CONTINGENT: (Include Full Name, Relationship to the Insured, Address, Social Security No. and Date of Birth for each beneficiary)

This change will apply to any Life and Accidental Death and Dismemberment Insurance in force under the above numbered Group Policy or Policies. The provisions listed below are accepted.

SIGNATURE

Unless specified otherwise, I request that the death proceeds of the above policy be paid equally to all beneficiaries named or to the survivor or survivors. The amendment will be made when this notice is received and is effective the date it was signed.
Please sign, date and return this form immediately to your HR department.

SIGNATURE _____ DATE SIGNED MM(DD/YYYY) _____

WITNESS SIGNATURE _____

If two or more primary beneficiaries are named, the proceeds payable at death will be paid equally to the named beneficiaries surviving the Insured unless unequal distribution percentages have been made. When unequal distribution percentages are listed, a contingent beneficiary must be provided for each primary beneficiary named. (Example of unequal distributions are 60/40 or 50/25/25 or 60/20/20 etc.

Death proceeds will be paid as though the beneficiary died before the Insured Individual if: the beneficiary dies at the same time as or within 15 days of the Insured Individual's death and the Company has not paid the proceeds to the beneficiary within the 15-day period.

If no beneficiary survives, payment will be made according to the terms of the policy. This designation revokes any and all previous designations. The right to change the beneficiary is reserved to the Insured.

BELOW THIS LINE FOR HOME OFFICE USE ONLY

Above Change of Beneficiary is recorded as part of the policy file this _____ day of _____, 20_____.

AUTHORIZED KANSAS CITY LIFE REPRESENTATIVE _____

KANSAS CITY LIFE
GROUP BENEFITS

Kansas City Life Insurance Company
PO Box 219425
Kansas City, MO 64121-9425

CHANGE OF INFORMATION REQUEST

To change information concerning your coverage please complete the appropriate section and return to your employer.
HIGHLIGHTED AREAS ARE COMPLETED BY EMPLOYER.

EMPLOYER NAME	GROUP POLICY NO.
EMPLOYEE NAME (First, Middle Initial, Last)	
SOCIAL SECURITY NO.	Personal Identification Number *(home office use only)*

☐ CHANGE OF NAME

FORMER NAME (First, Middle Initial, Last)	PRESENT NAME (First, Middle Initial, Last)

DATE OF CHANGE (MM/DD/YYYY) REASON FOR CHANGE ☐ MARRIAGE ☐ DIVORCE ☐ OTHER _____

☐ CHANGE OF INSURED BENEFITS

CHANGE CLASS FROM TO

CHANGE SALARY FROM $ ☐ per month ☐ per week TO $ ☐ per month ☐ per week

NEW JOB TITLE EFFECTIVE (MM/DD/YYYY)

AUTHORIZED BY DATE SIGNED (MM/DD/YYYY)

☐ CHANGE OF DEPENDENTS INSURANCE ☐ LIFE ☐ VOL LIFE ☐ DENTAL ☐ VISION ☐ ACCIDENT __ LOW __ MEDIUM __ HIGH

I WISH TO: ☐ ADD ☐ TERMINATE INSURANCE ON THE FOLLOWING DEPENDENT(S):

NAME (Show last name if different)	SEX	RELATIONSHIP	DATE OF BIRTH	SOCIAL SECURITY NO.
SPOUSE		-		
1. CHILD				
2. CHILD				

MUST SHOW DATE DEPENDENT ACQUIRED OR TERMINATED (MM/DD/YYYY) _____

REASON FOR CHANGE ☐ MARRIAGE ☐ DIVORCE ☐ OTHER _____

(If coverage is contributory evidence of insurability must accompany this form when adding dependent(s) more than 31 days after the dependent is acquired.)

☐ CHANGE OF ADDRESS – COMPLETE ONLY IF ENROLLED FOR **DENTAL** OR **VISION** OR **ACCIDENT** COVERAGE

STREET APT

CITY STATE ZIP

SIGNATURE

I hereby request Kansas City Life to update my insurance records to reflect the changes indicated and authorize deduction of any required cost from my earnings.

SIGNATURE _____ DATE SIGNED (MM/DD/YYYY) _____

KANSAS CITY LIFE

GROUP BENEFITS

Kansas City Life Insurance Company
P.O. Box 219282, Kansas City, MO 64121-9282
800-821-6164, ext. 6080 • Fax: 816-753-1198
kclclaims@kclife.com

Notice of Claim

Date: _____, 20 _____

1. Group policy number	2. Certificate number	3. Amount of coverage	4. Class

5. Insured employee and address

6. Date of birth and Social Security No. (if known)	7. Any other Kansas City Life policies (if known)
8. If claim is on dependent, show name	9. Dependent date of birth and Social Security No. (if known)

Notice of:	
☐ **Death**	Date last worked _____, 20 _____ Date of death _____, 20 _____ Cause (if known) _____ Name and relationship of beneficiary _____ Address and phone number of beneficiary _____
☐ **Waiver of premium**	Date last worked _____, 20 _____ Date total disability started _____, 20 _____ Cause (if known) _____ Name and address of employer _____
☐ **Dismemberment**	Date injury occurred _____, 20 _____ Cause (if known) _____ Location of injury (if known) _____

This is not a claim form. Claim forms will be forwarded to the group.

Contact name: _____

For: _____
Name of Group policyowner (employer, association or union)

Address: _____

Phone: _____

Signed: _____

Date: _____

Comments: _____

_____

_____

_____