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|---|--|---------------------------|----------|----------------------------|---------------------------|-------------------------------|
| 1. Last Name of Applicant | | First Name | | Middle Initial | 2. Social Security Number | |
| 3. Home Address | | | Street | | 4. Name of Employer | |
| 6. City | | State | Zip Code | | 5. Loc/Div | FILLED BY EMPLOYER |
| 7. Full-time Employment Date: | | 8. Rehire Date: | | 9. Earnings from Employer: | | |
| 10. <input type="checkbox"/> Male <input type="checkbox"/> Female | 11. <input type="checkbox"/> Single <input type="checkbox"/> Married | 12. Date of Birth (M,D,Y) | | 13. Occupation or Position | 14. Coverage Class | |

If you are declining coverage(s), complete the "Declination of Coverage" section on page 2 of this form. To apply for coverage(s), complete the following section and sign below. Indicate only those products available through your employer.

| | | | | | |
|--|---|---|--|--|--|
| 16. Coverage(s) for Applicant | | | 17. Coverage(s) for Dependents (Applicant Coverage Required) | | |
| <input type="checkbox"/> Life and AD&D <input type="checkbox"/> Supp Life Amount: \$ _____ | <input type="checkbox"/> STD <input type="checkbox"/> LTD <input type="checkbox"/> Dental | <input type="checkbox"/> Vision <input type="checkbox"/> Vol AD&D Principal Sum: \$ _____ | <input type="checkbox"/> Dep Life <input type="checkbox"/> Vol AD&D | Dental <input type="checkbox"/> Spouse <input type="checkbox"/> Child/ren | Vision <input type="checkbox"/> Spouse <input type="checkbox"/> Child/ren |

| | | |
|---|--|------------------|
| 18. Full Name of Primary Beneficiary (For Life and AD&D) | | 19. Relationship |
| 20. Full Name of Contingent Beneficiary (For Life and AD&D) | | 21. 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 to the Insured.

22. FOR DENTAL AND/OR VISION COVERAGE: List Each Dependent You Wish to Insure.

| Name (Show last name if different) | Sex | Relationship | Date of Birth | Social Security No. |
|------------------------------------|-----|--------------|---------------|---------------------|
| Spouse | | | | |
| 1. Child | | | | |
| 2. Child | | | | |
| 3. Child | | | | |
| 4. Child | | | | |
| 5. Child | | | | |

| | |
|--|--|
| 23. If COBRA continuee please give: Qualifying Event: _____ Date of Event: _____ | 24. SIGNATURE OF APPLICANT – To decline any coverages complete "Declination of Coverage" on page 2 of this form. _____ Date: _____ M/D/Y |
| 25. Spouse's Employer: _____ Spouse's Dental Carrier: _____ | |

***PROVISIONS ON PAGE 2 ACCEPTED**

DO NOT FILL IN BELOW THIS LINE

| | | | | |
|---|--------------------|-----------|-------|------------------|
| Group No: _____ Location/Division: _____ Certificate #: _____ | Effective Dates | MO DAY YR | Class | Coverage Amounts |
| | Life and AD&D | | | |
| | Dep Life | | | |
| | Supp Life and AD&D | | | |
| | STD | | | |
| | LTD | | | |
| | Dental | | | |
| | Vision | | | |
| Vol AD&D | | | | |

***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 that any disability indemnity coverage in force and applied for, with respect to myself, is less than 100% of my earnings.

*I further represent that I am not presently disabled and I am performing all the duties of my occupation at least the number of hours shown on page 1 of this form.

*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 card may result in a denial of a claim and/or discontinuance of coverage.

DECLINATION OF COVERAGE

TO REFUSE COVERAGE(S) for which you are required to pay a portion of the premium, complete the following section:

| | | | |
|--|---|---|---|
| 26. Last Name of Applicant | First Name | 27. Name of Employer | 28. Group No. |
| 29. Indicate Coverage(s) Declined Below: | | | |
| Coverage(s) for Applicant | | 30. Coverage(s) for Dependents (Applicant Coverage Required) | |
| <input type="checkbox"/> Life and AD&D <input type="checkbox"/> Supp Life <input type="checkbox"/> Vision | <input type="checkbox"/> STD <input type="checkbox"/> LTD <input type="checkbox"/> Dental | <input type="checkbox"/> Vol AD&D | <input type="checkbox"/> Dep Life <input type="checkbox"/> Vol AD&D |
| | | Dental <input type="checkbox"/> Spouse <input type="checkbox"/> Child/ren | Vision <input type="checkbox"/> Spouse <input type="checkbox"/> Child/ren |
| 31. REASON FOR REFUSING COVERAGE: | | | |
| 32. IF REFUSING DENTAL DUE TO SPOUSE'S GROUP INSURANCE PLAN, PLEASE INDICATE SPOUSE'S NAME, BIRTHDATE, EMPLOYER, AND INSURANCE COMPANY: | | | |
| 33. I have been given an opportunity to participate in the group insurance plan offered by my employer. I am refusing the coverages 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 dependents desire to participate at a later date, coverage(s) may be limited and proof of insurability may be required at my own expense. | | | |
| Dated this ____ day of _____, year of _____. | | _____ Signature of Applicant | |