

GROUP LIFE INSURANCE APPLICATION

To apply you must return this form & your check to: Kansas City Life Insurance Company, C/O North American Benefits Company, P.O. Box 3056, Southeastern, PA 19398-3056 – Questions call – 1-800-537-4565

Prior Employer Name: _____

Name of Applicant (Last, First, MI) _____ Social Security Number _____ Date of Birth _____ Male Female

Mailing Address (Street/P.O. Box, City, State, Zip) _____

Daytime Phone _____ Evening Phone _____ Alternative Phone _____ E-mail address _____

Reason for Termination: Policy cancellation Termination of membership in an eligible class
 Termination of employment Termination of the insurance of any class of individuals

I, the above applicant, request to continue the following amount of Voluntary Life Insurance:

Applicant \$ _____ Minimum \$20,000 (Increments of \$1,000) – Maximum no more than the amount insured on Group Life Insurance Policy.

Spouse \$ _____ Minimum \$10,000 (Increments of \$1,000) – Maximum no more than 50% of the Applicant's amount

Child(ren) \$2,500 \$5,000 (\$1,500 for Child(ren) age 7 days to 6 months)

Full Name of Primary Beneficiary _____ Relationship _____

Full Name of Contingent Beneficiary _____ 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 for the Insured.

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

If you are a resident of AZ, CA, ID, LA, NV, NM, WA or WI and you name someone other than your spouse as beneficiary, your spouse also must sign as written consent to the Beneficiary names on this form:

Print spouse name _____ Spouse Signature _____ Date _____

No agent has the authority to waive any of the Company's rights or requirements, or to make or alter any contract or policy. It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties could include imprisonment and fines, and may result in a denial of insurance benefits.

Applicant Signature _____ Date _____