



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 GROUP DENTAL CHECKLIST FOR THE STATE OF
OREGON**

- _____ Signed Application for Group Dental Insurance - Form GA120-A
- _____ Check for the first month's deposit premium made payable to [Kansas City Life Insurance Company](#)
- _____ Completed employee enrollment cards - Form GA173
 - Please contact your group Sales Representative or Sales Coordinator for a pre-printed enrollment card or census enrollment options
 - Either completed signed waivers or a list of waivers is required
- _____ For replacement coverage:
 - a copy of the prior carrier's benefit booklet or policy
 - a copy of the group's most **recent bill**
 - 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
- _____ Section 125 Flexible Benefit Plan form



Application for Group Insurance

Dental Insurance, Vision Insurance

Kansas City Life Insurance Company

1. Legal Name of Applicant (Policyholder)		2. Federal Tax I.D. No.	
3. Nature of Business	Standard Industrial Classification (SIC) Code	Three Digit Plan No.	
4. Street Address	City	State	Zip
5. Name of Subsidiaries, Divisions or Affiliates to be Covered			
6. Name and Title of Plan Administrator (Corporate Officer)			Phone No.
7. Name and Title of Correspondent (Routine Accounting Matters)			Phone No.
8. Billing Address(es) - If Different From Street Address			
9. Service of Legal Process Agent (If Different From Plan Administrator)			Phone No.
10. Street Address	City	State	Zip
11. Proposed Effective Date of Insurance	12. Advance Payment of \$ _____ is submitted with this application to be applied by the Company on premiums for insurance when and if issued.		

13. If the insurance applied for replaces, or is in addition to, any similar group or wholesale insurance now or previously in force, provide:

<u>Carrier</u>	<u>Type of Coverage</u>	<u>Date to be Discontinued</u>
_____	_____	_____

For dental insurance, this application must be accompanied by a copy of an in force 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).

Eligibility

<p>14. Eligible Classes:</p> <p><input type="checkbox"/> All Full-Time Employees</p> <p><input type="checkbox"/> Other* _____</p>	<p>15. Are any individuals currently disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, provide:</p> <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 50%; text-align: center;"><u>Full Name</u></th> <th style="width: 50%; text-align: center;"><u>Social Security Number</u></th> </tr> </thead> <tbody> <tr> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> </tr> </tbody> </table>	<u>Full Name</u>	<u>Social Security Number</u>	_____	_____
<u>Full Name</u>	<u>Social Security Number</u>				
_____	_____				
<p>16. Probationary Waiting Period:</p> <p>Current Individuals _____</p> <p>New Individuals _____</p> <p>Coverage to be effective the first of the month following completion of probationary waiting period? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>17. Are any former employees and/or dependents currently on continuation coverage provided by the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, list names of the enrollees, qualifying event and date of event on a separate sheet.</p>				

Coverage Applied For and Premium Contributions

18. Coverage applied for:	<input type="checkbox"/> Dental Insurance as quoted, proposal of _____, _____, Plan _____ <input type="checkbox"/> Vision Insurance as quoted, proposal of _____, _____, Plan _____		
	(Please attach copy of the proposal)		
Percentage of Employer Contribution*	Dental Insurance:	Employee _____%	Dependents _____%
	Vision Insurance:	Employee _____%	Dependents _____%

*An employer may limit eligibility to one or more classes of employees provided the employer pays 100% of both employee and dependent coverage.

Verification of Eligibility and Enrollment

19. Participation requirements are a condition of coverage. 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.

	<u>Dental Insurance</u>	<u>Vision Insurance</u>
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? <input type="checkbox"/> Yes <input type="checkbox"/> 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) (same as #4)	
8. Number of enrolled employees.	_____	_____
9. Number of COBRA participants.	_____	_____

Agreement and Signatures

20.

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.

Dated at _____ this _____ day of _____, year of _____
City, State

 Signature of Writing Agent Agent Code

 Officer's Signature

 Agent's Name and State License ID No. - SSN (Please Print)

 Please Print Name

 Signature of Other Agent(s) Agent Code

 Title

 Agent(s) Business Address City State Zip

 Agency Agency Code



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
-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

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		

***PROVISIONS OF COVERAGE**

- 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 column 5.
- Any person who submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud if there is intent to defraud or knowledge that fraud is being facilitated.
- 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.

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: <input type="checkbox"/> Basic Life & AD&D] <input type="checkbox"/> Voluntary/Supplemental Life] <input type="checkbox"/> Dental] <input type="checkbox"/> Voluntary STD] <input type="checkbox"/> Short-Term Disability] <input type="checkbox"/> Voluntary LTD] <input type="checkbox"/> Long-Term Disability] <input type="checkbox"/> Vision]	Coverage(s) for Dependents (Employee coverage required): [Life: <input type="checkbox"/> Spouse <input type="checkbox"/> Child/ren] [Dental: <input type="checkbox"/> Spouse <input type="checkbox"/> Child/ren] [Vision: <input type="checkbox"/> Spouse <input type="checkbox"/> Child/ren]
------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

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: _____

If requested to do so by Kansas City Life Insurance Company, please complete the following items.

Name of Employee:	Age	Gender	Height	Weight	Weight change in last year (gain/loss)
Name of Spouse of Employee (if applicable):	Age	Gender	Height	Weight	Weight change in last year (gain/loss)

During the past five years, have you (or anyone proposed for coverage) been diagnosed or treated by a member of the medical profession for any of the following: heart condition (including high blood pressure)*; cancer or tumor; chronic/recurrent respiratory disease; diabetes; kidney or liver disease; arthritis or any other disease of the joints, including neck and back disorders; any mental, emotional or nervous disorder; any disorder of the brain, nervous, digestive or reproductive system; muscle or connective tissue disorder; alcohol or drug abuse; or Acquired Immune Deficiency Syndrome (AIDS) or AIDS-Related Complex (ARC)?

Employee: Yes No Spouse (life coverage only): Yes No

During the past five years, have you been declined coverage for any life or disability insurance?

Employee: Yes No Spouse (life coverage only): Yes No

For female, disability applicants only: Are you currently pregnant? Yes No

Please supply full details to "Yes" answers. List date(s) of onset, last occurrence, types of treatment including medication. *For high blood pressure, give date and last reading. If you require additional space, please attach separate sheet.

I(we) authorize the following to give information (defined below) to Kansas City Life Insurance Company or any person or group acting on the part of Kansas City Life Insurance Company: any medical professional, medical care institution, the Medical Information Bureau, Inc., insurer, reinsurer, government agency, consumer reporting agency or employer. "Information" means facts of: a medical nature regarding my physical or mental condition; employment; other insurance coverage; or any other non-medical facts. I(we) understand that this information will be used by Kansas City Life Insurance Company to determine eligibility for insurance. I(we) agree this Authorization is valid for two and one-half years from the date signed. I (we) know that I(we) have a right to receive a copy of this Authorization upon request. I(we) agree that a photographic copy of this Authorization is as valid as the original.

I hereby represent that the above answers are complete and true to the best of my knowledge and belief concerning the past and present state of health and medical history of the person(s) to whom the answers relate. I agree that this document and all its contents shall form a part of my enrollment request for group benefits.

Signature of Employee: _____ Date: _____

Signature of Spouse: _____ Date: _____



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.



K·C·L G R O U P
B E N E F I T S

**Dental Insurance Coverage Options
with IRS Section 125
Flexible Benefit Program**

Employers who sponsor an insurance premium reimbursement program as part of their Section 125 Flexible Benefit (Cafeteria) Plan may elect to waive the late applicant provision for employees enrolled for Kansas City Life dental coverage. By completing the front of this form, your dental policy will be amended to waive the late applicant provision during your annual open enrollment period.

In order for us to determine how you want your Kansas City Life group dental plan administered, please respond appropriately to the questions below.

1. Does your company currently have a Section 125 Cafeteria/Flexible Benefit Plan in place and allow your employees to pay their portion of their dental premium with pre-tax dollars?

Yes No (Circle One) (If “no”, your company is ineligible for an open enrollment.
Please complete the 2nd page of this form.)

2. Our company’s Flex 125 plan year is _____ through _____.

3. Flex 125 dental open enrollment is held during the period of _____ for an effective date of _____.

4. By completing numbers 1-3 above, we request the late applicant provision of the dental insurance policy be waived for employees who enroll during the annual open enrollment period. Existing employees may enroll for coverage or add dependent coverage **ONLY** during the open enrollment period without restrictions, unless a qualifying event occurs.

When employers choose to waive the late applicant provision, we recommend that all employees be notified of their enrollment opportunities during their Flex 125 enrollment period. Annual notification of open enrollment will promote greater participation and reduce the likelihood of adverse selection.

Signature/Title of Officer: _____

Date: _____ Company Name: _____

Please Note: If your company does not wish to hold an open enrollment for dental insurance with Kansas City Life Ins. Co., please complete ONLY the 2nd page of this form.

Last updated: 9.12.06

**This Section applies only if you do not qualify for an open enrollment or
if you choose not to offer your employees open enrollment for the
Kansas City Life Ins. Co. dental plan**

**Impact of Not Allowing Open Enrollment and Not
Waiving the Late Applicant Provision**

Under the Kansas City Life policy, newly hired employees have 31 days after meeting their probationary waiting period to enroll for coverage without being considered late applicants. Employees who initially decline coverage for themselves or their dependents and later wish to enroll in the dental insurance program are late applicants. Late applicants are limited to Type I benefits until the beginning of the calendar year (January 1) following:

***12** consecutive months of coverage on Kansas City Life Employer Paid Dental Coverage
or Voluntary Dental Coverage.

This is to certify we **do not** wish to have an open enrollment period or **do not qualify** for an open enrollment period on this dental plan and **do** understand the Late Applicant Provision will apply.

Signature/Title of Officer: _____

Date: _____ Company Name: _____

Last updated: 9.12.06