KANSAS CITY LIFE

New Business Checklist

Please confirm that the following is submitted with all new cases.

- ❑ Completed application for group insurance
- ❑ Completed employee enrollment forms or census spreadsheet *(census is preferred for ease of processing)*
- ❑ Sold Quote with elected plan and rates from www.directbenefits.com
- ❑ If paying by ACH, please complete the included form (binder check for first premium required as noted below)
- ❑ For monthly billing by check please mail binder check for first month's premium payable to Kansas City Life Insurance Company at address below

If applicable, please confirm that all of the following documentation is provided prior to coverage on take-over cases:

- ❑ Copy of Prior Carrier's summary of benefits
- ❑ Copy of Prior Carrier's most recent billing statement

Policy Documents Delivery Acknowledgement

Policy documents will be delivered how requested on the master application. ID cards will be mailed to the employer for distribution.

After all the information listed above is completed and signed, submit all forms using one of the following delivery methods:

Email: agentsupport@directbenefits.com

Fax: **651-649-3502 ATTN: Group Sales**

Mail: **Direct Benefits, Inc.**
55 East 5th Street, Suite 500
Saint Paul, MN 55101

***Please send hard copy of binder check to the address above**

Submission Date:

New groups should be received no later than the 28th of the month of the prior to the desired effective date in order to review and submit to the carrier.

DirectBenefits
AN ALERA GROUP COMPANY

KANSAS CITY LIFE
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

Dental / Vision Verification of Eligibility and Enrollment

Participation requirements are a condition of coverage. These requirements may vary depending upon the plan selected. Statements may be used to contest a claim or the validity of the policy only if they are contained in the application. See the policy for further information. Please complete the following section to verify eligibility and enrollment.

		Dental Insurance	Vision Insurance
1.	Total number of employees on the payroll.		
2.	Total number of part-time employees including temporary or seasonal employees. (Employees working less than your group's definition of full-time; minimum of 30 hours per week.)		
3.	Total number of employees who have not completed the probationary waiting period.		
4.	Number of full-time employees (subtract #2 and #3 from #1).		

If the employer pays 100% of the employee's cost, skip to number 8 below.

5.	Are there other dental plans to be offered concurrently with your Kansas City Life group dental plan? ☐ Yes ☐ No		
	If yes, how many employees are enrolled in your other dental plans?		Not applicable
6.	Total number of employees who have waived because they are covered by their spouse's plan.		Not applicable
7.	Number of eligible employees (subtract #5 and #6 from #4). If #5 and #6 combined are more than 50% of #4, underwriting review is required.		(same as #4)
8.	Number of enrolled employees.		
9.	Number of COBRA participants.		

For Dental Insurance, this application must be accompanied by a copy of an inforce certificate and benefit schedule, a current month's billing from the current carrier, as well as proof of the effective date for each employee (and dependents, if insured).

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.

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.

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, MASSACHUSETTS, TENNESSEE, VIRGINIA, 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 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 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.

NOTICE TO OREGON APPLICANTS:

It may be crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties could include imprisonment and fines, and may result in a denial of insurance benefits.

NOTICE TO PENNSYLVANIA APPLICANTS:

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim 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 and subjects such person to criminal and civil penalties.

KANSAS CITY LIFE

GROUP BENEFITS

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

GRP # _____

Group Insurance Enrollment Form

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) ☐Initial enrollment ☐Late entrant ☐New hire ☐Change ☐Other _____	

COMPLETED BY EMPLOYEE

10. Last Name, First Name, Middle Initial		11. E-mail	
12. Home Address, City, State and Zip			
13. Social Security Number	14. ☐Male ☐Female	15. Date of Birth (M/D/Y) / /	16. ☐Single ☐Married

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

17. Coverage(s) for Employee and/or Dependents (Employee coverage required)

☐Basic Life & AD&D ☐ Voluntary Life Amount: _____
☐Dental If Applicable: ☐Low Plan ☐High Plan
☐Short-Term Disability ☐ Voluntary STD If Applicable: Amount: _____
☐Long-Term Disability ☐ Voluntary LTD If Applicable: Amount: _____
☐Vision If Applicable: ☐Low Plan ☐High Plan
☐Accident If Applicable: ☐Low Plan ☐Medium Plan ☐High Plan

18. Coverage(s) for Dependents (Employee coverage required)

For Dependent Life and/or Voluntary Life, the Spouse must be under age 70 to be eligible for Spouse coverage.

☐ Dependent Life Spouse Date of Birth (M/D/Y): _____
☐ Spouse Voluntary Life Amount: _____
☐ Child/ren Voluntary Life Amount: _____
Dental: ☐Spouse ☐Child/ren
Vision: ☐Spouse ☐Child/ren
Accident: ☐Spouse ☐Child/ren

19. If COBRA continuee, please supply qualifying event and date:

20. Full Name of Primary Beneficiary and Relationship to you:	21. Full Name of Contingent Beneficiary and Relationship to you:

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

22. Name (show last name if different from employee)		Gender	Relationship	Date of Birth
Spouse			N/A	/ /
Child				/ /
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 as shown in box 5.

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.

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.

23. Signature of Employee: _____ **Date:** _____

(To decline any coverages, complete "Declination of Coverage" on page 3.)

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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.

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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.

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NOTICE TO UTAH APPLICANTS IF DENTAL AND/OR VISION COVERAGE IS APPLIED FOR:
The policy provides dental / vision benefits only. Review your policy carefully.

NOTICE TO VIRGINIA APPLICANTS:
Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated the state law.

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

Indicate Coverage(s) Declined Below:

Coverage(s) for Employee:

- ☐ Basic Life & AD&D
- ☐ Dental
- ☐ Short-Term Disability
- ☐ Long-Term Disability
- ☐ Accident
- ☐ Voluntary/Supplemental Life
- ☐ Voluntary STD
- ☐ Voluntary LTD
- ☐ Vision

Coverage(s) for Dependents (Employee coverage required):

Life:	☐ Spouse	☐ Children
Dental:	☐ Spouse	☐ Children
Vision:	☐ Spouse	☐ Children
Accident:	☐ Spouse	☐ Children

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: _____

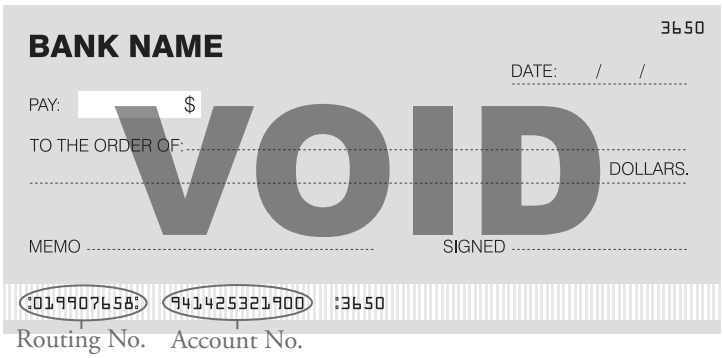
KANSAS CITY LIFE
GROUP BENEFITS

Internal Use Only: ____1 ____15

Electronic Debit Authorization Form/ACH

1. Group name	2. Group No.
3. Contact name	4. Contact phone No.
5. Bank name	
6. Bank routing No.	7. Bank account No.

Your routing and checking account numbers appear at the bottom of your check.



To ensure accuracy, please attach a voided check.

Please select one of the following:

_____ Automatic Debit – recurring debit from checking account. Please complete and sign this form, attach a voided check for the account you wish to debit and return to the address listed below.

_____ Change of accounts and/or financial institution. Please complete and sign this form, attach a voided check for the account you wish to debit and return to the address listed below.

_____ Cancel ACH participation. Please complete and sign this form for the account you wish to remove from ACH participation and return to the address listed below.

I certify that I have read and understand this Electronic Debit Authorization form allowing Kansas City Life Insurance Company to deduct the premium payment on the due date each month from the designated bank account through an electronic funds transfer. This authority will remain in effect until I have signed a new authorization or upon written notice to cancel ACH participation. I understand that a $20 service charge will apply for insufficient funds transactions.

Signature_____ Date_____

If you are interested in paperless billing, contact your Group Client Services Representative for details.
Please complete and sign this form and return to: **Kansas City Life Group Administration Department**
P.O. Box 219425, Kansas City, MO 64121-9425
Fax: 816-753-2964 • *afi@kclife.com*