KANSAS CITY LIFE
GROUP BENEFITS

Thank you for applying for benefits with Kansas City Life Insurance Company.

Plan provisions for this coverage require you and/or eligible dependents to complete this Health Statement as proof of Evidence of Insurability (EOI). If the form is to be completed for a dependent, please make sure to identify the employee to which the applicant is associated on the form. **Please complete the attached form in its entirety paying particular attention to items commonly overlooked as shown below.**

1. At the top of the form, indicate the **Group Number** and the name of your employer (**Policyholder**).

KANSAS CITY LIFE
GROUP BENEFITS

Group Number 123456 (sample data)

Policyholder Joe's Bait Shop (sample data)

Health Statement

2. Provide your **Birthdate**, **Build** (height and weight), and any significant **Weight Change in the past year.**

Print full names of all to be insured.	Relationship to Primary Insured	Birthdate			Age	Sex	Build			*Weight Change in the past year	
		Month	Day	Year			Ft.	In.	Lb.	Gain	Loss
1. John Doe (sample data)	Employee	05	15	1985	38	M	6	2	218		10
2.											

3. **It is important that you provide details for any question answered "Yes."** In the space provided, identify the name of the applicable individual, the question number, specify the condition, severity, dates, duration, and after-effects.

	Yes	No	
1. Do you take prescription medicine?	☒	☐	John – #1, Simvastatin, 25mg once/day due to high cholesterol

For example: On Question #1, if prescription medicine is marked as "Yes," include the name of the medication, dosage, and the reason for taking the medication.

4. Identify your **Physician** and their **Contact Information** at the bottom of Page 1.

Names, addresses, and phone numbers of personal or family physicians. (If none, list last physician, clinic, or hospital consulted.)

Date and reason: Dr. Krum; 5/19/2021; routine physical (sample data)

Clinic or VA last consulted: _____

Claim number: _____

5. You must **sign and date Page 2**. Importantly, if the proposed insured is a child and is age 18 or older, they will need to sign this Health Statement as well.

Send the completed form to:

Attn: Group Administration | Kansas City Life Group Benefits
P.O. Box 219425 | Kansas City, MO 64121-9425
grpadmin@kclife.com

KANSAS CITY LIFE
GROUP BENEFITS

Group Number 27549

Health Statement

Policyholder WC Staffing

Print full names of all to be insured.	Relationship to Primary Insured	Birthdate					Build			*Weight Change in past year	
		Month	Day	Year	Age	Sex	Ft.	In.	Lb.	Gain	Loss
1.											
2.											
3.											
4.											
5.											
6.											

Questions apply to all Proposed Insureds*

***Give DETAILS** to **Yes** answers. Identify Proposed Insured(s), question, specify conditions, severity, dates, duration, after-effects, weight gain or loss, and names and addresses of all attending physicians and medical facilities.

	Yes	**No**
1. Do you take prescription medicine?	☐	☐
2. Are you currently pregnant? Due Date?_____	☐	☐
3. Have you ever used or received treatment or counseling for the use of marijuana, heroin, cocaine, amphetamines, barbiturates, hallucinogenic agents or opium or its derivatives?	☐	☐
4. Have any of the Proposed Insureds used any form of nicotine/tobacco in the last 12 months? (i.e., cigar, pipe, smokeless tobacco, cigarettes, etc.) If cigarettes, how many packs per day?_____	☐	☐
5. Have you sought advice, been treated or arrested for the use of alcohol?	☐	☐

During the **last 5 years** have you:

6. been hospitalized or had medical advice, diagnostic tests recommended, or treatment by a physician or other medical practitioner?	☐	☐

During the **last 10 years** have you been diagnosed or treated for any disease or disorder of:

7. brain and nervous system - mental illness, epilepsy, seizures, stroke, paralysis?	☐	☐
8. sight or hearing?	☐	☐
9. blood - anemia or leukemia?	☐	☐
10. tumor or cancer?	☐	☐
11. heart/blood vessels - murmur, chest pain or pressure, palpitations, heart attack?	☐	☐
12. blood pressure?	☐	☐
13. thyroid or glandular trouble?	☐	☐
14. lungs - asthma, emphysema, tuberculosis?	☐	☐
15. digestive system - ulcer, intestines or rectum, polyps, colitis?	☐	☐
16. liver - elevated enzymes, cirrhosis, hepatitis?	☐	☐
17. diabetes - sugar in urine?	☐	☐
18. kidney/bladder or prostate - albumin, blood or pus in urine?	☐	☐
19. bone, joint, muscles, back or spine - arthritis?	☐	☐
20. breasts, uterus, ovaries?	☐	☐
21. menstruation or pregnancy?	☐	☐

Have you ever been diagnosed or treated for:

22. a sexually transmitted disease?	☐	☐
23. Acquired Immune Deficiency Syndrome (AIDS) or tested HIV positive?	☐	☐
24. In the **past 3 years,** have you applied for life or health insurance or reinstatement thereof, without receiving it exactly as requested?	☐	☐

Names, addresses and phone numbers of personal or family physicians. (If none, list last physician, clinic or hospital consulted.)

Date and Reason:_____ Clinic or VA last consulted:_____

_____ Claim Number: _____

Agreement and Signatures

It is understood and agreed as follows:

1. The statements and answers recorded in all parts of this application are true and complete.
2. No information regarding any Proposed Insured(s) will be considered known by the Company unless explicitly set out in writing on this application.
3. This application, and the answers to any required medical exam, will become a part of any insurance issued on it.
4. No agent has the authority to waive any of the Company's rights or rules, or to make or change any contract.
5. I (We) have received the Notice of Information Practices which explains my (our) rights under the Fair Credit Reporting Act.

AUTHORIZATION: I (We) authorize the following to give information (defined below) to Kansas City Life or any person or group acting on the part of Kansas City Life: any medical professional, medical care institution, the Medical Information Bureau, Inc., insurer, reinsurer, government agency, consumer reporting agency or employer. I authorize Kansas City Life Insurance Company, or its reinsurers, to make a brief report of my personal health information to MIB. "Information" means facts of: a medical nature in regard to my (our) 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 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.

Dated at _____ this _____ day of _____ , _____.
(City, State) (Day) (Month) (Year)

_____ _____
Employee's Signature **Spouse's Signature** (if coverage applied for)

EMPLOYER SECTION:

Reason for Submitting Health Statement:

☐ Late Applicant ☐ Adding Coverage ☐ Other _____
☐ Late Dependent ☐ Increasing Coverage _____

Coverage Type and Amount Applying For:

☐ Life $_____ ☐ WDI $ _____
☐ Supplemental Life $_____ ☐ LTD $ _____
☐ Dependent Life: Spouse _____ Child _____

_____ _____ _____

Information Provided By _____ Phone # _____ Date _____

HOME OFFICE USE ONLY:

Basic Max. _____ EOI _____
Supp. Max _____ EOI _____
Combined Max. _____ EOI _____
WDI Max. _____
LTD Max. _____
Notes: _____

Amount to be Approved Basic _____
Supp. _____
Total _____

Underwriting Action:

Approved ☐
Declined ☐
Withdrawn ☐

UND.	Decision Date

Notes:

KANSAS CITY LIFE

GROUP BENEFITS

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 PO Box 105, Essex Station, Boston, MA 02112. Telephone (617) 426-3660.

We or our reinsurers may also release information in our file to other life insurance companies to whom you apply for life or health insurance, or to whom a claim for benefits may be submitted.