ABACUS SERIES™

Underwritten by KANSAS CITY LIFE INSURANCE COMPANY

Employee Enrollment Form

❑ **New** ❑ **Replacement** ❑ **Change** _____ Certificate #

Group #_____ **Effective Date**_____

1 Last Name		First Name		Middle Initial	Birth Date
2 Age	Male ❑ Female ❑	Height	Weight	Social Security #	Cell/Home Phone
3 Street		City	State	ZIP Code	
4 Employer		Location	Occupation		
5 Salary $	❑ Hourly ❑ Bi-Weekly ❑ Weekly ❑ Monthly ❑ Annually	Weekly Hours Worked	Work Phone/Ext.	Hire Date	
6 Payroll Deduction Frequency: ❑ Weekly ❑ Bi-Weekly ❑ Semi-Monthly ❑ Monthly					

Select coverage with specific amounts for **Life, Short Term Disability (STD)** *and* **Long Term Disability (LTD)**.
Write Benefit Amount *in the appropriate column and indicate if coverage is:* (**N**) New (**I**) Increase (**D**) Decrease

7	Life Amount			STD Amount			LTD Amount		
	N / I / D	Benefit Amount	Premium	N / I / D	Benefit Amount	Premium	N / I / D	Benefit Amount	Premium
Employee		$	$		$ Weekly	$		$ Monthly	$
Spouse		$	$	Benefit Period: _____			Benefit Period: _____		
Child(ren)		$	$	Elimination Period: _____			Elimination Period: _____		

STD and LTD benefit amounts must be in multiples of $25 units (not to exceed maximum benefit).

Life Only.

Questions 8, 9 and 10 pertain to Spouse and Children. Questions 9, 10 and 11 pertain to Employee.

8	Name	Age	Birth Date	Sex	Place of Birth	Height	Weight	Last 4 digits SSN
Spouse								
Child								
Child								

9 Have you or your spouse used tobacco products in the last year? Employee: ❑ Yes ❑ No Spouse: ❑ Yes ❑ No

10 a.) Are all proposed insured employee/spouse/child(ren) actively at work in a job, as a homemaker, or full time student? ❑ Yes ❑ No

b.) Have any proposed insured been hospitalized or disabled in the past 30 days? ❑ Yes ❑ No

11 Beneficiary Name _____ %_____ Relationship_____

Beneficiary Name _____ %_____ Relationship_____

In absence of fraud, my answers in this enrollment form shall be deemed representations and not warranties. If any data has been misstated, the correct data will be used to determine if insurance is in force. If insurance is in force, the premium and/or benefits will be adjusted according to the facts.
I understand that "pre-existing conditions" are generally not covered under the coverage(s) applied for and I should read my Certificate for a more detailed explanation of the pre-existing exclusion.
I understand that other income that I am entitled to receive may affect my coverage and I should read my Certificate for more detailed information regarding the effect other income may have on my benefit.
I certify under penalties of perjury that the portion of the Social Security Number shown on this enrollment form is correct to the best of my knowledge and I am not subject to backup withholding.
The insurance applied for shall be in force as of the date of the payroll deduction authorization signed by me, provided that the company approves the enrollment form without any modification as to the plan, amount or premium, and, further provided that the company receives the first premium payment from my employer within 90 days from the date hereof. If the first premium is not received within 90 days, no insurance will become effective.
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.

12 _____ _____ _____

Signature of Employee | Date | Signed at (City, State)