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 Street	**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. ☐ Male ☐ Female	**11.** ☐ Single ☐ Married	**12.** Date of Birth (M,D,Y)	**13.** Occupation or Position	**14.** Coverage Class	**15.** No hours per week worked for employer

FILED BY EMPLOYER

If you are declining coverage(s), turn to the back of this card and complete the declination of Coverage section. To apply for coverage(s), complete the following and sign below. Indicate only those products available through your employer.

16. Coverage(s) for Applicant			**17.** Coverage (s) for Dependents (Applicant Coverage Required)		
☐ Life and AD&D	☐ WDI	☐ Vision	☐ Dep Life	**Dental**	**Vision**
☐ Supp Life	☐ LTD	☐ Vol AD&D	☐ Vol AD&D	☐ Spouse	☐ Spouse
Amount: $_____	☐ Dental	Principal Sum: $_____		☐ Child/ren	☐ Child/ren

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 dfferent)	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_____

25. Spouse's Employer: _____
Spouse's Dental Carrier:

24. SIGNATURE OF APPLICANT - To decline any coverage complete reverse.

_____

Date _____
M/D/Y

***PROVISIONS ON REVERSE SIDE ACCEPTED**

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					
WDI					
LTD					
Dental					
Vision					
Vol AD&D					

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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.

* 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, comple the following section:

26. Last name of Applicant First Name 27. Name of Employer 28. Group No.

29. Indicate Coverage(s) Declined Below:

Coverage(s) for Applicant			30. Coverage(s) for Dependents (Applicant Coverage Required)		
☐ Life and AD&D	☐ WDI	☐ Vol AD&D	☐ Dep Life	Dental	Vision
☐ Supp Life	☐ LTD		☐ Vol AD&D	☐ Spouse	☐ Spouse
☐ Vision	☐ Dental			☐ Child/ren	☐ 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 AND 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.

To Decline coverage, both copies of this form must be signed.

Dated this _____ day of _____, year of _____. _____

Signature of Applicant

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