



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. Home Address			12. 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: <input type="checkbox"/> Basic Life & AD&D <input type="checkbox"/> Voluntary/Supplemental 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			18. Coverage(s) for Dependents (Employee coverage required) <input type="checkbox"/> [Dependent Life] <input type="checkbox"/> Spouse Voluntary/Supplemental Life Amount: _____ <input type="checkbox"/> Child/ren Voluntary/Supplemental Life Amount: _____ [Dental: <input type="checkbox"/> Spouse <input type="checkbox"/> Child/ren] [Vision: <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 (applicable to life insurance only):]

[21. Full Name of Contingent Beneficiary and Relationship to you (applicable to life insurance only):]

For Dependent Coverage: List each dependent you wish to insure.

22. Name (show last name if different from employee)	Gender	Relationship	Date of Birth	[Other Dental Coverage]	
Spouse		N/A		Y	N
Child				Y	N
Child				Y	N
Child				Y	N
Child				Y	N

By signing below, I acknowledge I have read and I agree to the terms of the Provisions of Coverage contained on the reverse side of this Enrollment Form.

23. Signature of Employee: _____ Date: _____

(To decline any coverages, complete "Declination of Coverage" on page 2.)

PLEASE DO NOT FILL IN SHADED AREA BELOW – HOME OFFICE USE ONLY					
Group No. _____			Effective Date (M/D/Y)	Class	Coverage Amount
Loc/Div _____					
Cert. # _____					
____ Approved as requested	Employee _____	Basic Life& AD&D	_____	_____	_____
____ Approved with changes	Spouse _____	Basic Dep. Life	_____	_____	_____
	Child/ren _____	Vol/Supp Life EE	_____	_____	_____
		Vol/Supp Life SP	_____	_____	_____
		Vol/Supp Life Child	_____	_____	_____
		STD	_____	_____	_____
		LTD	_____	_____	_____
By: _____		Dental	_____	_____	_____
Date: _____		Vision	_____	_____	_____



KANSAS CITY LIFE
INSURANCE COMPANY

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 your 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 50 Braintree Hill Park, Suite 400, Braintree MA 02112. Telephone (617) 426-3660.

Kansas City Life, or its reinsurers, may also release information from its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.