KANSAS CITY LIFE
GROUP BENEFITS

GRP # _____

Kansas City Life Insurance Company

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. Home Address, City, State and Zip

12. Social Security Number	13. ☐Male ☐Female	14. Date of Birth (M/D/Y)	15. ☐Single ☐Married

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

16. Coverage(s) for Employee:	17. Coverage(s) for Dependents (Employee coverage required)
☐Basic Life & AD&D ☐ Voluntary/Supplemental Life Amount: _____	☐Dependent Life
☐Dental If Applicable: ☐Low Plan ☐High Plan	☐Spouse* Voluntary/Supplemental Life Amount:_____
☐Short-Term Disability ☐ Voluntary STD If Applicable: Amount: _____	☐Child/ren Voluntary/Supplemental Life Amount:_____
☐Long-Term Disability ☐ Voluntary LTD If Applicable: Amount: _____	Dental: ☐Spouse* ☐Child/ren
☐Vision	Vision: ☐Spouse* ☐Child/ren

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

19. Full Name of Primary Beneficiary and Relationship to you (applicable to life insurance only):

20. Full Name of Contingent Beneficiary and Relationship to you (applicable to life insurance only):

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

21. Name (show last name if different from employee)		Gender	Relationship	Date of Birth	Other Dental Coverage	
Spouse*			N/A		Y	N
Child					Y	N
Child					Y	N
Child					Y	N
Child					Y	N

By signing below, I acknowledge I have read and I agree to the terms of the Provisions of Coverage contained on the reverse side of this Enrollment Form.

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

***References to Spouse include persons in a civil union partnership (To decline any coverages, complete "Declination of Coverage" on page 2.)**

PLEASE DO NOT FILL IN SHADED AREA BELOW – HOME OFFICE USE ONLY

Group No. _____
Loc/Div _____
Cert. # _____

___Approved as requested
___Approved with changes
Employee _____
Spouse* _____
Child/ren _____

By: _____
Date: _____

	Effective Date (M/D/Y)	Class	Coverage Amount
Basic Life& AD&D			
Basic Dep. Life			
Vol/Supp Life EE			
Vol/Supp Life SP			
Vol/Supp Life Child			
STD			
LTD			
Dental			
Vision			

*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 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 column 5.
- 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 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.

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 ___Voluntary/Supplemental Life
___Dental ___Voluntary STD
___Short-Term Disability ___Voluntary LTD
___Long-Term Disability ___Vision

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

Life: ___Spouse* ___Child/ren
Dental: ___Spouse* ___Child/ren
Vision: ___Spouse* ___Child/ren

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:_____

If requested to do so by Kansas City Life Insurance Company, please complete the following items.

Name of Employee:	Age	Gender	Height	Weight	Weight change in last year (gain/loss)
Name of Spouse* of Employee (if applicable):	Age	Gender	Height	Weight	Weight change in last year (gain/loss)

During the past five years, have you (or anyone proposed for coverage) been diagnosed or treated by a member of the medical profession for any of the following: heart condition (including high blood pressure)*; cancer or tumor; chronic/recurrent respiratory disease; diabetes; kidney or liver disease; arthritis or any other disease of the joints, including neck and back disorders; any mental, emotional or nervous disorder; any disorder of the brain, nervous, digestive or reproductive system; muscle or connective tissue disorder; alcohol or drug abuse; or Acquired Immune Deficiency Syndrome (AIDS) or AIDS-Related Complex (ARC)?

Employee: ☐Yes ☐No Spouse* (life coverage only): ☐Yes ☐No

During the past five years, have you been declined coverage for any life or disability insurance?

Employee: ☐Yes ☐No Spouse* (life coverage only): ☐Yes ☐No

For female, disability applicants only: Are you currently pregnant? ☐Yes ☐No

Please supply full details to "Yes" answers. List date(s) of onset, last occurrence, types of treatment including medication. *For high blood pressure, give date and last reading. If you require additional space, please attach separate sheet.

***References to Spouse include persons in a civil union partnership**

I(we) authorize the following to give information (defined below) to Kansas City Life Insurance Company or any person or group acting on the part of Kansas City Life Insurance Company: 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 regarding my 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 Insurance Company to determine eligibility for insurance. I(we) agree this Authorization is valid for two 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.

I hereby represent that the above answers are complete and true to the best of my knowledge and belief concerning the past and present state of health and medical history of the person(s) to whom the answers relate. I agree that this document and all its contents shall form a part of my enrollment request for group benefits.

The policy provides limited benefits. Review your policy carefully.

Signature of Employee: _____ Date:_____

Signature of Spouse*: _____ Date:_____