

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. <input type="checkbox"/> Male <input type="checkbox"/> Female	11. <input type="checkbox"/> Single <input type="checkbox"/> 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			17. Coverage(s) for Dependents (Applicant Coverage Required)		
<input type="checkbox"/> Life and AD&D	<input type="checkbox"/> WDI	<input type="checkbox"/> Vision	<input type="checkbox"/> Dep Life	Dental	Vision
<input type="checkbox"/> Supp Life	<input type="checkbox"/> LTD	<input type="checkbox"/> Vol AD&D	<input type="checkbox"/> Vol AD&D	<input type="checkbox"/> Spouse	<input type="checkbox"/> Spouse
Amount: \$ _____		<input type="checkbox"/> Dental	Principal Sum: \$ _____		
<input type="checkbox"/> Child/ren			<input type="checkbox"/> 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. _____	Effective Dates	MO	DAY	YR	Class	Coverage Amounts
Location/Division _____	Life and AD&D	_____	_____	_____	_____	_____
Certificate # _____	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 knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

*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.
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29. Indicate Coverage(s) Declined Below:		
Coverage(s) for Applicant		30. Coverage(s) for Dependents (Applicant Coverage Required)
<input type="checkbox"/> Life and AD&D	<input type="checkbox"/> WDI	<input type="checkbox"/> Vol AD&D
<input type="checkbox"/> Supp Life	<input type="checkbox"/> LTD	<input type="checkbox"/> Dep Life Dental Vision
<input type="checkbox"/> Vision	<input type="checkbox"/> Dental	<input type="checkbox"/> Vol AD&D <input type="checkbox"/> Spouse <input type="checkbox"/> Spouse
		<input type="checkbox"/> Child/ren <input type="checkbox"/> 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