Kansas City Life Insurance Company

K·C·L GROUP BENEFITS

Group Life Application for Portability

To apply you must return this form and your check to:
Kansas City Life Insurance Company, Group Administration VLP
P.O. Box 219425, Kansas City, MO 64121-9425
For questions, call: 877-266-6767, ext. 8302

1. Prior Employer Name

2. Name of Applicant (Last, First, MI)	3. Social Security Number	4. Date of Birth	5. ☐ Male ☐ Female

6. Mailing Address (Street/P.O. Box, City, State, Zip)

7. Daytime Phone | Evening Phone | Alternative Phone | E-mail Address

8. Reason for Termination: ☐ Policy Cancellation ☐ Termination of membership in an eligible class ☐ Termination of employment ☐ Termination of the insurance of any class of individuals

9. Date of Termination

10. I, the above applicant, request to continue the following amount of Voluntary Life Insurance:

☐ Applicant $_____ Minimum $20,000 (Increments of $1,000) – Maximum no more than the amount insured on Group Insurance Policy

☐ Spouse $_____ Minimum $10,000 (Increments of $1,000) – Maximum no more than 50% of the Applicant's amount

☐ Child(ren) ☐$2,500 ☐$5,000 ($1,500 for Child(ren) age 7 days to 6 months)

11. Full Name of Primary Beneficiary — Relationship

12. Full Name of Contingent Beneficiary — 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 for the Insured.

13. No agent has the authority to waive any of the Company's rights or requirements, or to make or alter any contract or policy. It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties could include imprisonment and fines, and may result in a denial of insurance benefits.

_____
Applicant Signature — Date

14. If you are a resident of AZ, CA, ID, LA, NV, NM, WA or WI and you name someone other than your spouse as your beneficiary, your spouse also must sign as written consent to the Beneficiary names on this form:

_____
Print Spouse Name — Spouse Signature — Date

FOR HOME OFFICE USE ONLY

Rate:_____ Ported Policy Number: _____ Premium Paid: _____