K·C·L GROUP BENEFITS

GRP # _____

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

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]

Not Applicable

[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				/ /

Not Applicable

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.

The falsity of any statement in this application shall not bar the right to recovery under the policy unless such false statement was made with actual intent to deceive or unless it materially affected either the acceptance of the risk or the hazard assumed by the Company.

[23]. Signature of Employee: _____ Date: _____

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

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: _____