Kansas City Life Insurance Company **Group Insurance Enrollment Form**

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) ☐ Initial Enrollment ☐ Late Entrant ☐ Name change ☐ Regular Enrollee – New Hire ☐ Address change ☐ Beneficiary change ☐ 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. ☐ Male ☐ Female	15. ☐ Single ☐ 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)	
☐ Life Amount $ _____	☐ Spouse Life Amount $_____	☐ Child(ren) Life 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 _____ *PROVISIONS ON REVERSE SIDE ACCEPTED
M/D/Y

DO NOT FILL IN BELOW THIS LINE

Group No. _____
Location/Division _____
Certificate # _____

Effective Dates	MO DAY YR	Coverage Amounts
Employee Life	_____	_____
Spouse Life	_____	_____
Child/ren Life	_____	_____

☐ Approved as requested above

☐ Approved with changes
Employee _____
Spouse _____
Child(ren) _____

By: _____

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 and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

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
☐ Life	☐ Spouse Life ☐ 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 _____. _____
Signature of Applicant