KANSAS CITY LIFE INSURANCE COMPANY — Group Insurance Enrollment Card

1. Last Name of Applicant	First Name	Middle Initial	2. Social Security Number

3. Home Address Street			4. Name of Employer		5. Loc/Div	FILLED BY EMPLOYER
6. City	State	Zip Code	7. Full-time Employment Date	8. Rehire Date	9. Earnings from Employer	
10. ☐ Male ☐ Female	11. ☐ Single ☐ Married	12. Date of Birth (M,D,Y)	13. Occupation or Position	14. Coverage Class	15. No hours per week worked for employer	

If you are declining coverage(s), complete the Declination of Coverage section below. To apply for coverage(s), complete the following section and sign below. Indicate only those products available through your employer.

16. Coverage(s) for Applicant			17. Coverage(s) for Dependents (Applicant Coverage Required)		
				Dental	Vision
☐ Life and AD&D	☐ STD	☐ Vision	☐ Dep Life	☐ Spouse	☐ Spouse
☐ Supp Life Amount: $_____	☐ LTD	☐ Vol AD&D Principal Sum: $_____	☐ Vol AD&D	☐ Child/ren	☐ Child/ren
	☐ Dental				

18. Full Name of Primary Beneficiary (For Life and AD&D)	19. Relationship
20. Full Name of Contingent Beneficiary (For Life and AD&D)	21. Relationship

If two or more primary beneficiaries are named, the proceeds payable at death will be paid equally to the named beneficiaries surviving the Insured. If unequal distribution percentages are desired, a beneficiary change form will need to be completed.
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.

22. FOR DENTAL AND/OR VISION COVERAGE: List Each Dependent You Wish to Insure.

Name (Show last name if different)	Sex	Relationship	Date of Birth	Social Security No.
Spouse		——		
1. Child				
2. Child				
3. Child				
4. Child				
5. Child				

23. If COBRA continuee please give:
Qualifying Event_____
Date of Event_____

25. Spouse's Employer:_____
Spouse's Dental Carrier:

24. SIGNATURE OF APPLICANT – To decline any coverages complete "Declination of Coverage" on page 2 of this form.

_____

Date _____
M/D/Y *PROVISIONS BELOW ACCEPTED

DO NOT FILL IN BELOW THIS LINE

Group No._____

Location/Division _____

Certificate # _____

Effective Dates	MO DAY YR	Class	Coverage Amounts
Life and AD&D			
Dep Life			
Supp Life and AD&D			
STD			
LTD			
Dental			
Vision			
Vol AD&D			

PROVISIONS OF COVERAGE

*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 that any disability indemnity coverage in force and applied for, with respect to myself, is less than 100% of my earnings.

*I further represent that I am not presently disabled and I am performing all the duties of my occupation at least the number of hours shown above.

*Any person who submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud if there is intent to defraud or knowledge that fraud is being facilitated.

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

DECLINATION OF COVERAGE

TO REFUSE COVERAGE(S) for which you are required to pay a portion of the premium, complete the following section:

26. Last Name of Applicant First Name	27. Name of Employer	28. Group No.

29. Indicate Coverage(s) Declined Below:

Coverage(s) for Applicant	30. Coverage(s) for Dependents (Applicant Coverage Required)
☐ Life and AD&D ☐ Supp Life ☐ Vision ☐ STD ☐ LTD ☐ Dental ☐ Vol AD&D	☐ Dep Life ☐ Vol AD&D Dental ☐ Spouse ☐ Child/ren Vision ☐ Spouse ☐ Child/ren

31. REASON FOR REFUSING COVERAGE:

32. IF REFUSING DENTAL DUE TO SPOUSE'S GROUP INSURANCE PLAN, PLEASE INDICATE SPOUSE'S NAME, BIRTHDATE, EMPLOYER, AND INSURANCE COMPANY:

33. I have been given an opportunity to participate in the group insurance plan offered by my employer. I am refusing the coverages 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 dependents desire to participate at a later date, coverage(s) may be limited and proof of insurability may be required at my own expense.

Dated this _____ day of _____ , year of _____.

_____
Signature of Applicant