**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 |
|---|---|---|
| | | |

| **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 |
|---|---|---|---|---|---|
| | | | | | |

**FILLED BY EMPLOYER**

**If you are declining coverage(s), turn to the back of this card and complete the Declination of Coverage section. 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

☐ Life and AD&D ☐ WDI ☐ Vision
☐ Supp Life ☐ LTD ☐ Vol AD&D
Amount: $______________ ☐ Dental Principal Sum: $___________

**17.** Coverage(s) for Dependents (Applicant Coverage Required)

☐ Dep Life
☐ Vol AD&D

**Dental** ☐ Spouse ☐ Child/ren

**Vision** ☐ Spouse ☐ Child/ren

| **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 reverse.

______________________________________________

Date _______________
M/D/Y

***PROVISIONS ON REVERSE SIDE 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 | | | |
| WDI | | | |
| 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 on the front of this card.

*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 | ☐ WDI | ☐ Vol AD&D | ☐ Dep Life | Dental | Vision |
| ☐ Supp Life | ☐ LTD | | ☐ Vol AD&D | ☐ Spouse | ☐ Spouse |
| ☐ Vision | ☐ Dental | | | ☐ Child/ren | ☐ 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.

**To Decline coverage, both copies of this form must be signed.**

Dated this ____________ day of __________________ , year of ____ . ______________________________

Signature of Applicant



**White copy - KCL** **Yellow copy - Applicant**