



KANSAS CITY LIFE

GRP # \_\_\_\_\_

GROUP BENEFITS  
Kansas City Life Insurance Company  
3520 Broadway, Kansas City, MO 64111

### 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) <input type="checkbox"/> Initial enrollment <input type="checkbox"/> Late entrant <input type="checkbox"/> New hire <input type="checkbox"/> Change <input type="checkbox"/> Other _____			

#### COMPLETED BY EMPLOYEE

10. Last Name, First Name, Middle Initial			11. E-mail		
12. Home Address, City, State and Zip					
13. Social Security Number		14. <input type="checkbox"/> Male <input type="checkbox"/> Female	15. Date of Birth (M/D/Y) / /		16. <input type="checkbox"/> Single <input type="checkbox"/> 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 and/or Dependents (Employee coverage required) <input type="checkbox"/> Basic Life & AD&D <input type="checkbox"/> Voluntary Life Amount: _____ <input type="checkbox"/> Dental If Applicable: <input type="checkbox"/> Low Plan <input type="checkbox"/> High Plan <input type="checkbox"/> Short-Term Disability <input type="checkbox"/> Voluntary STD If Applicable: Amount: _____ <input type="checkbox"/> Long-Term Disability <input type="checkbox"/> Voluntary LTD If Applicable: Amount: _____ <input type="checkbox"/> Vision If Applicable: <input type="checkbox"/> Low Plan <input type="checkbox"/> High Plan <input type="checkbox"/> Accident If Applicable: <input type="checkbox"/> Low Plan <input type="checkbox"/> Medium Plan <input type="checkbox"/> High Plan			18. Coverage(s) for Dependents (Employee coverage required) <b>For Dependent Life and/or Voluntary Life, the Spouse must be under age 70 to be eligible for Spouse coverage.</b> <input type="checkbox"/> Dependent Life Spouse Date of Birth (M/D/Y): _____ <input type="checkbox"/> Spouse Voluntary Life Amount: _____ <input type="checkbox"/> Child/ren Voluntary Life Amount: _____ Dental: <input type="checkbox"/> Spouse <input type="checkbox"/> Child/ren Vision: <input type="checkbox"/> Spouse <input type="checkbox"/> Child/ren Accident: <input type="checkbox"/> Spouse <input type="checkbox"/> Child/ren		
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19. If COBRA continuee, please supply qualifying event and date:

20. Full Name of Primary Beneficiary and Relationship to you:		21. Full Name of Contingent Beneficiary and Relationship to you:	
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For Dependent Coverage: List each dependent you wish to insure.

22. Name (show last name if different from employee)	Gender	Relationship	Date of Birth
Spouse		N/A	/ /
Child			/ /
Child			/ /
Child			/ /
Child			/ /

**By signing below, I acknowledge I have read and I agree to the terms of the Provisions of Coverage as follows:**  
 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 box 5.  
 I understand any material misstatement on this enrollment form may result in a denial of a claim and/or discontinuance of coverage, subject to the conditions of the policy.  
 I have made a copy of this application for my records.

**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.**

23. Signature of Employee: \_\_\_\_\_ Date: \_\_\_\_\_

(To decline any coverages, complete "Declination of Coverage" on page 3.)

**NOTICE TO ARIZONA APPLICANTS:**

Any life insurance producer, examining physician or other person who knowingly makes a false or fraudulent statement or representation in or relative to an application for life or disability insurance, or who makes any such statement to obtain a fee, commission, money or benefit is guilty of a class 2 misdemeanor.

**NOTICES TO COLORADO APPLICANTS:**

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

**THIS POLICY DOES NOT INCLUDE COVERAGE OF PEDIATRIC DENTAL SERVICES AS REQUIRED UNDER FEDERAL LAW. COVERAGE OF PEDIATRIC DENTAL SERVICES IS AVAILABLE FOR PURCHASE IN THE STATE OF COLORADO, AND CAN BE PURCHASED AS A STAND-ALONE PLAN, OR AS A COVERED BENEFIT IN ANOTHER HEALTH PLAN. PLEASE CONTACT YOUR INSURANCE CARRIER, AGENT, OR CONNECT FOR HEALTH COLORADO TO PURCHASE EITHER A PLAN THAT INCLUDES PEDIATRIC DENTAL COVERAGE, OR AN EXCHANGE-QUALIFIED STAND-ALONE DENTAL PLAN THAT INCLUDES PEDIATRIC DENTAL COVERAGE.**

**NOTICE TO FLORIDA APPLICANTS:**

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

**NOTICE TO GEORGIA APPLICANTS:**

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 may be subject to fines and confinement in prison.

**NOTICE TO ILLINOIS APPLICANTS:**

**NOTICE TO POLICYHOLDER – ILLINOIS RELIGIOUS FREEDOM PROTECTION AND CIVIL UNION ACT**

The Illinois Department of Insurance requires that we inform you of Kansas City Life Insurance Company's compliance with the Illinois Religious Freedom Protection and Civil Union Act (the Act). The Act provides that the parties to a civil union are entitled to the same legal obligations, responsibilities, protections, and benefits that are afforded or recognized by the laws of Illinois to spouses. Therefore, Kansas City Life Insurance Company will administer both existing and newly issued policies and use processes and systems to ensure that parties to a civil union and a marriage are provided identical benefits, protections, and financial security.

Please contact your agent or the Home Office of Kansas City Life Insurance Company if you have questions regarding this notice

**NOTICE TO KANSAS APPLICANTS:**

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 may be guilty of insurance fraud as determined by a court of law.

**NOTICE TO KENTUCKY APPLICANTS:**

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

**NOTICE TO MAINE, TENNESSEE, AND WASHINGTON APPLICANTS:**

It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

**NOTICE TO MARYLAND APPLICANTS:**

Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**NOTICE TO OKLAHOMA APPLICANTS:**

WARNING: Any person who knowingly, and with intent to injure, defraud, or deceive any insurer makes any claim for the proceeds of an insurance policy containing any false, incomplete, or misleading information is guilty of a felony.

**NOTICE TO OREGON APPLICANTS:**

It may be 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.

**NOTICE TO PENNSYLVANIA APPLICANTS:**

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

**NOTICE TO UTAH APPLICANTS IF DENTAL AND/OR VISION COVERAGE IS APPLIED FOR:**

The policy provides dental / vision benefits only. Review your policy carefully.

**NOTICE TO VIRGINIA APPLICANTS:**

Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated the state law.

**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
- Dental
- Short-Term Disability
- Long-Term Disability
- Accident
- Voluntary/Supplemental Life
- Voluntary STD
- Voluntary LTD
- Vision

Coverage(s) for Dependents (Employee coverage required):

- Life:  Spouse  Children
- Dental:  Spouse  Children
- Vision:  Spouse  Children
- Accident:  Spouse  Children

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: \_\_\_\_\_

**Policyholder** \_\_\_\_\_

Print full names of all to be insured.	Relationship to Primary Insured	Birthdate			Age	Sex	Build			*Weight Change in past year	
		Month	Day	Year			Ft.	In.	Lb.	Gain	Loss
1.											
2.											
3.											
4.											
5.											
6.											

**Questions apply to all Proposed Insureds\***

\*Give **DETAILS** to **Yes** answers. Identify Proposed Insured(s), question, specify conditions, severity, dates, duration, after-effects, weight gain or loss, and names and addresses of all attending physicians and medical facilities.

- |  | Yes                      | No                       |
|--|--------------------------|--------------------------|
| 1. Do you take prescription medicine? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Are you currently pregnant? Due Date? _____   | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Have you ever used or received treatment or counseling for the use of marijuana, heroin, cocaine, amphetamines, barbiturates, hallucinogenic agents or opium or its derivatives? .....              | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Have any of the Proposed Insureds used any form of nicotine/tobacco in the last 12 months? (i.e., cigar, pipe, smokeless tobacco, cigarettes, etc.)<br>If cigarettes, how many packs per day? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Have you sought advice, been treated or arrested for the use of alcohol?  | <input type="checkbox"/> | <input type="checkbox"/> |

During the **last 5 years** have you:

- |  |                          |                          |
|--|--------------------------|--------------------------|
| 6. been hospitalized or had medical advice, diagnostic tests recommended, or treatment by a physician or other medical practitioner? ..... | <input type="checkbox"/> | <input type="checkbox"/> |
|--|--------------------------|--------------------------|

During the **last 10 years** have you been diagnosed or treated for any disease or disorder of:

- |   |                          |                          |
|---|--------------------------|--------------------------|
| 7. brain and nervous system - mental illness, epilepsy, seizures, stroke, paralysis? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. sight or hearing? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. blood - anemia or leukemia? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. tumor or cancer? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. heart/blood vessels - murmur, chest pain or pressure, palpitations, heart attack? ..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. blood pressure? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. thyroid or glandular trouble? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. lungs - asthma, emphysema, tuberculosis? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. digestive system - ulcer, intestines or rectum, polyps, colitis? .....                  | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. liver - elevated enzymes, cirrhosis, hepatitis? .....                                   | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. diabetes - sugar in urine? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. kidney/bladder or prostate - albumin, blood or pus in urine? .....                      | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. bone, joint, muscles, back or spine - arthritis? .....                                  | <input type="checkbox"/> | <input type="checkbox"/> |
| 20. breasts, uterus, ovaries? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 21. menstruation or pregnancy? .....  | <input type="checkbox"/> | <input type="checkbox"/> |

Have you ever been diagnosed or treated for:

- |   |                          |                          |
|---|--------------------------|--------------------------|
| 22. a sexually transmitted disease? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 23. Acquired Immune Deficiency Syndrome (AIDS) or tested HIV positive? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 24. In the <b>past 3 years</b> , have you applied for life or health insurance or reinstatement thereof, without receiving it exactly as requested? ..... | <input type="checkbox"/> | <input type="checkbox"/> |

**Names, addresses and phone numbers of personal or family physicians. (If none, list last physician, clinic or hospital consulted.)**

Date and Reason: \_\_\_\_\_ Clinic or VA last consulted: \_\_\_\_\_

Claim Number: \_\_\_\_\_

## Agreement and Signatures

**It is understood and agreed as follows:**

1. The statements and answers recorded in all parts of this application are true and complete.
2. No information regarding any Proposed Insured(s) will be considered known by the Company unless explicitly set out in writing on this application.
3. This application, and the answers to any required medical exam, will become a part of any insurance issued on it.
4. No agent has the authority to waive any of the Company's rights or rules, or to make or change any contract.
5. I (We) have received the Notice of Information Practices which explains my (our) rights under the Fair Credit Reporting Act.

**AUTHORIZATION:** I (We) authorize the following to give information (defined below) to Kansas City Life or any person or group acting on the part of Kansas City Life: any medical professional, medical care institution, the Medical Information Bureau, Inc., insurer, reinsurer, government agency, consumer reporting agency or employer. I authorize Kansas City Life Insurance Company, or its reinsurers, to make a brief report of my personal health information to MIB. "Information" means facts of: a medical nature in regard to my (our) physical or mental condition; employment; other insurance coverage; or any other non-medical facts.

I (We) understand that this information will be used by Kansas City Life to determine eligibility for insurance. I (We) agree this Authorization is valid for two and one-half years from the date signed.

I (We) know that I (we) have a right to receive a copy of this Authorization upon request.

I (We) agree that a photographic copy of this Authorization is as valid as the original.

Dated at \_\_\_\_\_ this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_.  
(City, State) (Day) (Month) (Year)

\_\_\_\_\_  
**Employee's Signature**

\_\_\_\_\_  
**Spouse's Signature** (if coverage applied for)

**EMPLOYER SECTION:**

**Reason for Submitting Health Statement:**

- |   |  |                                      |
|---|--|--------------------------------------|
| <input type="checkbox"/> Late Applicant | <input type="checkbox"/> Adding Coverage     | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Late Dependent | <input type="checkbox"/> Increasing Coverage | _____                                |

**Coverage Type and Amount Applying For:**

- |   |                                       |
|---|---------------------------------------|
| <input type="checkbox"/> Life \$ _____                | <input type="checkbox"/> WDI \$ _____ |
| <input type="checkbox"/> Supplemental Life \$ _____   | <input type="checkbox"/> LTD \$ _____ |
| <input type="checkbox"/> Dependent Life: Spouse _____ | Child _____                           |

Information Provided By \_\_\_\_\_ Phone # \_\_\_\_\_ Date \_\_\_\_\_

**HOME OFFICE USE ONLY:**

Basic Max. _____	EOI _____
Supp. Max. _____	EOI _____
Combined Max. _____	EOI _____
WDI Max. _____	
LTD Max. _____	
Notes: _____	
_____	
_____	
Amount to be Approved	Basic _____
	Supp. _____
	Total _____

**Underwriting Action:**

- Approved
- Declined
- Withdrawn

UND. _____	Decision Date _____
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Notes: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



KANSAS CITY LIFE

GROUP BENEFITS

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 PO Box 105, Essex Station, Boston, MA 02112. Telephone (617) 426-3660.

We or our reinsurers may also release information in our file to other life insurance companies to whom you apply for life or health insurance, or to whom a claim for benefits may be submitted.