KANSAS CITY LIFE
GROUP BENEFITS

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

GRP # 23004

Group Insurance Enrollment Form

COMPLETED BY EMPLOYER

Employer Bourbon County			Location
Full-time employment date	Occupation	Hours worked/week	Annual earnings
Coverage class	Rehire date	This enrollment is: (check all that apply) ☐ Initial enrollment ☐ Late entrant ☐ New hire ☐ Change ☐ Other ____	

COMPLETED BY EMPLOYEE

Last Name, First Name, Middle Initial			E-mail
Home Address, City, State, and Zip			
Social Security Number	☐ Male ☐ Female	Date of Birth (M/D/Y) / /	☐ Single ☐ Married

To apply for coverage(s) for Employee and/or Dependents, complete the following section and sign below. Indicate only those products available through your employer/plan sponsor. Employee coverage is required to enroll Dependents. Spouse must be under age 70 to be eligible for certain coverages.

☒ **Basic Life & AD&D** Amount: ____	☐ Dependent Life Spouse Age: ____	☐ I do not want this coverage.
☐ **Voluntary Life** Amount: ____	☐ Spouse Amount: ____ Spouse Age: ____ ☐ Child/ren Amount: ____	☐ I do not want this coverage.
☐ **Short-Term Disability** Amount: ____	☐ **Voluntary STD** (If Applicable) Amount: ____	☐ I do not want this coverage.
☐ **Long-Term Disability** Amount: ____	☐ **Voluntary LTD** (If Applicable) Amount: ____	☐ I do not want this coverage.
☐ **Dental** ☐ Spouse ☐ Child/ren	If Applicable: ☐ Low Plan ☐ High Plan	☐ I do not want this coverage. Reason for refusing coverage: ____
☐ **Vision** ☐ Spouse ☐ Child/ren	If Applicable: ☐ Low Plan ☐ High Plan	☐ I do not want this coverage.
☐ **Accident** ☐ Spouse ☐ Child/ren	If Applicable: ☐ Low Plan ☐ Medium Plan ☐ High Plan	☐ I do not want this coverage.
☐ **Critical Illness** Amount: ____	☐ Spouse Amount ____ Spouse Age: ____ ☐ Child/ren Amount: ____	☐ I do not want this coverage.
If COBRA enrollee, please supply qualifying event and date:		
Full Name of Primary Beneficiary and Relationship to you:	Full Name of Contingent Beneficiary and Relationship to you:	

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

Name (show last name if different from employee)		Gender	Relationship	Date of Birth
Spouse			N/A	/ /
Child				/ /
Child				/ /
Child				/ /

By signing below, I acknowledge I have read and I agree to the terms of the Provisions of Coverage as follows:
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 shown on this form.
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.
If refusing the coverage indicated – I have been given an opportunity to participate in the group insurance plan offered by my employer. 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.

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.

Signature of Employee: _____ **Date:** ____

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.

NOTICES 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.

THIS POLICY DOES NOT INCLUDE COVERAGE OF PEDIATRIC DENTAL SERVICES AS REQUIRED UNDER FEDERAL LAW. COVERAGE OF PEDIATRIC DENTAL SERVICES IS AVAILABLE FOR PURCHASE IN THE STATE OF COLORADO, AND CAN BE PURCHASED AS A STAND-ALONE PLAN, OR AS A COVERED BENEFIT IN ANOTHER HEALTH PLAN. PLEASE CONTACT YOUR INSURANCE CARRIER, AGENT, OR CONNECT FOR HEALTH COLORADO TO PURCHASE EITHER A PLAN THAT INCLUDES PEDIATRIC DENTAL COVERAGE, OR AN EXCHANGE-QUALIFIED STAND-ALONE DENTAL PLAN THAT INCLUDES PEDIATRIC DENTAL COVERAGE.

NOTICE TO ILLINOIS APPLICANTS | NOTICE TO POLICYHOLDER – ILLINOIS RELIGIOUS FREEDOM PROTECTION AND CIVIL UNION ACT
The Illinois Department of Insurance requires that we inform you of Kansas City Life Insurance Company's compliance with the Illinois Religious Freedom Protection and Civil Union Act (the Act). The Act provides that the parties to a civil union are entitled to the same legal obligations, responsibilities, protections, and benefits that are afforded or recognized by the laws of Illinois to spouses. Therefore, Kansas City Life Insurance Company will administer both existing and newly issued policies and use processes and systems to ensure that parties to a civil union and a marriage are provided identical benefits, protections, and financial security.
Please contact your agent or the Home Office of Kansas City Life Insurance Company if you have questions regarding this notice.

NOTICE TO KANSAS APPLICANTS:
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 may be guilty of insurance fraud as determined by a court of law.

NOTICE TO KENTUCKY APPLICANTS:
Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

NOTICE TO MAINE, TENNESSEE, AND WASHINGTON APPLICANTS:
It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

NOTICE TO MARYLAND AND ARKANSAS APPLICANTS:
Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

NOTICE TO NEW MEXICO APPLICANTS IF DENTAL, VISION, ACCIDENT, OR CRITICAL ILLNESS COVERAGE IS APPLIED FOR:
This type of plan is NOT considered "minimum essential coverage" under the Affordable Care Act and therefore does NOT satisfy the individual mandate that you have health insurance coverage. If you do not have other health insurance coverage, you may be subject to a federal tax penalty.

NOTICE TO OKLAHOMA APPLICANTS:
WARNING: Any person who knowingly, and with intent to injure, defraud, or deceive any insurer makes any claim for the proceeds of an insurance policy containing any false, incomplete, or misleading information is guilty of a felony.