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.

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

KANSAS CITY LIFE INSURANCE COMPANY

APPLICATION FOR SHORT TERM DISABILITY INCOME BENEFITS

This application package is divided into four sections, as follows:

Section I **Employer's Statement-** to be completed by the employer's authorized representative.

Section II **Employee's Statement-** to be completed by the employee who is applying for Short Term Disability benefits.

Section III **Authorization to Obtain Information-** to be signed by the employee.

Section IV **Attending Physician's Statement-** to be completed by the physician who is treating the employee.

PLEASE SEE THAT ALL SECTIONS ARE FULLY COMPLETED AND SIGNED.
FORWARD THE COMPLETED APPLICATION TO

DISABILITY CLAIM OFFICE
300 Southborough Drive, Suite 200
South Portland, ME 04106-6914
Fax: 207.766.3448

TOLL FREE: 1.888.305.0590
E-MAIL: Claims@DisabilityRMS.com

APPLICATION FOR SHORT TERM DISABILITY INCOME BENEFITS

KANSAS CITY LIFE INSURANCE COMPANY

Section I

Employer's Statement

To Be Completed by the Employer

This claim is for *(Employee's Name)*	Social Security Number	Date of Birth

Employee's Address *(Street, City, State, Zip)*

A. Information About the Employer

Company's Name	Group Policy Number

Address *(Street, City, State, Zip)*

Name and Address of Division Where Employee Works *(if different from above)*

B. Information About the Employee

Date employee was hired _____

Date employee became insured under this plan _____

What was the employee's regularly scheduled work week?

Hours per Week _____

Scheduled workdays M - F _____ Other _____

IS EMPLOYEE ENROLLED IN KANSAS CITY LIFE LONG TERM DISABILITY PLAN ? ☐ **YES** ☐ **NO**

IF "YES," EFFECTIVE DATE _____

Was the employee's STD insurance issued on the basis of a Personal Health Statement? ☐ Yes ☐ No If "Yes," attach copy.

Was the employee insured under your prior STD policy? ☐ Yes ☐ No

If "Yes," please provide the inclusive date of coverage. From _____ Through _____

Was the employee on Qualifed Family Leave when disability began? ☐ Yes ☐ No

Did STD & LTD insurance continue while on Family Leave? ☐ Yes ☐ No

Date Leave of Absence started under Family Leave Act _____

C. Information Needed for Withholding and Reporting Taxes

Based on the employer/employee premium contributions made over the last 3 years, what percentage of the STD _____ %

LTD _____ % benefit is considered taxable? *(See Section 7 of IRS Publication 15-A for information on determining the taxable percentage.)*

D. Information About the Claim

What was the employee's permanent job on his or her last day at work? ***(Please attach a copy of the employee's job description.)***

Last day employee actually worked

On that day, did the employee work a full day?

☐ Yes ☐ No If "No," how many hours were worked? _____

Why did employee stop working?

Is the employee's condition work related?

☐ Yes ☐ No

Has a claim been filed with Workers' Compensation?

☐ Yes ☐ No

If "Yes," send initial report of illness or injury or award notice.

Date employee is expected/did return to work? _____

Full time ? ☐ Yes ☐ No

E. Information About Salary

Employee's weekly/hourly rate of pay $ _____

Is employee receiving Salary Continuance or Sick Leave? ☐ Yes ☐ No

Weekly Amount $ _____ Date Payments Start _____ Date Payments Will End _____

Will/Is Employee receive(ing) Workers' Compensation Payments? ☐ Yes ☐ No

Weekly Amount $ _____ Date Payments Start _____ Date Payments Will End _____

F. Information About the Physical Aspects of the Employee's Job

Check the items below that relate to the employee's job and complete the information requested. Use these definitions for the frequency of occurrence.

Not Applicable means the person does not perform this activity.
Occasionally means the person does the activity up to 33% of the time.
Frequently means the person does the activity 34% to 66% of the time.
Continuously means the person does the activity 67% to 100% of the time.

Activity	Frequency of Occurrence			
	N/A	Occasionally	Frequently	Continuously
☐ Standing	☐	☐	☐	☐
☐ Walking	☐	☐	☐	☐
☐ Sitting	☐	☐	☐	☐
☐ Balancing	☐	☐	☐	☐
☐ Stooping	☐	☐	☐	☐
☐ Kneeling	☐	☐	☐	☐
☐ Crouching	☐	☐	☐	☐
☐ Crawling	☐	☐	☐	☐
☐ Reaching/Working Overhead	☐	☐	☐	☐
☐ Keyboard Use/Repetitive Hand Motion	☐	☐	☐	☐
☐ Climbing	☐	☐	☐	☐

Activity	Description	Frequency	Weight
☐ Pushing	_____	_____	_____ **lbs.**
☐ Pulling	_____	_____	_____ **lbs.**
☐ Lifting	_____	_____	_____ **lbs.**
☐ Carrying	_____	_____	_____ **lbs.**

Can the job be performed by alternating sitting and standing? ☐ Yes ☐ No

What are the major tasks requiring the use of one or both hands? Indicate the percentage of the employee's workday that is spent on each of these tasks.

_____ _____ %
_____ _____ %
_____ _____ %

G. Information About the Job as it Relates to the Disability

Can the job be modified to accommodate the disability either temporarily or permanently? ☐ Yes ☐ No If "Yes," explain.

Is it possible to offer the employee assistance in doing the job *(e.g., through the use of technology or personal assistance)*? ☐ Yes ☐ No If "Yes," explain.

H. Signature

_____ _____
Name (Please print or type) *Title*

_____ _____
Signature *Date*

( ) _____ ( ) _____
Area Code *Telephone Number* *Area Code* *Fax Number*

APPLICATION FOR GROUP DISABILITY INCOME BENEFITS

KANSAS CITY LIFE INSURANCE COMPANY

Employee's Statement

To Be Completed by the Employee (**BE SURE TO ANSWER ALL QUESTIONS — FAILURE TO DO SO MAY DELAY YOUR CLAIM**)

A. Information About You

Last name | First | Middle Initial | Social Security Number

Address *(Street)* | City | State/Province | Zip

Telephone Number ( ) Area Code | Date of Birth *(Month, Day, Year)* | ☐ Male ☐ Female | ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Your Employer *(include division, if applicable)*

B. For an Injury, answer the following questions

When *(i.e., date/time)*, where and how did the injury occur?

C. For Illness, Injury or Pregnancy, answer the following questions

Date you were first treated by a physician

(Month) (Day) (Year)

Name of Physician

Address of Physician

Telephone Number ( )

Before you stopped working, did your condition require you to change your job, or the way you did your job? ☐ Yes ☐ No
If "Yes," explain.

What aspect of your condition made you unable to work?

Are you receiving or eligible for ☐ Workers' Compensation ☐ State Disability ☐ No Fault Disability ☐ Other

If "Yes," show policy number and name and address of insurer

Weekly Amount $ Date Payments Start Date Payments Will End

Is your condition related to your occupation? ☐ Yes ☐ No If "Yes," explain.

Have you filed, or do you intend to file a Workers' Compensation claim? ☐ Yes ☐ No If "No," explain.

D. Information About the Disability

Last day you worked before the disability

(Month (Day) (Year)

Did you work a full day? ☐ Y es ☐ No
If "No," explain.

Date you were first unable to work

(Month (Day) (Year)

Since that date, have you done any work? ☐ Yes ☐ No
If "Yes," please indicate dates worked, name of employer and amount earned.

If you have not returned to work, do you expect to?
☐ Yes Part time *(date)* Full time *(date)*
☐ No

E. Information About Tax Withholding

Federal law requires us to withhold federal income tax from your check ***if you request us to do so.*** We are also required to send a report to your employer at the end of each calendar year showing your name, total amount of benefits paid to you, total amount withheld, if any, and your social security number. If you want us to withhold tax, please indicate on the line below the dollar amount to be withheld per benefit check. Whole dollars only (minimum is $20.00 per week): $ .00.

F. Signature

With the exception of any source(s) of income reported above in Section D of this form, I certify by my signature that I have not and am not eligible to receive any source of income, except for my Kansas City Life Disability Income. Further, I understand that should I receive income of any kind or perform work of any kind during any period Kansas City Life has approved my disability claim, I must report all details to Kansas City Life, immediately.

If I receive disability benefits greater than those which should have been paid, I understand that I will be required to provide a lump sum repayment to the insurance company. The insurance company has the option to reduce or eliminate future disability payments in order to recover any overpayment balance that is not reimbursed.

For residents of all states *EXCEPT* California, Florida, New Jersey, Colorado, Pennsylvania, Arkansas, New Mexico, Louisiana, Oregon, and Virginia: A person commits a fraudulent insurance act if that person knowingly, and with intent to defraud any insurance company or other person, either: (a) files an application for insurance or statement of claim containing any materially false information, or (b) conceals information concerning any material fact in order to obtain an insurance policy or a benefit under an insurance policy. **A fraudulent insurance act is a crime.** Kansas City Life shall pursue prosecution of any fraudulent insurance act to the fullest extent of the law.

For residents of Florida: 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.

For residents of New Jersey, Arkansas, New Mexico, and Louisiana: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties. Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

For residents of Colorado: It is unlawful to knowingly provide false, incomplete, or misleading 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 its agent who knowingly provides false, incomplete, or misleading information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to an insurance settlement or award shall be reported to the Colorado Division of Insurance.

For residents of Pennsylvania: 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 a person to criminal and civil penalties.

For residents of California: For your protection, California law requires the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

The statements contained in this form are true and complete to the best of my knowledge and belief.

X _____ **X** _____

SIGNATURE OF THE EMPLOYEE ***DATE***

AUTHORIZATION FOR RELEASE OF INFORMATION (excluding psychotherapy notes)
(HIPAA COMPLIANT)
(to be signed and dated by the insured/claimant)

I authorize any licensed physician, any other medical practitioner or provider, pharmacist, pharmacy benefits manager, hospital, clinic, other medical or medically related facility, federal, state or local government agency including the Social Security Administration, insurance or reinsuring company, consumer reporting agency or employer having information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment of me, and any non-medical information about me, (including any information, data or records regarding my Social Security, FICA earnings history, Worker's Compensation, State Disability, pension, credit, earnings and employment history) to give any and all such information to authorized representatives of Kansas City Life Insurance Company *excluding psychotherapy notes*, and including, but not limited to, any other mental or psychiatric records, medical, dental, hospital and pharmacy records (including psychiatric, alcohol, and drug abuse, and **HIV/AIDS*** information) which may have been acquired in the course of examination or treatment. I understand the information obtained by use of this authorization will be used by Kansas City Life Insurance Company and the above-described representatives to evaluate and adjudicate my current disability claim. The information may be re-disclosed to: (a) any medical, investigative, financial or vocational specialist or entity, or any other organization or person, employed by or representing Kansas City Life Insurance Company, to assist with the evaluation and adjudication of my current disability claim, (b) a Social Security vendor that may assist me in filing a claim with the Social Security Administration, and (c) other insurance companies or their representatives to help investigate and adjudicate other insurance claims related to me. I understand Kansas City Life Insurance Company and the above-described representatives may release information to my treating physicians and current or prospective employers relating to restrictions, accommodations and possible return to work. I understand the information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by HIPAA's Privacy rules, or any other federal or state law.

This authorization is valid for two (2) years following the date of my signature. A photocopy of this authorization is as valid as the original. I understand my authorized representative or I have the right to request and receive a copy of this authorization and the information to which it pertains.

I understand I have the right to revoke this authorization by notifying Kansas City Life Insurance Company in writing, of my revocation. However, such revocation is not effective to the extent Kansas City Life Insurance Company has relied previously upon this authorization for the use or disclosure of my protected health information. I understand Kansas City Life Insurance Company cannot condition the payment of a claim on my signing this authorization. However, I understand my revocation of, or my failure to sign this authorization may impair Kansas City Life Insurance Company's ability to evaluate my current disability claim and as a result lack of required information may be a basis for denying that current disability claim for benefits.

*If you reside in **California:** this authorization excludes the release of Human Immunodeficiency Virus (HIV) and Autoimmune Deficiency Disorder (AIDS) information and test results. Separate authorizations signed by the insured claimant, or employee-claimant (for self-insured business) are required each time results are released.

If you reside in **Connecticut, Maine, or Massachusetts: this authorization excludes the release of information about Human Immunodeficiency Virus (HIV) and Autoimmune Deficiency Disorder (AIDS). A separate authorization signed by the insured claimant, or employee-claimant (for self-insured business) are required each time results are released.

***If you reside in **Vermont:** this authorization EXCLUDES the release of any information about previously administered HIV-related tests, including but not limited to tests for HIV antibodies, T-Cell counts, AIDS or ARC. The proposed insured is NOT AUTHORIZING Kansas City Life Insurance Company to forward the results from any new test, requested by us, to any outside, non-affiliated company or entity not under specific contract with us to perform underwriting services, and Kansas City Life Insurance Company shall comply, as applicable with the provisions of Title 8, Section 4724 (20) of the Vermont Statutes.

Claimant Name:_____ Date of Birth:_____

Claimant Signature (or Authorized Representative): _____
Date: _____

Description of Personal Representative's Authority (If applicable):
(*If signed by authorized representative, attach verification of identity)

Attending Physician's Statement

HISTORY

Patient's Name _____ SSN _____ D.O.B. _____ Height _____ Weight _____

Patient's condition is the result of ☐ Illness ☐ Injury ☐ Pregnancy ☐ Mental/Nervous Condition

If pregnancy, what is the expected date of delivery? Month _____ Day _____ Year _____ LMP Date _____

Is condition due to an illness or an injury that is work related? ☐ Yes ☐ No

DIAGNOSIS

Diagnosis *(including any complications)* _____

ICD9 Codes _____

Subjective Symptoms _____

Physical Findings *(list all test results, or enclose test)*

Test _____ Date _____ Results _____

Test _____ Date _____ Results _____

Blood Pressure (Systolic) _____ (Diastolic) _____ (Date) _____

Remarks: _____

TREATMENT

Date of onset of this condition? _____ List all dates of treatment for this condition since patient ceased work _____

_____ Date of next office visit _____

Has patient been referred to any other physician? ☐ Yes ☐ No Date(s) _____

If "Yes," name and address _____ Specialty _____

Nature of treatment for this condition *(including surgery/medications)* _____

_____

Was patient hospitalized for this condition? ☐ Yes ☐ No If "Yes," date(s) admitted _____ date(s) discharged _____

Name and Address of Hospital(s) _____

Was surgery performed? ☐ Yes ☐ No If "Yes," Date _____ Procedure _____ CPT Code _____

Progress *(please check one)* ☐ Recovered ☐ Improved ☐ Unchanged ☐ Retrogressed

IMPAIRMENT

What are the patient's current physical limitations and restrictions?

☐ No limitation of functional capacity; capable of heavy work, no restrictions.
(Lifting 100 lbs. maximum with frequent lifting and/or carrying objects weighing up to 50 lbs.)

☐ Medium manual activity
Lifting 50 lbs. maximum with frequent lifting and/or carrying of objects weighing up to 25 lbs.)

☐ Slight limitation of functional capacity; capable of light work
Lifting 20 lbs. maximum with frequent lifting and/or carrying of objects weighing up to 10 lbs. Even though the weight lifted may be only a negligible amount, a job is in this category when it involves sitting most of the time with a degree of pushing and pulling of arm and/or leg controls, or when it requires walking or standing to a significant degree.)

☐ Moderate limitation of functional capacity; capable of clerical/administrative (sedentary) activity
(Lifting 10 lbs. maximum and occasionally lifting and/or carrying articles. Although a sedentary job is defined as one which involves sitting, a certain amount of walking and standing is often necessary in carrying out job duties.)

☐ Severe limitation of functional capacity; incapable of minimal (sedentary) activity

What is the psychiatric impairment *(if applicable)*?

☐ Inadequate information to make assessment.
☐ Essentially good functioning in all areas. Occupationally and socially effective.
☐ Slight difficulty in occupational functioning, but generally functioning well. Has some meaningful interpersonal relationships.
☐ Moderate impairment in occupational functioning. Limited in performing some occupational duties.
☐ Major impairment in several areas--work, family relations. Avoidant behavior, neglects family, is unable to work.
☐ Inability to function in almost all areas.

Date patient ceased work due to this impairment: _____ *(Month)* _____ *(Day)* _____ *(Year)*

If physical or psychiatric limitations exist, indicate the date limitations have lasted, or will last through: _____ *(Month)* _____ *(Day)* _____ *(Year)*

Attending Physician's Name _____ Telephone #: ( ) _____ *Area Code* Fax # ( ) _____ *Area Code*

SS# or E.I.N. # _____ Degree _____ Specialty _____

Street Address _____ City _____ State _____ Zip Code _____

Signature _____ Date Signed _____