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.
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.

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 CIVIL FINES AND CRIMINAL PENALTIES.

Applicant Signature Date