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## Verification of Eligibility

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20. Participation requirements are a condition of coverage. These requirements will vary depending upon the plan selected. Please complete the following section to verify eligibility. Statements may be used to contest a claim or the validity of this policy only if they are contained in the application. See the policy for further information.

1. Total number of employees on the payroll. \_\_\_\_\_
2. Total number of employees working 1-29 hours per week (include temporary or seasonal employees). \_\_\_\_\_
3. Total number of employees who have not completed probationary waiting period. \_\_\_\_\_
4. Number of full time employees (subtract #2 and #3 from #1). \_\_\_\_\_

If you have purchased an employee paid voluntary group dental product, participation percentages are always calculated from the number of full time employees (#4). No waivers for coverage under another program are allowed in calculating participation for voluntary dental programs.

For employer paid group coverage, (with rates calculated from a census) #5 and #6 below may be subtracted from the total number of full time employees (#4). Participation requirements will be calculated from that number. In no case will coverage be provided for an employer paid group with waivers for more than 50% of the full time employees (#4).

5. Total number of employees enrolled in a DMO or HMO with dental. (Proof must be submitted). \_\_\_\_\_
6. Total number of employees who are covered under their spouse's plan. (An enrollment card with a signed waiver indicating spouse's carrier must be submitted.) \_\_\_\_\_
7. Number of eligible employees. (subtract #5 and #6 from #4.) Must be at least 50% of #4 or group is not eligible. \_\_\_\_\_

**No waivers for coverage under another program are allowed in calculating participation on employee paid voluntary dental programs. Participation percentages for voluntary dental programs are always calculated from the number of full time employees (#4).**

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## Agreement and Signatures

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**21. 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; and (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 \_\_\_\_\_, 19\_\_\_\_.  
City, State

Signature of Writing Agent	Agent Code	Applicant's Signature
Signature of Other Agent(s)	Agent Code	Type or Print Name
Type or Print Agent(s) name(s)		Title
Agent(s) Business Address	City	State
Zip	Agency	Agency Code

GA127



**KANSAS CITY LIFE  
INSURANCE COMPANY**

Broadway at Armour/P O Box 219425/Kansas City MO 64121-9425