Marketed by
North American Benefits Company

Kansas City Life Insurance Company
Dental 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. _ Male _ Female	**10.** _ Single _ Married	**11.** Date of Birth (M,D,Y)	**12.** Occupation or Position	**13.** Coverage Class	**14.** No. of hours per week worked for employer

Shaded Area Filled By Employer

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

15. Coverage(s) for Applicant	**16.** Coverage(s) for Dependents (Applicant Coverage Required)
_ Dental	**Dental** _ Spouse _Child/ren

17. List Each Dependent You Wish to Insure.

Name (Show last name if different)	Sex	Relationship	Date of Birth	Social Security Number
Spouse		-		
1. Child				
2. Child				
3. Child				
4. Child				
5. Child				

18. If COBRA continue please give:
Qualifying Event ___________________
Date of Event ___________________

20. Spouse's Employer: ___________________
Spouse's Dental Carrier:

19. Signature of Applicant – To decline any coverages complete below.

____

Date ____________
M/D/Y *Provisions below accepted.

PROVISIONS OF COVERAGE UNDERWRITTEN BY KANSAS CITY LIFE INSURANCE COMPANY

* 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 am performing all the duties of my occupation at least the number of hours shown on this card.
* Any person who submits an application or files a claim containing false or deceptive statement may be guilty of insurance fraud if there is intent to defraud or knowledge that fraud is being facilitated.
* I understand any material misstatement on this enrollment card may result in a denial of a claim and/or discontinuance of coverage.

DECLINATION OF DENTAL COVERAGE

TO REFUSE COVERAGE(S) for which you are required to pay a portion of the premium, complete the following section.

21. Select to Decline Applicant Coverage	**22.** Select to Decline Dependent Coverage
_ Dental	**Dental** _ Spouse _ Child/ren

23. Reason for Refusing Coverage:

24. If refusing dental due to spouse's group insurance plan, please indicate spouse's name, birthdate, employer, and insurance company:

25. 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

GA156