K·C·L GROUP BENEFITS

Application for Group Insurance

Kansas City Life Insurance Company
3520 Broadway
Kansas City, MO 64111

Legal Name of Applicant (Policyholder)	Federal Tax ID No.

Nature of Business	Standard Industrial Classification (SIC)	Type of Business
		☐ Corporation ☐ Sole Proprietor ☐ Partnership ☐ LLC ☐ Other

Street Address, City, State, Zip

Name of Subsidiaries, Divisions or Affiliates to be Covered

Name and Title of Plan Administrator (Corporate Officer)	Phone No.	E-mail	Fax

Name and Title of Correspondent (Routine Accounting Matters)	Phone No.	E-mail	Fax

Billing Address(es) - If Different From Street Address

Proposed Effective Date of Insurance	Advance Payment of $_____ is submitted with this application to be applied by the Company on premiums for insurance when and if issued.

If the insurance applied for replaces, or is in addition to, any similar group or wholesale insurance now or previously in force, provide:

Carrier Name	Type of Coverage	Date to be Discontinued

This application must be accompanied by a copy of the inforce carrier policy or certificate with benefit schedule. If Dental, also include a current month's Dental billing from current carrier.

Coverage Applied For

☐ **Basic Term Life Insurance**	☐ **Voluntary Term Life Insurance**	☐ **Short Term Disability (STD)**
☐ Accidental Death & Dismemberment	☐ Accidental Death & Dismemberment	
☐ Dependent Life Benefit	☐ Spouse and Children Life Benefit	
☐ **Long Term Disability (LTD)**	☐ **Dental Insurance**	☐ **Vision Insurance**

Premium

What percentage does the employer contribute towards the premium?

_____% Basic Term Life _____% Dependent Life _____% Voluntary Term Life

_____% Short Term Disability (STD) ☐ STD Gross-Up Plan _____% Long Term Disability (LTD) ☐ LTD Gross-Up Plan

(For Voluntary/Contributory STD and LTD only, is the employee paid portion of premium ☐ Pre-Tax basis or ☐ Post-Tax basis?)

Dental Insurance _____% Employee _____% Dependents Vision Insurance _____% Employee _____% Dependents

Schedule of Benefits

Please attach a copy of the proposal(s) of benefits sold. Only complete the following if benefits applied for are different from those proposed.

Additional Options to be included:

Eligibility

Eligible Classes:

Basic Term Life Insurance	Voluntary Term Life Insurance	Short Term Disability (STD)	Long Term Disability (LTD)
☐ All Full-Time Employees working _____ hours/week	☐ All Full-Time Employees working _____ hours/week	☐ All Full-Time Employees working _____ hours/week	☐ All Full-Time Employees working _____ hours/week
☐ Other_____	☐ Other_____	☐ Other_____	☐ Other_____

Dental Insurance		Vision Insurance	
☐ All Full-Time Employees working _____ hours/week	☐ Other _____	☐ All Full-Time Employees working _____ hours/week	☐ Other _____

Probationary Waiting Period:

Basic Term Life	Voluntary Term Life	Short Term Disability (STD)	Long Term Disability (LTD)
_____days/months	_____days/months	_____days/months	_____days/months
Dental	**Vision**	**If Probationary Waiting Period differs by class, specify here:**	
_____days/months	_____days/months	_____	

Does this apply to current employees hired on or before the effective date? If no, all currently enrolled employees will be covered on the policy effective date regardless of employment date.

☐ Yes ☐ No

Coverage to be effective the first of the month following completion of probationary waiting period?

☐ Yes ☐ No

Number of eligible and enrolled individuals:

Basic Life/ Dependent Life	Voluntary Life	Short Term Disability	Long Term Disability	Dental	Vision
# eligible _____/_____	# eligible _____	# eligible _____	# eligible _____	# eligible _____	# eligible _____
#enrolled_____/_____	#enrolled_____	#enrolled_____	#enrolled_____	#enrolled_____	#enrolled_____

Are any individuals currently disabled? ☐ Yes ☐ No If yes, provide:

Full Name	Diagnosis/Prognosis	Estimated Return to Work Date

Are any former employees and/or dependents currently on continuation coverage provided by the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985? ☐ Yes ☐ No If yes, list names of the enrollees, qualifying event, and date of event:

Full Name	Qualifying Event	Date of Event	COBRA End Date

Agreement and Signatures

It is understood and agreed as follows:

1. No coverage is effective until approved by Kansas City Life Insurance Company at its Home Office in Kansas City, Missouri.
2. Insurance will be effective with regard to those individuals listed above in the Eligibility Section, on the latest of the following dates: (a) the effective date approved by the Company; (b) the date this application is signed; or (c) the date the first premium is paid in full.
3. No agent has the authority to waive any of the Company's rights or requirements, or to make or alter any contract or policy.

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 fines and confinement in prison.

Dated at _____ this _____ day of _____ , year of _____
City, State

FLORIDA – Statement of Agent:	**~~NORTH CAROLINA – Certification of Agent~~**
Is this a replacement policy? ☐ Yes ☐ No	I certify that the information supplied by the Applicant (proposed Policyholder) has been truly and accurately recorded in this application.

6434315

Signature of Writing Agent — Agent Code	Officer's Signature
Agent's Name and State License ID No. – SSN (Please Print)	Please Print Officer's Name
Signature of Other Agent(s) — Agent Code	Officer's Title
Agent(s) Business Address — City, State, Zip	Agency — Agency Code

NOTICE TO ARIZONA APPLICANTS:
Any life insurance producer, examining physician or other person who knowingly makes a false or fraudulent statement or representation in or relative to an application for life or disability insurance, or who makes any such statement to obtain a fee, commission, money or benefit is guilty of a class 2 misdemeanor.

NOTICE TO CALIFORNIA APPLICANTS:
NOTICE: California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.

NOTICE TO COLORADO APPLICANTS:
It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

NOTICE TO FLORIDA APPLICANTS:
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.