K·C·L GROUP BENEFITS

Application for Group Insurance

Dental Insurance, Vision Insurance

Kansas City Life Insurance Company

1. Legal Name of Applicant (Policyholder)	2. Federal Tax I.D. No.

3. Nature of Business | Standard Industrial Classification (SIC) Code | Three Digit Plan No.

4. Street Address | City | State | Zip

5. Name of Subsidiaries, Divisions or Affiliates to be Covered

6. Name and Title of Plan Administrator (Corporate Officer) | Phone No.

7. Name and Title of Correspondent (Routine Accounting Matters) | Phone No.

8. Billing Address(es) - If Different From Street Address

9. Service of Legal Process Agent (If Different From Plan Administrator) | Phone No.

10. Street Address | City | State | Zip

11. Proposed Effective Date of Insurance	12. Advance Payment of $ _____ is submitted with this application to be applied by the Company on premiums for insurance when and if issued.

13. If the insurance applied for replaces, or is in addition to, any similar group or wholesale insurance now or previously in force, provide:

Carrier	Type of Coverage	Date to be Discontinued
_____	_____	_____

For dental insurance, this application must be accompanied by a copy of an in force certificate and benefit schedule, a current month's billing from the current carrier, as well as, proof of the effective date for each employee (and dependents, if insured).

Eligibility

14. Eligible Classes:

☐ All Full-Time Employees

☐ Other* _____

15. Are any individuals currently disabled? ☐ Yes ☐ No

If yes, provide:

Full Name	Social Security Number
_____	_____

16. Probationary Waiting Period:

Current Individuals _____

New Individuals _____

Coverage to be effective the first of the month following completion of probationary waiting period? ☐ Yes ☐ No

17. Are any former employees and/or dependents currently on continuation coverage provided by the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985?

☐ Yes ☐ No

If yes, list names of the enrollees, qualifying event and date of event on a separate sheet.

Coverage Applied For and Premium Contributions

18. Coverage applied for:

☐ Dental Insurance as quoted, proposal of _____, _____, Plan _____

☐ Vision Insurance as quoted, proposal of _____, _____, Plan _____

(Please attach copy of the proposal)

Percentage of Employer Contribution*

Dental Insurance: Employee _____% Dependents _____%

Vision Insurance: Employee _____% Dependents _____%

*An employer may limit eligibility to one or more classes of employees provided the employer pays 100% of both employee and dependent coverage.

Verification of Eligibility and Enrollment

19. Participation requirements are a condition of coverage. Statements may be used to contest a claim or the validity of the policy only if they are contained in the application. See the policy for further information. Please complete the following section to verify eligibility and enrollment.

		Dental Insurance	Vision Insurance
1.	Total number of employees on the payroll.		
2.	Total number of part-time employees including temporary or seasonal employees. (Employees working less than your group's definition of full-time; minimum of 30 hours per week.)		
3.	Total number of employees who have not completed the probationary waiting period.		
4.	Number of full-time employees (subtract #2 and #3 from #1).		

If the employer pays 100% of the employee's cost, skip to number 8 below.

5.	Are there other dental plans to be offered concurrently with your Kansas City Life group dental plan? ☐ Yes ☐ No If yes, how many employees are enrolled in your other dental plans?		Not applicable
6.	Total number of employees who have waived because they are covered by their spouse's plan.		Not applicable
7.	Number of eligible employees.	(subtract #5 and #6 from #4)	(same as #4)
8.	Number of enrolled employees.		
9.	Number of COBRA participants.		

Agreement and Signatures

20.

It is understood and agreed as follows:

1. No coverage is effective until approved by Kansas City Life Insurance Company at its Home Office in Kansas City, Missouri.
2. Insurance will be effective with regard to those individuals listed above in the Eligibility Section, on the latest of the following dates: (a) the effective date approved by the Company; (b) the date this application is signed; or (c) the date the first premium is paid in full.
3. No agent has the authority to waive any of the Company's rights or requirements, or to make or alter any contract or policy.
4. 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.

Dated at_____ this _____ day of _____, year of_____
City, State

Signature of Writing Agent — Agent Code

Officer's Signature

Agent's Name and State License ID No. - SSN (Please Print)

Please Print Name

Signature of Other Agent(s) — Agent Code

Title

Agent(s) Business Address — City — State — Zip

Agency — Agency Code

K·C·L GROUP BENEFITS

Kansas City Life Insurance Company

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. Home Address		12. 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:	18. 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]

[19. If COBRA continuee, please supply qualifying event and date:]

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

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

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

22. 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.

23. Signature of Employee:_____ Date:_____

(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.

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.

Signature of Employee: _____ Date:_____

Signature of Spouse: _____ Date:_____

KANSAS CITY LIFE
INSURANCE COMPANY

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 50 Braintree Hill Park, Suite 400, Braintree MA 02112. Telephone (617) 426-3660.

Kansas City Life, or its reinsurers, may also release information from its file to other insurance companies to who you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com .

As _____ representative, I verify that all employees were provided an opportunity to enroll in the coverage(s) offered by Kansas City Life Insurance Co. as of the proposed effective date.

Current employees who did not complete an enrollment card understand that coverage is considered to be waived by KCL. It is also understood that any employee who did not enroll when first eligible, wishing to enroll for coverage at a later date, must submit evidence of insurability and late applicant provisions may apply.

List Names Here

The above list of employees is accurate and complete to the best of my knowledge.

_____ _____

Date Signature of employer representative