

KANSAS CITY LIFE INSURANCE COMPANY **Group Insurance Enrollment Card**

1. Last Name of Applicant		First Name	Middle Initial	2. Social Security Number	
3. Home Address			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), complete the Declination of Coverage section below. 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"/> STD	<input type="checkbox"/> Vision	<input type="checkbox"/> Dep Life	Dental <input type="checkbox"/> Spouse	Vision <input type="checkbox"/> Spouse
<input type="checkbox"/> Supp Life	<input type="checkbox"/> LTD	<input type="checkbox"/> Vol AD&D	<input type="checkbox"/> Vol AD&D	<input type="checkbox"/> Child/ren	<input type="checkbox"/> Child/ren
Amount: \$ _____	<input type="checkbox"/> Dental	Principal Sum: \$ _____			

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 _____	24. SIGNATURE OF APPLICANT – To decline any coverages complete "Declination of Coverage" below. _____ Date _____ M/D/Y *PROVISIONS BELOW ACCEPTED
25. Spouse's Employer: _____ Spouse's Dental Carrier: _____	

DO NOT FILL IN BELOW THIS LINE

Group No. _____ Location/Division _____ Certificate # _____	Effective Dates	MO DAY YR	Class	Coverage Amounts
	Life and AD&D			
	Dep Life			
	Supp Life and AD&D			
	STD			
	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.

*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 policy holder or claimant for the purpose of defrauding or attempting to defraud the policy holder 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.

*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 <input type="checkbox"/> Life and AD&D <input type="checkbox"/> STD <input type="checkbox"/> Vol AD&D <input type="checkbox"/> Supp Life <input type="checkbox"/> LTD <input type="checkbox"/> Vision <input type="checkbox"/> Dental	30. Coverage(s) for Dependents (Applicant Coverage Required) <input type="checkbox"/> Dep Life Dental Vision <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.

Dated this _____ day of _____, year of _____.

_____ Signature of Applicant