



COMPLETED BY EMPLOYER

1. Employer		2. Location	
3. Full-time employment date	4. Occupation	5. Hours worked/week	6. Annual earnings
7. Coverage class	8. Rehire date	9. This enrollment is: (check all that apply) <input type="checkbox"/> Initial enrollment <input type="checkbox"/> Late entrant <input type="checkbox"/> New hire <input type="checkbox"/> Change <input type="checkbox"/> Other _____	

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

To apply for coverage(s), complete the following section and sign below. Indicate only those products available through your employer/plan sponsor.

16. Coverage(s) for Employee: <input type="checkbox"/> Basic Life & AD&D <input type="checkbox"/> Voluntary/Supplemental Life Amount: _____ <input type="checkbox"/> Dental If Applicable: <input type="checkbox"/> Low Plan <input type="checkbox"/> High Plan <input type="checkbox"/> Short-Term Disability <input type="checkbox"/> Voluntary STD If Applicable: Amount: _____ <input type="checkbox"/> Long-Term Disability <input type="checkbox"/> Voluntary LTD If Applicable: Amount: _____ <input type="checkbox"/> Vision	17. Coverage(s) for Dependents (Employee coverage required) <input type="checkbox"/> Dependent Life <input type="checkbox"/> Spouse Voluntary/Supplemental Life Amount: _____ <input type="checkbox"/> Child/ren Voluntary/Supplemental Life Amount: _____ Dental: <input type="checkbox"/> Spouse <input type="checkbox"/> Child/ren Vision: <input type="checkbox"/> Spouse <input type="checkbox"/> Child/ren
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18. If COBRA continuee, please supply qualifying event and date: _____

19. Full Name of Primary Beneficiary and Relationship to you (applicable to life insurance only): _____

20. Full Name of Contingent Beneficiary and Relationship to you (applicable to life insurance only): _____

For Dependent Coverage: List each dependent you wish to insure.

21. Name (show last name if different from employee)	Gender	Relationship	Date of Birth	Other Dental Coverage	
Spouse		N/A		Y	N
Child				Y	N
Child				Y	N
Child				Y	N
Child				Y	N

By signing below, I acknowledge I have read and I agree to the terms of the Provisions of Coverage contained on the reverse side of this Enrollment Form.

22. Signature of Employee: _____ Date: _____

(To decline any coverages, complete "Declination of Coverage" on page 2.)

PLEASE DO NOT FILL IN SHADED AREA BELOW - HOME OFFICE USE ONLY

Group No. _____	Effective Date (M/D/Y)	Class	Coverage Amount
Loc/Div _____			
Cert. # _____			
_____ Approved as requested	Basic Life& AD&D	_____	_____
_____ Approved with changes	Basic Dep. Life	_____	_____
Employee _____	Vol/Supp Life EE	_____	_____
Spouse _____	Vol/Supp Life SP	_____	_____
Child/ren _____	Vol/Supp Life Child	_____	_____
By: _____	STD	_____	_____
Date: _____	LTD	_____	_____
	Dental	_____	_____
	Vision	_____	_____

***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 represent I am not presently disabled and I am performing the material and substantial duties of my occupation for at least the number of hours as shown in column 5.
- Any person who submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud if there is intent to defraud or knowledge that fraud is being facilitated.
- I understand any material misstatement on this enrollment form may result in a denial of a claim and/or discontinuance of coverage.
- I have made a copy of this application for my records.

DECLINATION OF COVERAGE

To refuse coverage(s) for which you are required to pay a portion of the premium, please complete the following section:

Last Name, First Name, Middle Initial	Employer
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Indicate Coverage(s) Declined Below:

Coverage(s) for Employee: <input type="checkbox"/> Basic Life & AD&D <input type="checkbox"/> Voluntary/Supplemental Life <input type="checkbox"/> Dental <input type="checkbox"/> Voluntary STD <input type="checkbox"/> Short-Term Disability <input type="checkbox"/> Voluntary LTD <input type="checkbox"/> Long-Term Disability <input type="checkbox"/> Vision]	Coverage(s) for Dependents (Employee coverage required): Life: <input type="checkbox"/> Spouse <input type="checkbox"/> Child/ren Dental: <input type="checkbox"/> Spouse <input type="checkbox"/> Child/ren Vision: <input type="checkbox"/> Spouse <input type="checkbox"/> Child/ren
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Reason for refusing coverage: _____

I have been given an opportunity to participate in the group insurance plan offered by my employer. I am refusing the coverage 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.

Signature: _____ Date: _____

If requested to do so by Kansas City Life Insurance Company, please complete the following items.

Name of Employee:	Age	Gender	Height	Weight	Weight change in last year (gain/loss)
Name of Spouse of Employee (if applicable):	Age	Gender	Height	Weight	Weight change in last year (gain/loss)

During the past five years, have you (or anyone proposed for coverage) been diagnosed or treated by a member of the medical profession for any of the following: heart condition (including high blood pressure)*; cancer or tumor; chronic/recurrent respiratory disease; diabetes; kidney or liver disease; arthritis or any other disease of the joints, including neck and back disorders; any mental, emotional or nervous disorder; any disorder of the brain, nervous, digestive or reproductive system; muscle or connective tissue disorder; alcohol or drug abuse; or Acquired Immune Deficiency Syndrome (AIDS) or AIDS-Related Complex (ARC)?

Employee: Yes No Spouse (life coverage only): Yes No

During the past five years, have you been declined coverage for any life or disability insurance?

Employee: Yes No Spouse (life coverage only): Yes No

For female, disability applicants only: Are you currently pregnant? Yes No

Please supply full details to "Yes" answers. List date(s) of onset, last occurrence, types of treatment including medication. *For high blood pressure, give date and last reading. If you require additional space, please attach separate sheet.

I(we) authorize the following to give information (defined below) to Kansas City Life Insurance Company or any person or group acting on the part of Kansas City Life Insurance Company: any medical professional, medical care institution, the Medical Information Bureau, Inc., insurer, reinsurer, government agency, consumer reporting agency or employer. I authorize Kansas City Life Insurance Company, or its reinsurers, to make a brief report of my personal health information to MIB. "Information" means facts of: a medical nature regarding my physical or mental condition; employment; other insurance coverage; or any other non-medical facts. I(we) understand that this information will be used by Kansas City Life Insurance Company to determine eligibility for insurance. I(we) agree this Authorization is valid for two and one-half years from the date signed. I (we) know that I(we) have a right to receive a copy of this Authorization upon request. I(we) agree that a photographic copy of this Authorization is as valid as the original.

I hereby represent that the above answers are complete and true to the best of my knowledge and belief concerning the past and present state of health and medical history of the person(s) to whom the answers relate. I agree that this document and all its contents shall form a part of my enrollment request for group benefits.

Signature of Employee: _____ Date: _____

Signature of Spouse: _____ Date: _____