Kansas City Life Insurance Co.

Mail to: Claims Dept.
NABCO
P.O. Box 3056
Southeastern, PA 19398-3056

CLAIMANT'S STATEMENT

NOTE: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

INFORMATION ABOUT THE INSURED (Please print or type)

His/Her Name ______________________ Date of Death ______________________
First MI Last — Mo. Day Year

Cause of Death* ____________ is claim being made for Accidental Death Benefits? [] Yes [] No

*(If death was caused by suicide, homicide, or an accident, or if the policy was issued or reinstated within two years prior to the date of death, an Authorization for Medical Information may be needed.)

Please list all life insurance policies under which this claim is being made. All policies listed should be submitted with your claim.
NOT APPLICABLE FOR GROUP POLICIES.

If policies are not attached please state why: ______________________

Policy Numbers: ______________________

His/Her Resident Address ______________________
Street City State Zip Code

His/Her Date of Birth ____________ Place of Birth ______________________
Mo. Day Year — City State

INFORMATION ABOUT THE BENEFICIARY (Please Print or Type)

Beneficiary's Name ______________________ ( )
First Middle Last — Telephone No

Beneficiary's Address ______________________
Street City State Zip Code

Beneficiary's Social Security Number/TaxI.D.# ______________________

The beneficiary has not been notified by The Internal Revenue Service that he/she is subject to a back-up withholding order on interest or dividends. (If he/she has been so notified, cross out this entire statement.)

Date of Birth ____________ Relationship to the Deceased ______________________
Month Day Year

Have you been informed that you will require a Life Insurance Statement (IRS Form 712)? [] NO [] YES

SETTLEMENT OPTIONS (Check one of the following)

[] Pay proceeds immediately. *
[] Withhold payment while I decide whether I want the proceeds immediately or wish to elect a different settlement.
If I do not inform you otherwise within one month you will pay the proceeds to me immediately. *
[] I am interested in the Special Payment Plan Options (e.g.,Deposit, Installment or Life Income Options). Please send me additional information on these options.

* If your proceeds are eligible and exceed the current applicable minimum set by the Company, an interest bearing checking account will be opened for you and you will promptly receive your personalized checks. You may immediately utilize all or a portion of those funds by writing your checks against that account. The funds in the account, meanwhile, will earn interest at a competitive variable rate. For a current quote on the interest being paid thereon (or the current Company minimum) or for further information regarding this or any other settlement option, call our toll free number **1-800-821-6164.**

______________________ ____________
Beneficiary's Signature — Current Date

____________ ____________ ____________
Witness Signature — Witness Address — Current Date

NOTE: COMPLETE REVERSE SIDE ALSO

THIS SECTION MUST ALWAYS BE COMPLETED IN FULL. (Please Print Clearly)

Beneficiary's Name ____
First Middle Last Date of Birth

Address ____
Street City State Zip Code

Policy Number(s) ____

Social Security No./Taxpayer I.D. ________________ Relation to Deceased ________________

Home Telephone # (___) ________________ Business Telephone # (___) ________________

If the correct Taxpayer I.D. or Social Security Number is not supplied, Federal and State income tax withholding may apply. Under penalty of perjury, I certify that the information supplied on this form is true, correct and complete.

X ____

Beneficiary/Payee Signature **Current Date**

EMPLOYER'S STATEMENT

NOTE: Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

1. Group Name________________________________Group Pol. No.__________ Cert. No.______
2. Name of Deceased________________________________Relationship to employee __________
3. Name of Employee________________________________Social Security No.______________
4. Address of Employee____
5. Effective Date of Coverage____________________ Date Premium Paid To______________
6. Amount of Insurance ____
7. Employer___________________________Employer's Address____________________________
8. Occupation__________________________Duties____________________________________
9. Date Last Worked _________________________Employed at Death? [] Yes [] No
10. If not: Date Terminated ___________________ Reason______________________________
11. Salary or Wages: Monthly _________________ Weekly_______________Hourly___________
12 If Association or Union: Name of___________________________Date Joined______________
13. Status at Death____Dues Paid To______________
14. Beneficiary's Name_______________________________Relationship____________________
    Address____
    Date of Birth____Social Security No._____-___-______

The above statement and attached documents are true and complete to the best of my knowledge and belief.

Dated _________________,20____ By____
Signature Title

For______________________________
NAME OF EMPLOYER

Address__________________________________
Street City State Zip

INSTRUCTIONS

The group claim should be submitted with a claimant statement from the beneficiary (if more than one, all should sign), the policyowner's statement, a certified death certificate, copies of the current enrollment card, last beneficiary change form, if any, assignment, if any, and the Group Certificate, if any. If minor or incompetent beneficiaries are involved, or the beneficiary is deceased, or the estate is claiming benefits, or any other questions arise on processing the claim, please consult with Kansas City Life Insurance representative or the Home Office.

Authorization

[Instructions: The authorization should be completed and signed by the Insured. If the Insured is unable to sign, the authorization should be completed and signed by the legal guardian or next-of-kin.]

To all physicians, hospitals, medical service providers, druggists, employers, consumer reporting agencies, law enforcement agencies, and any other agencies or organizations (including other insurance companies, Social Security Administration, Blue Cross-Blue Shield, self-insured and prepaid health plans):

You are authorized to permit the Kansas City Life Insurance Company, or, its Third Party Administrators, and its authorized representatives to view and obtain a copy of ALL RECORDS including employment, law enforcement, tax, financial, insurance claim records, and medical records as to examination, history, diagnosis, treatment, and prognosis with respect to any physical or mental condition including information relating to mental illness, drug or alcohol treatment, HIV (AIDS virus), and disease of

____
Print Name of Insured

I understand the information obtained will only be used by the Kansas City Life Insurance Company to determine eligibility for insurance and benefits claimed under the Insured's policy. I consent to redisclosure of such information to reinsuring companies, the Medical Information Bureau and such other persons or organizations performing business or legal services in connection with my claim, or as may be otherwise lawfully required. Such information will not be given, sold, transferred, or relayed to any other person not specified in this form without my written consent.

I understand this authorization may be revoked by written notice to the Kansas City Life Insurance Company, but this revocation will not apply to information already released. If not revoked, this authorization will be valid while the claim is pending but not to exceed a maximum of two years from the date below. I know I may request a copy of this authorization. I also agree a photographic copy of this authorization shall be as valid as the original.

Date:	Signed:	Relationship to Insured if signed by other than Insured:

[If signed by other than the Insured, please print name and address and include guardianship papers or other evidence of legal representation.]

Kansas City Life Insurance Company

Please complete and return to:

North American Benefits Company
P.O. Box 3056
Southeastern PA 19398-3056
(800) 346-7813