K·C·L GROUP BENEFITS

Group Number _____

Policyholder _____

Health Statement

Kansas City Life Insurance Company

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 HIV positive?	☐	☐	
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. "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 _____ (City, State) this _____ (Day) day of _____ (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: