



K·C·L G R O U P
B E N E F I T S

3520 Broadway / P.O. Box 219425 / Kansas City, Missouri 64121-9425
Telephone: (877) 266-6767 / Fax: (816) 531-4648

**NEW BUSINESS SELECT TRUST PLUS CHECKLIST FOR THE STATE OF
WASHINGTON**

Products include Dental Only

- Signed Application for Group Trust Insurance - Form GA172 *(The group and the agent must sign both pages of the application)*
- Check for the first month's deposit premium made payable to [Kansas City Life Insurance Company](#)
- Completed employee enrollment cards - Form GA173
- For dental replacement coverage please supply:
 - a copy of the prior carrier's benefits booklet or policy
 - a copy of the group's **most recent bill** showing the employees **original effective dates of coverage**. If the bill does not show effective dates, then please provide the most recent bill along with a 12 month old bill or adequate proof of effective dates for all employees. *(A letter on the group's letterhead, signed by an officer of the company stating the employee's names and original effective dates will suffice is adequate proof if not available.)*
 - a deductible report from the prior carrier. If no report is supplied, employees and their dependents will be required to submit the prior carrier's EOB to prove calendar year deductible has been met
- If agent is not contracted with Kansas City Life Insurance Company, request licensing materials from Sales Representative or Sales Coordinator

All papers must be signed and dated on or before the requested effective date and be received by Kansas City Life within five working days of that requested effective date to receive that effective date.

****Note:**

To receive dental takeover, the group must have coverage in force for at least 24 months prior to the requested effective date. Takeover benefits are available only to those individuals insured under the employer's dental plan in effect at the time of the employer's application for the KCL Select Trust Plus Dental plan. New hires and future additions will not get credit for prior coverage.



EMPLOYER (CORRECT LEGAL NAME)		FEDERAL TAX I.D. NUMBER	
MAILING ADDRESS		PHONE NUMBER	FAX NUMBER
STREET ADDRESS		NATURE OF BUSINESS (SIC)	
CITY	STATE	ZIP	EMAIL ADDRESS
NAME AND TITLE OF CONTACT: CONTRACTUAL MATTERS		NAME AND TITLE OF CONTACT: BILLING MATTERS <input type="checkbox"/> Same as Contractual	

Requested Effective Date (mm/dd/yy) Waiting Period for Insured Individuals (Current and future hires): First of month following: <input type="checkbox"/> 30 days <input type="checkbox"/> 60 days <input type="checkbox"/> 90 days <input type="checkbox"/> 180 days <input type="checkbox"/> Waive the waiting period for current individuals Are any individuals currently disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide full name and Social Security Number (Note: disabled employees are not eligible until returning to full-time work)	Employer Contribution (minimum of 25% employer contribution required) <input type="checkbox"/> All coverages are 100% employer paid <input type="checkbox"/> All coverages are _____% employer paid <input type="checkbox"/> Life Insurance is _____% employer paid <input type="checkbox"/> Dependent Life Insurance is _____% employer paid <input type="checkbox"/> Dental Insurance is _____% employer paid for employee and _____% for dependents <input type="checkbox"/> Short Term Disability is _____% employer paid <input type="checkbox"/> Long Term Disability is _____% employer paid
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Coverage Applied For:

Life Insurance _____ # eligible _____ # participating **Eligibility** All full-time employees All full-time _____

Benefit Amount:
 Flat Amount \$_____ per individual (minimum of \$10,000)
 One Two Three times annual salary rounded to next higher \$1,000 if not multiple thereof. Minimum of \$10,000, maximum of \$_____
 Class Schedule (complete below)

Dependent Life Insurance _____ # eligible _____ # participating

Short Term Disability (STD) _____ # eligible _____ # participating **Long Term Disability (LTD)** _____ # eligible _____ # participating

Eligibility All full-time employees All full-time _____

Benefit Period: 13 weeks 26 weeks
 Benefit Amount: 60% of weekly base salary, maximum of _____
 \$500 \$750 other _____

Class Schedule (complete below) Flat \$_____ per week

Eligibility All full-time employees All full-time _____

Elimination Period: 90 days 180 days
 Maximum Monthly Benefit: \$1,000 \$5,000
 Industry: I II

Dental Insurance

Eligibility: All full-time employees All full-time _____
 _____ # eligible employees
 _____ # participating employees
 _____ # employees with eligible dependents
 _____ # participating employees with enrolled dependents

Orthodontia: Yes No
Calendar Year Maximum: \$1,000 \$1,500 \$2,000
Preventive deductible: Yes No
Takeover Coverage: Yes No
 (If yes, include copies of current bill, 12 month prior bill and certificate)

Class Schedule	<input type="checkbox"/> Life	<input type="checkbox"/> STD	(minimum of two employees per class)
Definition of Employee Class	1.	2.	3.
Benefit Amount	1.	2.	3.

DATE APPLICATION COMPLETED _____ EXECUTED AT _____

EMPLOYER SIGNATURE _____ NAME AND TITLE _____

PRODUCER SIGNATURE _____ Name of producer _____

Producer Address _____ Producer Phone Number _____

GENERAL AGENT _____ Address _____ Phone _____

Before submitting the group application, please read and sign the Joinder Agreement on the back of this form.

Joinder Agreement- IMPORTANT - READ CAREFULLY BEFORE SIGNING

The undersigned Employer applies for membership in the Select Trust Plus Group Insurance Trust and for participation in the insurance coverage.

The undersigned Employer, engaged primarily in the business described in the Agreement, applies for enrollment in the group insurance plan and adopts and subscribes to the terms of the Trust Agreement establishing the Select Trust Plus Group Insurance Trust. For purposes of this Agreement, the insurance company, Kansas City Life Insurance Company, will hereafter be referred to as KCL.

1. The Employer agrees to follow all terms, provisions, conditions and limitations of said Trust Agreement and all amendments thereto. The Employer further agrees to follow all terms, provisions, conditions and limitations contained in the Master Group Insurance Contract, established for and issued to the policyholder of the Select Trust Plus Group Insurance Trust (THE TRUSTEE, BLUE RIDGE BANK & TRUST).
2. The Employer agrees to pay the required contributions monthly, said contributions being comprised of insurance premium and administrative fees. The contributions must be made in the form of a check drawn against the account of the business, payable to Kansas City Life Insurance Company at the address designated by KCL. Employer understands that the contribution is payable on the first day of each month and will become delinquent if not received by KCL by the 31st of the month for which the contribution is due. Employer further understands that a delinquent status is cause for termination from the Trust, effective the last day of the calendar month for which complete contributions have been received.
3. The Employer agrees to make timely notification to KCL of any employee terminations, status changes or other material changes which serve to modify the statements contained in this application or render the Employer ineligible for continued participation in this Trust. Timely notification will be defined as being no more than 31 days past the actual date of such changes.
4. The Employer understands that all new employees are eligible for participation in this plan the first day of the month following completion of the elected waiting period and coverage will become effective on that date if the enrollment form is received by KCL before the employee's eligibility date. (When evidence of insurability is required, the application must be approved before coverage becomes effective.)
5. A minimum of two of the eligible members must be insured. If the employees contribute to the cost, the following relationship is required between eligible and enrolled employees:

**APPLICABLE FOR LIFE, SHORT TERM DISABILITY
AND LONG TERM DISABILITY ONLY**

Number of Eligible Employees	Minimum Requirement
2 - 5	100%
6 - 9	all but one
10 through 24	75%

**APPLICABLE FOR DENTAL
ONLY**

Number of Eligible Employees	Minimum Requirement
2-4	100%
5 or more	75%
Number of Eligible Employees (for dependent coverage)	
2-4 employees with eligible dependents	All but one must enroll
5 or more employees with eligible dependents	50% participation

6. The Employer understands that KCL is not responsible for complying with any state or federal laws or regulations which affect benefits that must be provided by employers to their employees.
7. The Employer understands that KCL conducts periodic audits to assure that eligibility, participation and contributions requirements are being met by all Employers on a continuing basis. Further, the Employer agrees to cooperate with KCL in the event of an audit with respect to the Employer's Employee Benefit Plan. Specific cooperation includes, but is not limited to, providing payroll documentation, copies of business licenses or Wage and Contribution Reports. Failure to cooperate upon request of KCL may result in termination or cancellation of coverage at the option of KCL.

The undersigned Employer certifies that it has read all sections of this document and fully understands and agrees to abide by all requirements and conditions stated therein. The Employer certifies that it has discussed eligibility and participation requirements with the producer of record and fully understands the limitations as applicable. The Employer understands that any false statements made in this application constitute the basis for termination or cancellation of coverage retroactive to the effective date and denial of all claims incurred. The Employer further understands that an inspection report may be ordered to verify the statements made in this application.

We understand that COVERAGE WILL NOT COMMENCE UNTIL this application has been approved by KCL and notice of approval has been transmitted to us as named Employer.

I understand that I should NOT CANCEL any existing coverage until notified that this application has been accepted by Kansas City Life Insurance Company.

DATE APPLICATION COMPLETED _____ EXECUTED AT _____

EMPLOYER SIGNATURE _____ NAME AND TITLE _____

PRODUCER SIGNATURE _____ Type or print name of producer _____

Producer Address _____ Producer Phone Number _____

GENERAL AGENT NAME Matrix Insurance Marketing Address 1225 S. Weller St. Suite 320, Seattle, WA 98144 Phone 206-521-9451



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) <input type="checkbox"/> Initial enrollment <input type="checkbox"/> Late entrant <input type="checkbox"/> New hire <input type="checkbox"/> Change <input type="checkbox"/> Other _____	

COMPLETED BY EMPLOYEE

10. Last Name, First Name, Middle Initial			
11. Home Address, City, State and Zip			
12. Social Security Number	13. <input type="checkbox"/> Male <input type="checkbox"/> Female	14. Date of Birth (M/D/Y)	15. <input type="checkbox"/> Single <input type="checkbox"/> Married

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

16. Coverage(s) for Employee: <input type="checkbox"/> Basic Life & AD&D <input type="checkbox"/> Voluntary/Supplemental Life Amount: _____ <input type="checkbox"/> Dental If Applicable: <input type="checkbox"/> Low Plan <input type="checkbox"/> High Plan <input type="checkbox"/> Short-Term Disability <input type="checkbox"/> Voluntary STD If Applicable: Amount: _____ <input type="checkbox"/> Long-Term Disability <input type="checkbox"/> Voluntary LTD If Applicable: Amount: _____ <input type="checkbox"/> Vision	17. Coverage(s) for Dependents (Employee coverage required) <input type="checkbox"/> Dependent Life <input type="checkbox"/> Spouse Voluntary/Supplemental Life Amount: _____ <input type="checkbox"/> Child/ren Voluntary/Supplemental Life Amount: _____ Dental: <input type="checkbox"/> Spouse <input type="checkbox"/> Child/ren Vision: <input type="checkbox"/> Spouse <input type="checkbox"/> Child/ren
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18. If COBRA continuee, please supply qualifying event and date: _____

19. Full Name of Primary Beneficiary and Relationship to you (applicable to life insurance only): _____

20. Full Name of Contingent Beneficiary and Relationship to you (applicable to life insurance only): _____

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

21. Name (show last name if different from employee)	Gender	Relationship	Date of Birth	[Other Dental Coverage]
Spouse		N/A		Y N
Child				Y N
Child				Y N
Child				Y N
Child				Y N

By signing below, I acknowledge I have read and I agree to the terms of the Provisions of Coverage contained on the reverse side of this Enrollment Form.

22. Signature of Employee: _____ Date: _____

(To decline any coverages, complete "Declination of Coverage" on page 2.)

PLEASE DO NOT FILL IN SHADED AREA BELOW - HOME OFFICE USE ONLY

Group No. _____	Effective Date (M/D/Y)	Class	Coverage Amount
Loc/Div _____			
Cert. # _____			
___ Approved as requested	Basic Life& AD&D		
___ Approved with changes	Basic Dep. Life		
Employee _____	Vol/Supp Life EE		
Spouse _____	Vol/Supp Life SP		
Child/ren _____	Vol/Supp Life Child		
By: _____	STD		
Date: _____	LTD		
	Dental		
	Vision		



KANSAS CITY LIFE
INSURANCE COMPANY

To obtain further information contact:
New Business Department
Kansas City Life Insurance Company
PO Box 219371
Kansas City, MO 64121-9371

NOTICE OF INFORMATION PRACTICES

Including Fair Credit Reporting Act Notice and MIB, Inc. Notice

Thank you for your application. It is the major source of information about you which we use in evaluating your application and issuing your contract. However, we wish to inform you that an investigative consumer report may be ordered as to your insurability. If an investigative consumer report is prepared in connection with this application, you may request to be interviewed in connection with the preparation of this report. This report may include, if applicable, information as to your character, general reputation, personal characteristics and mode of living (except as may be related directly or indirectly to your sexual orientation) as may be obtained through interviews with family members, friends, neighbors and associates. If you would like to know whether such a report was ordered and, if so, receive additional information as to its nature and scope, including the name, address and phone number of the reporting agency, we will be pleased to furnish this information upon your written request to our Home Office at the address above. You may receive a copy of such report by contacting the reporting agency. Our experience shows that information from investigative reports usually does not have any adverse effect on our underwriting decision. However, if it should, we will notify you in writing of this fact as well as provide you the identity by name and address of the reporting agency. You may then wish to discuss the matter with that agency.

We are committed to protecting the privacy of our customer's nonpublic personal information. We will only disclose our customer's nonpublic personal information: among the affiliated companies of the Kansas City Life Group; to provide services to our customers and administer our business; to market products; and as otherwise permitted by law. We may disclose our customer's nonpublic personal information to our agents and representatives to provide services to our customers and for marketing purposes. When we contract with other entities to provide support or marketing services, we will require them to adhere to our privacy standards.

Sometimes we acquire medical information about our customers, for instance, to underwrite an insurance contract or to process an insurance claim. We will keep our customer's medical information confidential. We will not share our customer's medical information even among the affiliated companies of the Kansas City Life Group without the customer's consent. We will only use or disclose our customer's medical information to underwrite insurance, process claims, administer our business, to comply with laws and regulations or as otherwise authorized by our customers.

You have the right to obtain access to certain items of information we have collected about you, and you have the further right to request correction of information if you feel it is inaccurate.

If you wish to have a more detailed description of our information practices, we will be pleased to furnish this information upon your written request to our New Business Department, Kansas City Life Insurance Company, PO Box 219371, Kansas City, MO 64121-9371.

MIB, Inc. Notice

While the information you provide to us regarding you insurability is treated as confidential, Kansas City Life or its reinsurers may make a brief report thereon to the Medical Information Bureau, a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. Should you apply for life or health insurance, or submit a claim for benefits to another member company, the Medical Information Bureau, upon request from that member company, will supply the information in its file.

Upon written request from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of the information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedure set forth in the Federal Fair Credit Reporting Act. The address of the Bureau's information office is 50 Braintree Hill Park, Suite 400, Braintree MA 02112. Telephone (617) 426-3660.

Kansas City Life, or its reinsurers, may also release information from its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.