Group Insurance Benefits

Bourbon County

Life and AD&D Insurance

Class 01

KANSAS CITY LIFE
INSURANCE COMPANY

General Purposes and Limitations of the Kansas Life and Health Insurance Guaranty Association
K.S.A. 40-3001 et. seq.

DISCLAIMER

THE KANSAS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION MAY NOT PROVIDE COVERAGE FOR ALL OR A PORTION OF THIS POLICY. IF COVERAGE IS PROVIDED, IT MAY BE SUBJECT TO SUBSTANTIAL LIMITATIONS OR EXCLUSIONS AND IS DEPENDENT UPON CONTINUED RESIDENCE IN KANSAS. THEREFORE, YOU SHOULD NOT RELY UPON COVERAGE BY THE KANSAS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION IN SELECTING AN INSURANCE COMPANY OR IN SELECTING AN INSURANCE POLICY. INSURANCE COMPANIES AND THEIR AGENTS ARE PROHIBITED BY LAW FROM USING THE EXISTENCE OF THE KANSAS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION IN SELLING YOU ANY FORM OF AN INSURANCE POLICY OR TO INDUCE YOU TO PURCHASE ANY FORM OF AN INSURANCE POLICY. EITHER THE KANSAS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION OR THE KANSAS INSURANCE DEPARTMENT WILL RESPOND TO ANY QUESTIONS YOU MAY HAVE REGARDING THIS DOCUMENT.

KANSAS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION
2909 SW Maupin Lane
Topeka, KS 66614-5335

THE KANSAS INSURANCE DEPARTMENT
420 Southwest 9th Street
Topeka, KS 66612-1678

This is a summary of the basic provisions of the Kansas Life and Health Insurance Guaranty Association Act. It is only a summary and does not provide an in-depth analysis of that Act. Nothing in this summary modifies the rights of persons who are protected by the Act or the rights or duties of the Association.

The purpose of the Kansas Life and Health Insurance Guaranty Association Act is to protect certain individuals who purchase life insurance, annuities or health insurance in Kansas. The act provides for the establishment of a funding mechanism to pay benefits or provide insurance coverage to individuals when a life or health insurance company is unable to meet its obligations by reason of insolvency or financial impairment.

However, not all individuals with a right to recover under life or health insurance policies are protected by the Act. An individual is only provided protection when:

1. the individual, regardless of where they reside, except for nonresident certificate holders under group policies or contracts, is the beneficiary, assignee or payee of a covered policy or contractholder;
2. the individual policy or contractholder is a resident of the State of Kansas;
3. the individual is not a resident of the State of Kansas, but only with respect to an annuity contract which has been awarded pursuant to a judgment or settlement agreement in a medical malpractice liability action;
4. the individual is not a resident of the State of Kansas, but only under **all** of the following conditions:
    a. the impaired or insolvent insurer was a Kansas domestic insurer; and
    b. the insurer never had a license to do business in the state the individual resides; and
    c. the state in which the individual resides has an association similar to this state's; and
    d. the individual is not eligible for coverage by the association of the state in which the individual resides.

Additionally, the Association may not provide coverage for the entire amount the individual expects to receive from the policy. The Association does not provide coverage for any portion of the policy where the individual has assumed the risk, for any policy of reinsurance, for interest rates that exceed a specified average rate, for employers' plans that are self-funded, for parts of plans that provide dividends

or credits in connection with the administration of the policy, for policies sold by companies not authorized to do business in Kansas, for any unallocated annuity contract, or for policies or contracts that provide benefits under Medicare Part C or Part D. Also, the Association will not provide coverage where any guaranty protection is provided to the individual under the laws of the insolvent or impaired insurer's state of domicile.

The Act also limits the amount the Association is obligated to pay individuals on various policies to those limits in effect on the date the Association became liable for that impaired or insolvent insurer. The Association does not pay more than the amount of the contractual obligation of the insurance company. Regardless of the number of policies or contracts, the Association is not obligated to pay amounts over $300,000 in life insurance death benefits; $100,000 in net cash surrender and net cash withdrawal values for life insurance; $100,000 in health insurance benefits, including any net cash surrender and net cash withdrawal values; $250,000 in the present value of annuity benefits, including net cash surrender and net cash withdrawal values, unless the annuity contract is awarded pursuant to a judgment or settlement agreement in a medical malpractice liability action; or more than $300,000 in the aggregate for the above coverages with respect to any one life.

Certificate of Group Insurance

Kansas City Life Insurance Company certifies that in accordance with and subject to the terms of the Group Life Insurance Policy, You are insured for the benefits described in this certificate. Your insurance is subject in every respect to the terms of the Group Life Insurance Policy which alone constitutes the contract under which payments are made.

This certificate summarizes the principal provisions of the Group Life Insurance Policy. This is not a contract nor does it modify or amend the Group Life Insurance Policy. This certificate supersedes and replaces any which may have been issued to You previously.

Signed for Kansas City Life Insurance Company, a stock company, at its Home Office, 3520 Broadway, PO Box 219425, Kansas City, MO 64121-9425, Toll Free 1-877-266-6767.

Secretary

President, CEO and Chairman

Guide to Certificate Provisions

Federally required Summary Plan Description information accompanies this certificate.

Schedule of Benefits

Policyholder	Policy Number	Policy Effective Date
Bourbon County	23004	August 1, 2015

Employer

Bourbon County

Classes of Eligible Individuals

Class 01: All Full Time Active Employees and Commissioners working 35 or more hours per week

Employees must be U.S. citizens or legal residents of the U.S. excluding temporary, seasonal or part-time employees.

Waiting Period As noted in Your Employer's Group Life Insurance Policy

Benefit and Premium Schedule

CLASSIFICATION OF INDIVIDUAL	AMOUNT OF LIFE INSURANCE	AMOUNT OF ACCIDENTAL DEATH AND DISMEMBERMENT
Class 01: All Full Time Active Employees and Commissioners working 35 or more hours per week	$20,000	$20,000

Employees must be U.S. citizens or legal residents of the U.S. excluding temporary, seasonal or part-time employees.

Coverage reduces 35% at Your age 65, 55% of the original amount at Your age 70, 70% of the original amount at Your age 75 and 80% of the original amount at Your age 80. Coverage ceases at Your Retirement from the Policyholder.

**AD & D includes the following riders:

Seat Belt/Air Bag Benefit

Repatriation Benefit

Child(ren) Education Benefit

Spouse Education Benefit

Day Care Benefit

CONTRIBUTIONS FROM INSURED INDIVIDUALS ARE: Not Required

Definition of Certain Terms

Actively-at-work
You are considered Actively-at-work with the Employer on a day that is Your regularly scheduled workday, if You are performing the material and substantial duties of Your job in the usual manner at Your regular place of employment on a full-time basis for a minimum of 35 hours per week. You will be deemed to be Actively-at-work on a day that is not one of Your scheduled workdays only if You were Actively-at-work on the preceding scheduled workday.

Amount of Life Insurance
The amount elected on the Enrollment Form, as approved by the Company.

Annual Salary
Your annual fixed rate of compensation in effect immediately prior to the date of loss, excluding overtime, bonuses, expenses, allowances and other compensation except commissions. Commissions will be included for the preceding 24 months or from the date of employment, whichever is less.

Your Amount of Insurance will be calculated based on the lesser of Your Annual Salary as calculated above or the premium amount actually received by Us.

Beneficiary
The person designated by You to receive the proceeds of the policy payable upon a Covered Person's death.

Company
Kansas City Life Insurance Company, a Missouri corporation, whose Home Office is 3520 Broadway, PO Box 219425, Kansas City, MO 64121-9425, and telephone number is 816-753-7000. The Company is also referred to as We, Our or Us.

Covered Person
All individuals whose insurance is in force under the policy.

Employee
A person who works the minimum number of regularly scheduled hours for the Employer indicated on the Schedule of Benefits. This specifically excludes a Retired Employee. An Employee is not someone who is temporary or seasonal; who is a consultant to the Employer; who is a subcontractor or independent contractor; or who is a member of the board of directors of the Employer. Owners, partners and sole proprietors are considered to be Employees only if they work the minimum number of regularly scheduled hours for the Employer.

Employer
The Employer and covered Subsidiaries, Divisions or Affiliates as indicated in the Group Life Insurance Policy in Section 1 Policy Data.

Enrollment Form
A form provided by or acceptable to Kansas City Life which may be used for the purpose of collecting coverage information from You.

Evidence of Insurability
A statement of an individual's current health and medical history upon which Kansas City Life Insurance Company will determine acceptance for insurance.

Group Life Insurance Policy
The policy of insurance made by the Company and the Policyholder to insure individuals participating in the plan.

Guaranteed Issue Amount
The maximum Amount of Life Insurance which is available to You without Evidence of Insurability. The Guaranteed Issue Amount only applies at initial eligibility.

Policyholder
The entity to which the Group Life Insurance Policy is issued.

Principal Sum
The amount of the Accidental Death & Dismemberment Benefit. The Principal Sum will be the same as the Amount of Life Insurance elected on the Enrollment Form, as approved by the Company.

Retirement, Retired means the earlier of the following:

1) the date Your retirement pension benefits commence under any law of federal state, county, or municipal retirement system if such pension benefits include any credit for employment with the Policyholder;
2) the date Your retirement pension benefits commence under any plan which the Policyholder sponsors, makes or has made contributions to; or
3) the date Your retirement benefits commence under the United States Social Security Act, or under any similar plan or act.

You/Your
The Insured Employee to whom this certificate is issued.

General Provisions

When can this plan be contested?
Except for non-payment of premium, Your coverage under this Policy cannot be contested after two years from the date You become covered under this plan.

No statement relating to insurability will be used to contest the insurance for which the statement was made after the insurance has been in force for two years during the individual's lifetime. In order to contest coverage, the statement must be in writing and signed by the affected individual.

Can We have a claimant examined or request an autopsy?
We reserve the right to have a claimant examined and to have an autopsy performed, if not forbidden by law. Any such examinations will be as reasonably required by Us and at Our expense.

When can legal action be taken?
Legal action cannot be taken against Us:

1) sooner than 60 days after proof of loss has been furnished; or

2) five or more years after the time proof of loss is required to be furnished according to the terms of the Policy.

Who interprets policy terms and conditions?
Pursuant to the Employee Retirement Income Security Act of 1974, as amended (ERISA), Your Employer has delegated to Us the fiduciary responsibility to determine eligibility for benefits and to construe and interpret all terms and provisions of the Policy. We have the continuing duty to act prudently and in the interest of You, Your beneficiaries and the other plan participants. If You have a claim for benefits which is denied or ignored, in whole or in part, then You may file suit in state or federal court for a review of Your eligibility or entitlement to benefits under the Policy.

How does this plan affect Workers' Compensation coverage?
The policy does not replace Workers' Compensation or affect any requirement for Workers' Compensation coverage.

Eligibility and Effective Dates

How do I apply for coverage?
You need to complete, sign and return an individual Enrollment Form to set up Your insurance record.

What are the eligibility requirements?
You must be a member of one of the classes of individuals eligible for insurance shown in the Schedule of Benefits and complete the waiting period on or after the effective date of the Group Life Insurance Policy.

The waiting period as shown in the Schedule of Benefits is the time period that You must be employed by the Policyholder and Actively-at-work before being eligible for insurance.

When will my coverage be effective?
Except as stated in **What is the Deferred Effective Date provision for Employees?**, Your coverage becomes effective at 12:01 a.m. on the latest of the following dates, provided You are Actively-at-work on the date:

1) You become eligible for coverage;
2) You sign a payroll deduction order and make written application for coverage if any part of the cost for the coverage is paid by You; and
3) Your Evidence of Insurability, if required, is approved by the Company.

Evidence of Insurability, that is satisfactory to the Company and provided at Your expense, must be submitted if:

1) written application for coverage is made more than 31 days after You became eligible for coverage; or
2) coverage is elected after You have requested:
    a) termination of coverage; or
    b) cancellation of payroll deduction.

What is the Deferred Effective Date provision for Employees?
If You are absent from work due to a physical or mental condition on the date Your insurance, an increase in coverage or a new benefit added to the Policy would otherwise have become effective, the effective date of Your insurance, any increase in insurance or the additional benefit will be deferred until the date You return to work as an Active Full-time Employee.

Beneficiary

What is the definition of Beneficiary?
The person designated by You to receive the proceeds of the Group Life Insurance Policy payable upon Your death, the death of Your Spouse or Child(ren). The Policyholder may not be named as Beneficiary.

How do I designate or change the Beneficiary?
You may designate a Beneficiary or change the Beneficiary subject to the following:

1) a written request must be made on a form satisfactory to the Company;

2) the form must be signed and filed with the Company while You are living and while insurance is in force; and

3) the change will be effective on the date the request was signed but will have no effect on any payment made by the Company before the change was filed.

How will payment be made to the Beneficiary?
If more than one Beneficiary is designated and You do not specify their respective interests, the beneficiaries will share equally. The share of any Beneficiary who dies before You will be paid equally to the surviving beneficiaries, unless otherwise designated.

Any Beneficiary designation in an application for a policy to be issued under the Conversion provisions will be deemed notice of change of Beneficiary or beneficiaries for the Policy.

Death benefits will be paid as though the Beneficiary died before You if:

1) the Beneficiary dies simultaneously with or within 15 days after Your death; and

2) the Company has not paid the proceeds to the Beneficiary within the 15-day period.

What if there is no Beneficiary living at death?
In the event of the death of the Beneficiary before the death of the Covered Person, and thereafter the Covered Person dies without having named another Beneficiary and without having disposed of the benefit proceeds by will, then the benefit proceeds will go to the estate of the Covered Person.

Any amount payable to a Beneficiary, who is a minor or is otherwise legally incompetent to give a valid release, will go to the estate of the Covered Person.

Are the death benefit proceeds subject to the claims of my creditors?
To the extent permitted by law, the death benefit proceeds are not subject to any claims of Your creditors or any beneficiaries.

Termination Provisions

When will my insurance terminate?
All insurance provided for You will terminate at 11:59 p.m. on the earliest of the following:

1) on the date the Group Life Insurance Policy terminates;

2) on the date You cease to be in an eligible class;

3) on the date Your employment with the Policyholder organization terminates. This will be the date You cease active work. Accrued vacation and/or sick days will not extend termination date; or

4) the end of the period for which You have made any required contribution.

If You are no longer Actively-at-work as a result of a disability, layoff, or leave of absence, the Employer may continue Your insurance as follows, provided premiums are paid when due:

1) Insurance may be continued as a result of disability until the lesser of: the end of 12 months following the month in which the disability began or the attainment of age 65.

2) Insurance may be continued as a result of a layoff until the end of 1 month following the month during which the layoff began.

3) Insurance may be continued as a result of leave of absence until the end of 1 month following the month in which the leave of absence began.

4) Insurance may be continued as governed by the Employer's Human Resource policy on FMLA absence for up to 12 weeks during a leave of absence elected under the federal Family and Medical Leave Act of 1993. The leave of absence must be approved and in writing by the Employer.

5) Insurance may be continued as governed by the Employer's Human Resource policy on Military Services leave of absence for up to 12 weeks. The leave of absence must be approved in advance and documented as leave for military purposes by the Employer.

If Your insurance is continued, the following will apply:

1) the required premium must be paid;

2) Your benefit level, or the amount of earnings upon which Your benefits may be based, will be that in effect on the day before said leave commenced; and

3) such continuation will cease immediately if one of the following events should occur:

   a) the leave terminates prior to the agreed upon date;

   b) the termination of the Group Life Insurance Policy;

   c) Your Employer ceases to be a Participant Employer, if applicable;

   d) non-payment of premium when due by the Policyholder or You; or

   e) the Group Life Insurance Policy no longer insures Your class.

Life Insurance

What is the life insurance benefit?
Upon Your death, the Company will pay the Amount of Insurance as determined from Your Enrollment Form, as approved by the Company. This amount will be payable to Your Beneficiary after the Company receives satisfactory proof of Your death . The Company may, at its option, pay a portion of the death benefit to any person appearing to the Company to be equitably entitled by reason of having incurred funeral or other expenses incident to Your last illness or death. The amount payable will not exceed $250.

What should be done in the case of death?
Normally, if You die while a member of the group, Your plan administrator will be aware of that fact. Consequently, the plan administrator will initiate a procedure for making a death benefit claim to the Company. Your Beneficiary may have to supply the plan administrator or the Company with certain information before a death benefit claim procedure may begin.

It is always a good idea to keep Your Beneficiary informed concerning Your coverage under this plan. In event of Your death, it will be up to Your Beneficiary or legal representative to inform the plan administrator so that a death claim procedure may begin.

What recourse do You or Your Beneficiary have if Your claim is denied?
On any claim, the claimant or His representative must appeal to Us for a full and fair review.

1) You or Your Beneficiary must request a review upon written application within:
   a) 180 days of receipt of claim denial if the claim requires a determination of disability, or
   b) 60 days of receipt of claim denial for all other claims and
2) You or Your Beneficiary may request copies of all documents, records, and other information relevant to Your claim; and
3) You or Your Beneficiary may submit written comments, documents, records, and other information relating to Your claim.

We will respond to You or Your Beneficiary in writing with our final decision on Your claim.

Conversion Privilege

If my group life coverage ends, what rights do I have to convert to a new individual policy?
The Company will issue You a new individual policy of life insurance without Evidence of Insurability, subject to the following:

1) If Your group life insurance or any portion of it ends due to termination of employment with the Policyholder organization or membership in any of this policy's classes, You may convert all or any portion of Your life insurance which was in force on the date of termination. However, the Amount of Insurance may not be greater than the amount which terminated.

2) If Your group life insurance ends due to termination of the Group Life Insurance Policy or amendment of the Group Life Insurance Policy which makes Your class ineligible for life insurance, You may convert a limited Amount of Insurance. You must have been continuously insured under this Group Life Insurance Policy for at least five (5) consecutive years immediately before termination. The Amount of Insurance may not exceed the lesser of the amount which terminated or $5,000.

The new individual policy will be issued only if application is made and the first premium is paid to the Company within 31 days after the termination of Your insurance.

The new individual policy may be any permanent (non-term) plan in use and approved for Conversion by the Company at Your attained age. The new individual policy will be issued without:

1) Waiver of Premium, Accidental Death and Dismemberment, Accelerated Death Benefit, or any other rider or additional benefits;

2) preferred risk premium rates; or

3) other premium discounts.

The premium will be at the Company's customary rate then applicable to the class of risk to which You belong, and must be paid within 31 days after termination of Your group coverage. The new individual policy will take effect at the end of the 31-day period during which application for that policy may be made. The new individual policy will be in place of all benefits under the Group Life Insurance Policy.

What happens if I die during the Conversion period?
If You die during the Conversion period, the Amount of Life Insurance which You are entitled to convert will be paid to Your Beneficiary. This benefit will be paid even if You had not applied for Conversion.

Accelerated Death Benefit

ANY BENEFIT PAID UNDER THIS PROVISION MAY BE TAXABLE. IF SO, YOU OR YOUR BENEFICIARY MAY INCUR A TAX OBLIGATION. AS WITH ALL TAX MATTERS, YOU SHOULD CONSULT YOUR PERSONAL TAX ADVISOR TO ASSESS THE IMPACT OF THIS BENEFIT.

What is the Accelerated Death Benefit?
Upon diagnosis of a Terminal Illness or Injury, You may make a one-time election to accelerate a partial payment of death benefits.

How will the amount I receive be determined?
The amount available for acceleration will be the Amount of Insurance provided under the Group Life Insurance Policy less any reductions that would occur within twelve months of the request. The maximum benefit is 50% of the Amount of Insurance. See the minimum and maximum benefit limitations below.

Example:	The Amount of Insurance	$20,000*
	Accelerated Death Benefit Requested (50%)	10,000
	Accelerated Death Benefit Payment	10,000
Balance Payable at Death (subject to any scheduled reductions)		$10,000

*The above example assumes no scheduled reductions within 12 months.

What is a Terminal Illness or Injury?
A Terminal Illness or Injury is any non-correctable medical condition that, in the physician's best medical judgment, will result in Your death within 12 months from the date of the physician's certification. The Terminal Illness or Injury must be diagnosed after Your effective date under the Group Life Insurance Policy to which this Accelerated Death Benefit Provision is included.

What is the minimum and maximum amount available as an Accelerated Death Benefit?
The minimum Accelerated Death Benefit that may be elected is $2,500. If 50% of the Amount of Insurance provided under all Kansas City Life Insurance Company Group Master Policies is less than $2,500, no benefit will be available. The maximum Accelerated Death Benefit available on any one Insured Individual under all Kansas City Life Insurance Company Group Master Policies which have the Accelerated Death Benefit Provision is $100,000.

How will election of an Accelerated Death Benefit affect my remaining Amount of Insurance?
When an Accelerated Death Benefit is paid, the Amount of Insurance will be reduced by the amount of the Accelerated Death Benefit. The remaining Amount of Insurance will be paid according to the terms of the Group Life Insurance Policy, subject to any reduction and termination provisions. Also, any amount You could otherwise have converted to an individual contract will be reduced by the amount of the Accelerated Death Benefit.

How do I request an Accelerated Death Benefit?
You may claim the Accelerated Death Benefit by forwarding to the Company a physician's certification satisfactory to the Company and a completed claim form, executed by You. Claim forms are available from the Company. The Company reserves the right to request additional medical information from any physician or institution that may have provided treatment for the Terminal Illness or Injury. The Company may require You to be examined by a physician of their choice and at their expense.

The Company reserves the right to require the written consent of any assignee or creditor Beneficiary. Irrevocable beneficiaries must consent in writing to payment of the Accelerated Death Benefit.

If You die after a request for an Accelerated Death Benefit is submitted but before an Accelerated Death Benefit is paid, no Accelerated Death Benefit will be payable.

A Physician is a licensed doctor of medicine (M.D.) or licensed doctor of osteopathy (D.O.) operating within the scope of licensure. This does not include You, Your parents, Spouse, Children, stepchildren, aunts, uncles, grandparents, grandchildren, siblings, or in-laws.

This provision terminates on the date the Group Life Insurance Policy terminates for any reason.

Waiver of Premium Benefit

(This coverage is not available for Conversion.)

What is the definition of Total Disability/Totally Disabled?
Total Disability means disability which prevents You from engaging in the material and substantial duties of any gainful business or occupation, for which You are or could reasonably become qualified by reason of education, training or experience.

Total Disability requires:

1) the regular attendance by a licensed physician other than You or a family member;

2) that disability occurs while the Waiver of Premium benefit is in force with respect to You and is the result of sickness or bodily injury; and

3) that disability began prior to the policy anniversary date when Your age is 60.

What is the Waiver of Premium benefit?
The Company will waive the payment of Your life insurance premiums for coverage under the Group Life Insurance Policy, excluding Accidental Death and Dismemberment, if You are Totally Disabled for a minimum of 9 months.

What risks are not covered under the Waiver of Premium benefit?
Premiums will not be waived if disability results from:

1) any intentionally self-inflicted injury, suicide, or suicide attempt, whether sane or insane;

2) war, or any act of war, whether declared or undeclared;

3) any injury received while in any armed service of a country which is at war or engaged in armed conflict;

4) taking part in a riot or insurrection or an act of riot or insurrection; or

5) participation in an illegal occupation or activity or attempt to commit a felony.

What are the proof of disability requirements?
Satisfactory written proof of Total Disability must be received by the Company before premiums will be waived. Proof must be given to the Company:

1) during Your lifetime and continued Total Disability; and

2) within one year after Total Disability begins.

Does the Company require proof of continued disability?
Yes. After initial proof of Total Disability, the Company may require, at reasonable intervals, proof that You are still Totally Disabled. However, after two years of continuous Total Disability, proof will not be required more often than once a year. The Company may require You to be examined by a medical examiner chosen by the Company and at its expense. If You fail to submit any required proof or refuse to be examined as required by Us, then Your coverage may terminate.

What should be done when I recover or return to work?
You should give immediate notice to the Company when You recover from Total Disability or return to work.

Should premiums continue to be paid prior to a disability claim being approved?
Yes. Premiums due before a Total Disability claim is approved should be paid prior to the expiration of the grace period. If the claim is approved, any premium paid which is eligible for waiver will be refunded.

Does the Waiver of Premium benefit continue if coverage ceases under the Group Life Insurance Policy?
If coverage ceases under the Group Life Insurance Policy, after You qualify for Waiver of Premium, Your coverage will not be affected.

What Amount of Insurance will be waived under this benefit?
The Amount of Insurance for which premiums will be waived and for which a death benefit may be paid, will be the Amount of Life Insurance, excluding Accidental Death and Dismemberment, shown in Your Enrollment Form, as approved by the Company. However, the death benefit cannot exceed the amount in force on the date disability commenced and will be subject to all benefit reductions and termination provisions in the Group Life Insurance Policy.

When will insurance terminate under this provision?
This benefit terminates on the earliest of:

1) the first day You cease to be Totally Disabled;
2) the date You fail to supply proof of continuous disability as required above;
3) the date You fail to be examined as required above;
4) the date You attain age 70;
5) the date You return to active full-time work; or
6) the date You are Retired.

Following the termination of this benefit:

1) if You are then eligible for insurance under the Group Life Insurance Policy, insurance will be subject to all the provisions of the Group Life Insurance Policy; or
2) if You are not then eligible for insurance under the Group Life Insurance Policy, You will be entitled to Conversion.

Accidental Death and Dismemberment (AD&D) Benefit

(This coverage is not available for Conversion, Waiver of Premium or Accelerated Death.)

What conditions are necessary for benefits to become payable?
The Company will pay a benefit if You suffer an accidental injury while that Covered Person is insured and:

1) a Loss results directly from such injury, independent of all other causes; and

2) such Loss occurs within 90 days after the date of the accident causing the injury.

When should the Company be notified of a claim?
A claimant must give the Company, or Our appropriate representative, written notice of a claim within 20 days after the Loss happens or starts. If notice cannot be given within that time, it must be given as soon as reasonably possible.

Such notice must include:

1) the claimant's name and address; and

2) the Policy number.

Are special forms required to file a claim?
Within 15 days of receiving a notice of claim, the Company or Our appropriate representative will send forms to the claimant for providing proof of Loss. If the forms are not provided within 15 days, the claimant may submit any other written proof which fully describes the nature and extent of the claim.

When must proof of Loss be given?
Satisfactory written proof of Loss must be sent to the Company or Our appropriate representative within 90 days after the date of such Loss. However, all claims must be submitted to the Company within 90 days of the date any individual's insurance terminates.

If proof is not given by the time it is due, it will not affect the claim if:

1) it was not possible to give proof within the required time; and

2) proof is given as soon as possible, but no later than a year after it is due unless the claimant is not legally competent.

When and to whom will a claim be paid?
Benefits for Loss of life will be paid in accordance with Your life insurance Beneficiary designation. Unless otherwise specified, benefits for all other Losses are payable to You.

Benefits for all other Losses will be paid as soon as written proof is received. Benefits for all other Losses will be paid not more than 60 days after written proof is received.

Benefits due under the Policy are overdue if not paid within forty-five (45) days after the Company receives proof of Loss, necessary medical information, and other information essential for the Company to administer policy provisions.

If the claim is not denied for valid and proper reasons by the end of the forty-five (45) day period, the Company will pay You interest on accrued benefits at the rate of one and one-half percent (1 ½%) per month on the amount of such claim until it is settled or adjudicated.

In the event the Company fails to pay benefits when due, You may bring action to recover such benefits, any interest which may accrue, and any other damages as may be allowable by law.

Any payments other than for Loss of life which are owed at Your death may be paid to Your estate. If any payment is owed to:

1) Your estate;

2) a person who is a minor; or

3) a person who is not legally competent,

then the Company may pay up to $1,000 to Your relative who is entitled to it in the Company's opinion. Any such payment shall fulfill the Company's responsibility for the amount paid.

What types of injuries are excluded from coverage?
No benefit will be paid for a Loss caused or contributed to by:

1) sickness;
2) disease;
3) any medical or surgical treatment for items (1) or (2);
4) any infection, except a pus-forming infection of an accidental cut or wound;
5) war or any act of war, whether war is declared or not;
6) any injury received while in any armed service of a country which is at war or engaged in armed conflict;
7) any intentionally self-inflicted injury, suicide, or suicide attempt, whether sane or insane;
8) taking drugs, sedatives, narcotics, barbiturates, amphetamines or hallucinogens unless prescribed for or administered by a licensed physician;
9) the injured person's intoxication;
10) riding in or boarding or alighting from any vehicle or device for aerial navigation as a pilot or crew member;
11) driving or riding in any vehicle used in a race, speed or endurance test or for acrobatic or stunt driving; or
12) participation in an illegal occupation or activity or attempt to commit a felony.

Intoxication means that blood alcohol content or the results of other means of testing blood alcohol level, meet or exceed the legal presumption of intoxication under the law of the state where the accident took place.

What is the benefit payable?
The benefit payable for any Loss is that which is shown opposite the Loss in the following schedule. The Principal Sum is defined earlier in this certificate. No benefit is payable for any Loss which is not shown in the schedule below.

Description of Loss	**Benefit**
Loss of life	Principal Sum
Loss of a hand	One-half the Principal Sum
Loss of a foot	One-half the Principal Sum
Loss of an eye	One-half the Principal Sum
Loss of speech or hearing	One-half the Principal Sum
Loss of thumb and index finger on either hand	One-quarter the Principal Sum
Loss of movement of both upper and lower limbs (Quadriplegia)	Principal Sum
Loss of movement of three limbs (Triplegia)	Three-quarters the Principal Sum
Loss of movement of both lower limbs (Paraplegia)	Three-quarters the Principal Sum
Loss of movement of both upper and lower limbs on one side of the body (Hemiplegia)	One-half the Principal Sum
Loss of movement of one limb (Uniplegia)	One-quarter the Principal Sum
More than one of the above resulting from one accident	Principal Sum or the sum of the Benefits payable for each Loss, whichever is less.

Loss means the following:

1) Loss of a hand or foot means that it is completely cut off at or above the wrist or ankle joint.
2) Loss of an eye means that sight in the eye is completely lost and cannot be recovered or restored.
3) Loss of speech or hearing means that speech or hearing is lost entirely and the Loss cannot be recovered or restored. Hearing must be lost in both ears.
4) Loss of movement of limbs means that the movement is completely lost and is irreversible.
5) Loss of thumb and index finger means actual severance through or above the metacarpophalangeal joints.

Seat Belt/Air Bag Benefit

(This coverage is not available for Conversion, Waiver of Premium or Accelerated Death.)

Subject to all conditions and limitations of this AD&D Benefit, if You suffer a Loss under the AD&D Benefit, while:

1) a passenger riding in; or

2) the licensed operator of,

an Automobile and, at the time of the accident, You were properly wearing a Seat Belt, as verified on the police report, then a Seat Belt Benefit will be payable in addition to the Principal Sum.

What is the Seat Belt Benefit payable?
The Seat Belt Benefit payable is the lesser of:

1) 10% of the Principal Sum; or

2) $10,000.

What conditions are necessary for an Air Bag Benefit to become payable?
If a Seat Belt Benefit is payable, the Company will pay an additional 5% of the Principal Sum, subject to a maximum of $5,000, as an Air Bag Benefit, provided that:

1) You were positioned in a seat that was equipped with a factory installed Air Bag;

2) You were properly strapped in the Seat Belt when the Air Bag inflated; and

3) the police report establishes that the Air Bag inflated properly upon impact.

Air Bag means an inflatable supplemental passive restraint system installed by the manufacturer of the Automobile, or proper replacement parts as required by the Automobile manufacturer's specifications, that inflates upon collision to protect an individual from injury and death. An Air Bag is not considered a Seat Belt.

Automobile means a duly-registered, four-wheeled, private-passenger car, pick-up truck, van, self-propelled motor home, or sport utility vehicle which is not being used as a Common Carrier.

Common Carrier means a conveyance operated by a concern, other than the Employer, organized and licensed for the transportation of passengers for hire and operated by an Employee of that concern.

Seat Belt means an unaltered belt, lap restraint, or lap and shoulder restraint installed by the manufacturer of the Automobile, or proper replacement parts as required by the Automobile manufacturer’s specifications.

Repatriation Benefit

(This coverage is not available for Conversion, Waiver of Premium or Accelerated Death.)

Subject to all conditions and limitations of this AD&D Benefit, if You die, then a Repatriation Benefit will be paid in addition to the Principal Sum. For a Repatriation Benefit to be payable, the death must occur at least 100 miles from the deceased person's place of permanent residence.

What is the Repatriation Benefit payable?
The Repatriation Benefit payable is the lesser of:

1) the expense incurred for:
    a) preparation of Your body for burial or cremation; and
    b) transportation of Your body to the place of burial or cremation; or
2) 5% of the Principal Sum; or
3) $5,000.

Child(ren) Education Benefit

(This coverage is not available for Conversion, Waiver of Premium or Accelerated Death.)

Subject to all conditions and limitations of this AD&D Benefit, if You die, then an Education Benefit will be paid in addition to the Principal Sum. This benefit is payable to each of Your dependents who qualifies as a Student.

Who may qualify as a Student?
A Student, for the purpose of this Education Benefit, means a person who is Your dependent on the date of Your death, and who:

1) is a post-high school student who attends a school for higher learning on a Full-time basis on the date of Your death; or

2) became a Full-time post-high school student in a school for higher learning within 365 days after Your death and was a student in the 12th grade on the date of Your death.

The term "Full-time" student shall mean registered for not less than 12 course credit hours per semester. If the institution establishes Full-time student status by a method other than semester credit hours, the Company reserves the right to determine whether the student qualifies as Full-time.

No benefit is payable to any dependent who has not furnished proof to the Company of his Student status.

What is the Education Benefit payable?
The Education Benefit payable is the lesser of:

1) the actual tuition expense for any one school year; or

2) 2.5% of the Principal Sum; or

3) $2,500.

The Company will not pay more than one Education Benefit per Student during any one school year.

If the Student is a minor, the Company will pay benefits to the Student's legal representative.

When will payments terminate?
The Education Benefit will no longer be payable on the first to occur of:

1) the date on which the fourth Education Benefit for a Student is paid; or

2) the end of the 12th consecutive month during which the dependent has not furnished satisfactory proof to the Company that he is a Student.

What benefits are payable if no dependent qualifies as a Student?
If no dependent qualifies as a Student, then the Company will pay $1,250 in accordance with Your Beneficiary designation.

Spouse Education Benefit

(This coverage is not available for Conversion, Waiver of Premium or Accelerated Death.)

Subject to all conditions and limitations of this AD&D Benefit, if You die, then a Spouse Education Benefit will be paid in addition to the Principal Sum. This benefit is payable to Your Spouse.

What conditions are necessary for Spouse Education Benefits to become payable?
To qualify for this Benefit, Your Spouse must enroll in an Occupational Training program:

1) for the purpose of obtaining an independent source of income; and

2) within one year of the date of your death.

What is the Spouse Education Benefit payable?
The Spouse Education Benefit payable is the lesser of:

1) the Expense Incurred for Occupational Training; or

2) 2.5% of the Principal Sum; or

3) $2,500.

The Company will pay the Spouse Education Benefit immediately after the Company receives proof that Your Spouse has enrolled in an Occupational Training program.

What benefits are payable if there is no surviving Spouse?
If there is no surviving Spouse, the Company will pay $1,250 in accordance with Your Beneficiary designation.

Occupational Training means any:

1) education;

2) professional; or

3) trade training;

program which prepares the Spouse for an occupation for which he otherwise would not have been qualified.

Expense Incurred means:

1) the actual tuition charged, exclusive of room and board; and

2) the actual cost of the materials needed

for the Occupational Training program. The expense must be incurred during the two year period that begins on the date of Your death.

Day Care Benefit

(This coverage is not available for Conversion, Waiver of Premium or Accelerated Death.)

Subject to all conditions and limitations of this AD&D Benefit, if You die, then a Day Care Benefit is payable in addition to the Principal Sum. The Day Care Benefit is payable for each dependent if:

1) such dependent is less than age seven (7) at the time of death; and

2) proof of such dependent's enrollment in a Day Care Program is provided as described below.

What is the Day Care Benefit payable?
The Day Care Benefit payable is the lesser of:

1) $2,500; or

2) 2.5% of Your Principal Sum.

One Day Care Benefit is payable each year for each dependent who qualifies for Day Care Benefits. No more than four Day Care Benefits will be payable for each dependent. Payment will be made to the person who has primary responsibility for such dependent's expenses.

What proof must be given?
Proof of a dependent's enrollment in a Day Care Program may be in the form of, but will not be limited to, the following:

1) a copy of the dependent's approved enrollment application in a Day Care Program;

2) canceled check(s) which prove payment for a Day Care Program; or

3) a letter from the Day Care Program stating that the dependent:

    a) is attending a Day Care Program; or

    b) has been enrolled in a Day Care Program and will be attending within 365 days of the date of Your death.

Proof of enrollment must be sent to the Company prior to the last day of the 12th month on or next following the date of Your death.

Day Care Program means a program of Child care which:

1) is operated in a private home, school or other facility;

2) provides and charges a fee for the care of children; and

3) is licensed as a Day Care Center or is operated by a licensed Day Care Provider, if such licensing is required by the state or jurisdiction in which it is located; or

4) if licensing is not required, provides childcare on a daily basis for 12 months a year.

A Day Care Program will not mean a program of childcare which is provided by an immediate relative of the Child receiving the care. An immediate relative is a sibling, parent, step-parent, grandparent, aunt, or uncle.

What benefits are payable if no person is eligible for Day Care Benefits?
If no dependent qualifies for Day Care Benefits, then the Company will pay $1,250 in accordance with Your Beneficiary designation.

KANSAS CITY LIFE
INSURANCE COMPANY
Broadway at Armour / Box 219139 / Kansas City, Missouri 64121-9139
Telephone: (816) 753-7000
Web Site: www.kclife.com

How the Group Accelerated Death Benefit Rider Works:

You may request an Accelerated Death Benefit of up to 50% of the Amount of Insurance if you are diagnosed by a physician with a terminal illness. A terminal illness is any non-correctable medical condition that, in the physician's best medical judgment, will result in your death within twelve months from the date of the physician's certification.

The benefit is equal to 50% of the Amount of Insurance, up to $100,000.

The maximum amount available is 50% of the Amount of Insurance, up to $100,000. The minimum amount available must be at least $2,500. We will adjust the Amount of Insurance after the Accelerated Death Benefit is paid.

Example: You request an Accelerated Death Benefit of 50% of the Amount of Insurance.

Current Amount of Insurance	$30,000.00
Accelerated Death Benefit Percentage	50%
Accelerated Death Benefit requested	$15,000.00
Accelerated Death Benefit payment	$15,000.00

ANY BENEFITS PAID UNDER THIS RIDER MAY BE TAXABLE. IF SO, THE INSURED INDIVIDUAL OR THEIR BENEFICIARY MAY INCUR A TAX OBLIGATION. AS WITH ALL TAX MATTERS INSURED INDIVIDUALS SHOULD CONSULT THEIR PERSONAL TAX ADVISOR TO ASSESS THE IMPACT OF THIS BENEFIT.

The Following Important Notice is Provided by Your Employer for Your Information Only.

Conforming Instrument
For the purpose of meeting certain requirements of the Employee Retirement Income Security Act of 1974, the following information and the attached Claim Procedures and Statement of ERISA Rights are provided for use with your booklet-certificate to form the Summary Plan Description.

The benefits described in your booklet are provided under a group plan by the Insurance Company and are subject to the terms and conditions of that plan.

A copy of this plan is available for your review during normal working hours in the office of the Plan Administrator.

1. Plan Name

Group Plan for employees of Bourbon County

2. Plan Number

3. Plan Sponsor

Bourbon County
210 S. National
Fort Scott, KS 66701

4. Employer

Bourbon County
210 S. National
Fort Scott, KS 66701

5. Employer Identification Number

486036941

6. Type of Plan

Welfare Benefit Plan providing Group Life benefits.

7. Plan Administrator

Bourbon County
210 S. National
Fort Scott, KS 66701

8. Agent for Service of Legal Process

For the Plan:

Bourbon County
210 S. National
Fort Scott, KS 66701

For the Policy:
Kansas City Life Insurance Company
PO Box 219425
Kansas City, MO 64121-9425

In addition to the above, Service of Legal Process may be made on a plan trustee or the plan administrator.

9. **Sources of Contributions** -- The Employer pays the premium for the insurance, but may allocate part of the cost to the employee. The Employer determines the portion of the cost to be paid by the employee.

10. **Type of Administration** -- The plan is administered by the Plan Administrator with benefits provided in accordance with the provisions of the applicable group plan.

11. The Plan and its records are kept on a Policy Year basis.

12. Labor Organizations

None

13. Names and Addresses of Trustees

Bourbon County
210 S. National
Fort Scott, KS 66701

14. Plan Amendment Procedure

The Plan Administrator reserves full authority, at its sole discretion, to terminate, suspend, withdraw, reduce, amend or modify the Plan, in whole or in part, at any time, without prior notice. The Employer also reserves the right to adjust your share of the cost to continue coverage by the same procedures

Statement of ERISA Rights

You are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

1) Receive Information About Your Plan and Benefits:

   a. Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

   b. Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

   c. Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

2) Prudent Actions by Plan Fiduciaries:

In addition to creating rights for plan participants ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called ""fiduciaries"" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

3) Enforce Your Rights:

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

4) Assistance with Your Questions:

If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the, Employee Benefits Security Administration, U.S.

Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Claim Procedures for Life Insurance Plans

1) Claims for Benefits:

   If you would like to present a claim for benefits for yourself or your insured dependents, you should obtain a claim form(s) from your Employer or Plan Administrator. The applicable section of such form(s) should be completed by (1) you, (2) the Employer or Administrator and (3) the Attending Physician or hospital.

   Following completion, the claim form(s) must be forwarded to the individual authorized to process and pay the claims (Administrator or Insurance Company's Claim Representative). The individual authorized to process and pay the claims will compute benefits due, and will issue draft(s) in settlement. Unless the employee assigns benefits to a doctor or to a hospital, drafts will be made payable to you.

   A decision will be made by the Insurance Company no more than 90 days after receipt of due proof of loss, except in special circumstances (such as the need to obtain further information), but in no case more than 180 days after the due proof of loss is received. The written decision will include specific reasons for the decision and specific references to the plan provisions on which the decision is based.

2) Appealing Denial of Claims -- If a claim for benefits is wholly or partially denied, notice of the decision shall be furnished to you. This written decision will:

   a. give the specific reason or reasons for denial;

   b. make specific reference to policy provisions on which the denial is based;

   c. provide a description of any additional information necessary to prepare the claim and an explanation of why it is necessary; and

   d. provide an explanation of the review procedure.

   On any denied claim you or your representative may appeal to the Insurance Company for a full and fair review. You may:

   e. request a review upon written application within 60 days of receipt of claim denial;

   f. review pertinent documents; and

   g. submit issues and comments in writing.

A decision will be made by the Insurance Company no more than 60 days after receipt of the request for review, except in special circumstances (such as the need to hold a hearing), but in no case more than 120 days after the request for review is received. The written decision will include specific reasons for the decision and specific references to the plan provisions on which the decision is based.