KANSAS CITY LIFE

GROUP BENEFITS

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

GRP # __25515_____

Group Insurance Enrollment Form

COMPLETED BY EMPLOYER

1. Employer Evangelical Lutheran Education Association			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.)

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 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 GEORGIA 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 subject to fines and confinement in prison.

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 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 a 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.

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: _____