

FILLED BY EMPLOYER			
1. Name of employer		2. Location	
3. Full-time employment date	4. Rehire date	5. Earnings from Employer	6. Occupation or Position
7. Coverage Class	8. Hours worked per week for employer	9. This change is due to: (check all that apply) <input type="checkbox"/> Initial Enrollment <input type="checkbox"/> Late Entrant <input type="checkbox"/> Name change <input type="checkbox"/> Regular Enrollee – New Hire <input type="checkbox"/> Address change <input type="checkbox"/> Beneficiary change <input type="checkbox"/> Other _____	

FILLED BY EMPLOYEE				
10. Last Name of Applicant		First Name	Middle Initial	11. Social Security Number
12. Home Address		Street	13. City	State ZIP Code
14. <input type="checkbox"/> Male <input type="checkbox"/> Female	15. <input type="checkbox"/> Single <input type="checkbox"/> Married	16. Date of Birth (M,D,Y)		

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

17. Coverage(s) for Applicant		18. Coverage(s) for Dependents (Applicant Coverage Required)	
<input type="checkbox"/> Life Amount \$ _____		<input type="checkbox"/> Spouse Life <input type="checkbox"/> Child(ren) Life Amount \$ _____ Amount \$ _____	
19. Full Name of Primary Beneficiary			20. Relationship
21. Full Name of Contingent Beneficiary			22. 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.

23. SIGNATURE OF APPLICANT (To decline any coverages complete reverse.)

Date _____ M/D/Y

***PROVISIONS ON REVERSE SIDE ACCEPTED**

DO NOT FILL IN BELOW THIS LINE

Group No. _____	Effective Dates	MO DAY YR	Coverage Amounts
Location/Division _____	Employee Life	_____	_____
Certificate # _____	Spouse Life	_____	_____
	Child/ren Life	_____	_____

Approved as requested above Approved with changes

Employee _____ Spouse _____ By: _____

Child(ren) _____ Date: _____

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 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 that any material misstatement on this enrollment card may result in a denial of a claim and/or discontinuance of coverage.
- Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

DECLINATION OF COVERAGE

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

24. Last Name of Applicant	First Name	Middle Initial	25. Name of Employer	26. Group No.
Indicate Coverage(s) Declined Below:				
27. Coverage(s) for Applicant			28. Coverage(s) for Dependents	
<input type="checkbox"/> Life			<input type="checkbox"/> Spouse Life <input type="checkbox"/> Child(ren) Life	
29. REASON FOR REFUSING COVERAGE:				
30. 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 Spouse or Child(ren) 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 _____. _____ <div style="text-align: right;">Signature of Applicant</div>				