KANSAS CITY LIFE INSURANCE COMPANY

PENNSYLVANIA – ICC17A193	ACCELETERM APPLICATION FOR INDIVIDUAL LIFE INSURANCE SUBMISSION CHECKLIST

To Submit An Application:

Fax:	Overnight Address:	Email:	Mailing Address:
877-295-3806	New Business Department Kansas City Life Insurance Company 3520 Broadway Kansas City, Missouri 64111	new_business@kclife.com	New Business Department Kansas City Life Insurance Company PO Box 219428 Kansas City, MO 64121-9428

Application Submission Guidelines:

- Attach a cover letter or additional information as needed.
- Please make sure that all questions are answered.
- Always provide the client with the "Notice of Information Practices" (last page of the application form).
- All changes must be initialed by the Owner (if different from Proposed Insured).
- If applying for Accidental Death Benefit, a Rider Amount must be entered on the application (Page 2).
- If applying for Children's Term Rider, the number of units must be entered on the application (Page 2) and full name, date of birth, age, and build of all children to be covered (Page 3).

Other Forms / Supplements

- M720 Authorization for Release of Information to Insurance Agent or Agency
- ICC17M721 Accelerated Death Benefit Riders Disclosure || Submit with all applications.
- M705 Notice Regarding Replacement of Life Insurance and Annuities
- ICC17A185 Military Questionnaire Supplement to Application for Life Insurance || All, if applicable.
- ICC17A163 Designation of Death Benefit Payout Endorsement Supplement to Application || All, if applicable.
- 7577 Request to Discount Premiums || Term only, if applicable.

KANSAS CITY LIFE INSURANCE COMPANY

Kansas City Life AcceleTerm New Business Information

Tele-interviews

Phone interviews are mandatory for:

- All face amounts for issue ages 61 and above, and
- All issue ages with a face amount above $250,000.

If a mandatory phone interview is required, the phone interview should be initiated by the agent at the point of sale. If the agent is not able to complete the phone interview at this time, please indicate on the application that an interview *was not* completed and one outbound call will be made.

Kansas City Life Tele-interview phone number: 877-884-0953

The tele-interview phone line is staffed from 8:00 am to 9:00 pm Central Time, Monday through Friday and from 10:00 am to 2:00 pm on Saturday.

For outbound calls, Kansas City Life will call the client one time, leave a message if necessary, and then add a note on kclic.net as a reminder to have the client call the number above.

Status updates

Upon underwriter decision, you will receive an email update to your kclic.net email address containing the status of your case (approved or declined). Policies will be issued and mailed within 48 hours of this email.

Kansas City Life Underwriting phone number: 800-572-2467

Nick Armour extension 8895

Nancy Hasse extension 8225

Drafting/Dating Rules

Complete the PAC Instructions by checking the box to request that KCL draft the initial premium when the policy is issued.

Preferred Method – Leave the Draft Date on the PAC Instructions blank or write in the words "due date." In this case, the initial draft will be made on the issue date. This same day of the month will also be used for future draft dates.

Example Draft Date: due date

- If a policy is issued on October 25, the PAC will be drafted on October 25. The second draft will occur on November 25.

If the policyholder needs to delay the initial or future drafts, Kansas City Life can accommodate. To provide the most timely commission payments, this is not recommended.

Note: Actual PAC draft date may vary due to holidays or weekends.

KANSAS CITY LIFE INSURANCE COMPANY

P.O. Box 219139, Kansas City, MO 64121-9139

Application for Individual Life Insurance – AcceleTerm

PERSONAL DATA

Proposed Insured Information

Full Name (First, Middle, Last)	☐ Male ☐ Female	Date of Birth (Month/Day/Year) / /

State of Birth	SSN or Tax ID	☐ Married ☐ Divorced ☐ Widowed ☐ Single ☐ Separated

Height feet inches	Weight pounds	Weight Change in the last 12 months Gain Loss Provide details, if applicable:

In the past 12 months, has the proposed Insured used any form of tobacco, or any form of nicotine replacement therapy? ☐ Yes ☐ No

Are all proposed Insureds U. S. citizens? ☐ Yes ☐ No	If **No**, how long has (have) the proposed Insured(s) been in the United States?

Visa Type?	Visa Number		
Street Address	City	State	Zip
Mailing Address (if different)	City	State	Zip

Home Phone ( )	Cellular Phone ( )	Email
Annual Income	Driver's License No.	State of Issue
Employer	Street Address	
City	State	Zip
Occupation and Duties		Years Employed

Are you a member of the armed forces? ☐ Yes ☐ No If **Yes**, please complete the Military Questionnaire.

Ownership Information PLEASE COMPLETE THIS SECTION IN ITS ENTIRETY.

(The Insured will be the Owner unless otherwise stated. If multiple owners, complete Additional Owner Information Supplement.)

Primary Owner (First, Middle, Last)	☐ Male ☐ Female	Date of Birth (Month/Day/Year) / /

State of Birth	SSN or Tax ID	Relationship to Insured	Email	
Street Address		City	State	Zip

Beneficiary Information* (with right to change) PLEASE COMPLETE THIS SECTION IN ITS ENTIRETY.

Primary Beneficiary (First and Last Name)	Relationship to Insured	SSN or Tax ID #	Date of Birth
Contingent Beneficiary (First and Last Name)	**Relationship to Insured**	**SSN or Tax ID #**	**Date of Birth**

*Unless otherwise stated, benefits are payable equally to the named beneficiaries or to the surviving beneficiaries. If benefits are payable other than equally, please indicate a contingent beneficiary for each primary beneficiary.

PLAN DATA

Term Life Insurance

Plan Name: _____	Face Amount $_____	Modal Premium $_____

Riders/Benefits

☐ Accidental Death $_____ ☐ Children's Term _____ units ☐ Waiver of Premium

BILLING INFORMATION

Premium Mode: ☐ Annual ☐ Semi-Annual ☐ Quarterly ☐* Pre-Authorized Check ☐ Combined Bill	
Premium Notices Delivered To:	☐ Owner ☐ Primary Insured ☐ Other (provide name and address)

OTHER COVERAGE INFORMATION

1)	Do you have any life insurance policies and/or annuity contracts on any person proposed for insurance that are now pending, are now in force (including any that have been assigned or sold), or that have terminated in the last 13 months? If yes, list all below.	☐ Yes ☐ No
2)	Has the proposed Insured had, or intend to have, any life insurance policies, or annuity contracts replaced, converted, reduced, reissued, sold, subjected to borrowing, or otherwise discontinued because of this application? **The producer shall comply with any additional state and/or Company replacement requirements.**	☐ Yes ☐ No
3)	**In the past 10 years**, has the proposed Insured been declined, rated, or issued at a higher premium than quoted for life insurance coverage?	☐ Yes ☐ No
4)	Has the proposed Insured been offered cash or any other consideration for obtaining this policy?	☐ Yes ☐ No
5)	Are you planning to enter into a finance arrangement to pay any premium payments due under this policy?	☐ Yes ☐ No
6)	Do you intend to sell or transfer ownership of this policy to a third party, or have you sold or transferred ownership of a policy to a third party in the last five years?	☐ Yes ☐ No

If "Yes" to questions 1 - 6, provide information in Comments section.

COMMENTS

Provide any additional information necessary and the details of "Yes" answers. Always identify question number.

SPECIAL REQUESTS (Policy date, additional policy, existing PAC or CB number, etc.)

EVIDENCE OF INSURABILITY

Print full names of all children to be insured.	**Birthdate**			**Age**	**Sex**	**Build**			**Weight Change In the last 12 months**	
	Month	Day	Year			Ft.	In.	Lb.	Gain	Loss
1)										
2)										
3)										
4)										

Questions apply to all proposed Insureds. If any proposed Insured answers "Yes" to questions 1 through 7 in this section, that person is not eligible for coverage under this application.

1) Has the proposed Insured **ever** been diagnosed with, treated by a member of the medical profession for, or tested positive for Human Immunodeficiency Virus (AIDS virus), "AIDS" Related Complex (ARC) or Acquired Immune Deficiency Syndrome (AIDS)?	☐ Yes ☐ No
2) Has the proposed Insured **ever** (i) been diagnosed with, or (ii) received care or treatment for, or (iii) been advised by a member of the medical profession to seek treatment for, or (iv) consulted with a health care provider regarding:	
a) Cancer, Leukemia, Melanoma, or any other cancer (except basal cell or squamous cell skin cancer)?	☐ Yes ☐ No
b) Chronic Kidney Disease, end-stage Renal Disease with dialysis, or Liver Disease including Cirrhosis, Hepatitis B or Hepatitis C?	☐ Yes ☐ No
c) Systemic Lupus or Scleroderma?	☐ Yes ☐ No
d) Coronary Artery Disease, Heart Attack, Coronary Artery Bypass Surgery, Angioplasty, Stent Placement, Valvular Heart Disease with Repair or Replacement, Cardiomyopathy, Congestive Heart Failure, Congenital Heart Disease, Pacemaker/Implantable Cardioverter Defibrillator, Stroke, Transient Ischemic Attack (TIA)/mini-stroke, abnormal heart rhythm, or Cerebral, Aortic or Thoracic Aneurysm?	☐ Yes ☐ No
e) an organ transplant?	☐ Yes ☐ No
f) Chronic Lung Disease (except mild Asthma), including Chronic Obstructive Pulmonary Disease (COPD), Chronic Bronchitis, Emphysema, Sarcoidosis or Cystic Fibrosis?	☐ Yes ☐ No
g) Psychosis, Bipolar Depression, Schizophrenia, Alzheimer's Disease, Dementia, Parkinson's Disease, Sickle Cell Anemia, Lou Gehrig's Disease (ALS), Muscular Dystrophy, Demyelinating Disease including Multiple Sclerosis, Huntington's Disease, Hydrocephalus, Quadriplegia, Paraplegia, Down's Syndrome, Autism, mental incapacity, or any other disease of the central nervous system?	☐ Yes ☐ No
3) **In the past 10 years**, has the proposed Insured:	
a) used alcohol to a degree that required treatment or been advised to limit or discontinue its use by a member of the medical profession?	☐ Yes ☐ No
b) used or been convicted of possession of unlawful drugs or used prescription drugs other than as prescribed in any form?	☐ Yes ☐ No
c) been convicted of or currently awaiting trial for a felony	☐ Yes ☐ No
d) been hospitalized for high blood pressure or any mental or nervous disorder?	☐ Yes ☐ No
4) **In the past 5 years**, has the proposed Insured been convicted of driving under the influence of drugs or alcohol, been convicted of reckless driving or been convicted of four or more moving violations?	☐ Yes ☐ No

EVIDENCE OF INSURABILITY (CONTINUED)

5) **In the past 12 months**, has the proposed Insured:	
a) been advised by a member of the medical profession to have a surgical operation, diagnostic testing other than for routine screening purposes or for those related to HIV/AIDS, treatment, or other procedure which has not been done?	☐ Yes ☐ No
b) consulted a physician for chronic cough, unexplained weight loss greater than 10 pounds (other than due to diet or exercise), fatigue, or unexplained gastrointestinal bleeding?	☐ Yes ☐ No
6) Has the proposed Insured **currently or within the past 12 months**:	
a) required the assistance of another person or a device of any kind for bathing, dressing, eating, toileting, getting in and out of a chair or bed, or the management of bowel or bladder problems?	☐ Yes ☐ No
b) received, or been advised by a member of the medical profession to have, any of the following types of care: nursing home, assisted living facility, adult day care facility, home health care services or is the proposed Insured currently confined to any hospital or other medical facility?	☐ Yes ☐ No
c) used any of the following: walker, wheelchair, electric scooter, oxygen, or catheter?	☐ Yes ☐ No
7) **In the next 2 years**, will the proposed Insured engage in any motor sports racing, boat racing, parachuting/skydiving, hang gliding, base jumping, rock or mountain climbing, private piloting (excluding commercial), ultra-light flying, white water rafting, bungee jumping, or ice climbing?	☐ Yes ☐ No
8) Has the proposed Insured **ever** (a) received care or treatment by a member of the medical profession for, or (b) been advised by a physician or health care provider to seek treatment for:	
a) Diabetes?	☐ Yes ☐ No
b) Diabetes before age 50 (other than Gestational Diabetes) or requiring insulin treatment?	☐ Yes ☐ No
c) Diabetes at any age with complications of Retinopathy (eye), Nephropathy (kidney), Neuropathy (nerve) or Peripheral Vascular Disease (PVD or PAD)?	☐ Yes ☐ No
9) **In the past 12 months**, has the proposed Insured applied for or received disability, hospital or medical benefits from any insurance company, government, employer or other source (other than for maternity, fractures, spinal or back disorders or hip or knee replacement)?	☐ Yes ☐ No
10) **In the past 5 years**, has the proposed Insured consulted with a doctor or been hospitalized or treated by a health care provider for any other health condition (other than for routine physical checkups, eye, cosmetic, employment, or FAA examinations)?	☐ Yes ☐ No

If answered "Yes" to any of questions 8-10, please list details below. If more space is needed, use the previous Comments section.

Person Proposed for Insurance	Medical Impairment, Injury, Illness, or Results of Testing or Examination (if operation was performed, state type)	Month and Year	Duration	Name, Address, ZIP, and Telephone Number of Hospital and/or Attending Physician

Agreement

It is understood and agreed as follows:

1) The statements and answers recorded in all parts of this application are true and complete, to the best of my knowledge and belief.

2) No information regarding any proposed Insured 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 policy 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) The insurance applied for will take effect only after the following occur while the proposed Insured(s) is(are) living and his/her(their) health is as stated in this application: (1) the policy is delivered to and accepted by the Owner; and (2) the first full premium is paid in cash. The only exception to this is provided in the Conditional Receipt if it has been issued and the advance payment required by the agreement has been made.

6) I(We) have received the Notice of Information Practices which explains my(our) rights under the Fair Credit Reporting Act.

7) I(We) have paid $_____* to the agent in exchange for the Conditional Receipt and I(we) acknowledge that I(we) fully understand and accept its terms.

***All premium checks must be made payable to Kansas City Life Insurance Company. Do not make the check payable to the agent or leave the payee blank.**

By signing on page 6 of this application, you certify that you have completely read and fully understand the above statements.

Taxpayer Identification Number Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
3. I am a U.S. citizen or other U.S. person (defined below); and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN.

The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.

_____ _____

Primary Insured's Signature **Owner's/Trustee's Signature (if other than Primary Insured)**

Definition of a U.S. person. For federal tax purposes, you are considered a U.S. person if you are:

- An individual who is a U.S. citizen or U.S. resident alien;
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States;
- An estate (other than a foreign estate); or
- A domestic trust (as defined in Regulations section 301.7701-7).

Authorization for the Release of Personal and Medical Information

To obtain a copy of or to revoke this authorization, contact:
New Business Department
Kansas City Life Insurance Company
PO Box 219428
Kansas City, MO 64121-9428

This authorization applies to all persons whose signatures appear below. The proposed Primary Insured and all other proposed Insureds must sign.

I authorize any health plan; physician; health care professional; hospital; clinic; laboratory; pharmacy or pharmacy benefit manager; medical facility; or other health care provider that has provided payment, treatment or services to me or on my behalf within the past 10 years ("My Providers"); MIB, Inc.; insurers; reinsurers; government agencies; consumer reporting agencies and/or employers to disclose my entire medical record, prescription history, medications prescribed and any other personal, financial, or protected health information concerning me to Kansas City Life Insurance Company or any person acting on behalf of Kansas City Life Insurance Company. 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 regarding my physical or mental condition (including the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection; sexually transmitted diseases; mental illness; the use of alcohol, drugs, and tobacco; but excluding psychotherapy notes); employment; other insurance coverage; financial status; or any other relevant information about me or my minor children. Information obtained will be released only to reinsurers; MIB, Inc.; persons and entities performing business duties as delegated or contracted for by Kansas City Life Insurance Company related to my application and subsequent insurance-related functions as permitted or required by law or as I further authorize. Some of the health information obtained may be disclosed to persons or organizations that are not subject to federal health information privacy laws, resulting in the information no longer being protected under such laws.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct any health plan; physician; health care professional; hospital; clinic; laboratory; pharmacy or pharmacy benefit manager; medical facility; or other health care provider that has provided payment, treatment or services to me or on my behalf within the past 10 years ("My Providers"); MIB, Inc.; insurers; reinsurers; government agencies; consumer reporting agencies and/or employers to release and disclose my entire medical record without restriction.

This protected health information is to be disclosed under this authorization so that Kansas City Life Insurance Company may: 1) underwrite my application for coverage, make eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 4) administer coverage; and 5) conduct other legally permissible activities that relate to any coverage I have or have applied for with Kansas City Life Insurance Company.

This authorization shall remain in force for 24 months following the date of my signature below, and a copy of this authorization is as valid as the original. This time limit complies with the time limit, if any, permitted by applicable law in the state where the policy is delivered or issued for delivery. I understand that I have the right to revoke this authorization in writing at any time by providing written notification to the entity identified above, and I understand that a revocation is not effective to the extent that any of My Providers has already relied on this authorization to disclose information about me or to the extent that Kansas City Life Insurance Company has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information that is disclosed pursuant to this authorization is no longer covered by federal rules governing privacy and confidentiality of health information, but it will not be redisclosed by the recipient except as authorized by me or as required by law.

I understand that My Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this authorization or otherwise condition my enrollment or eligibility for health benefits on my signing this authorization. I further understand that if I refuse to sign this authorization to release my complete medical record, Kansas City Life Insurance Company may not be able to process my application or, if coverage has been issued, may not be able to make any benefit payments. I understand that any authorized representative or I will receive a copy of this authorization upon request.

Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

Dated at _____ this _____ day of _____, 20_____.
City/State **Month** **Year**

_____ _____
Primary Insured's Signature **Owner's/Trustee's Signature (if other than Primary Insured)**

Statement of Agent

I certify that the statements of the Primary Insured, Owner, and any other proposed Insured(s) have been correctly recorded in this application and that any premium payment shown in item 7) under Agreement on page 5 has been collected by me and that a Conditional Receipt has been given to the Owner.

Does the proposed Insured have any existing annuity contracts or life insurance policies? ☐ Yes ☐ No

To the best of my knowledge, the insurance applied for in this application ☐ will ☐ will not replace existing insurance.

Did you see all proposed Insureds at the time of application? ☐ Yes ☐ No (If **No**, an examination may be required.)

Has the proposed Insured purchased a home or refinanced a home within the last 2 years? ☐ Yes ☐ No

If "Yes", please provide details below.

Approximate mortgage loan amount $_____

Mortgage loan financial institution name _____

Agent Code	Signature of Writing Agent	Split Percent
		%
		%
		%
		%

Agency Code **Agency**

KANSAS CITY LIFE INSURANCE COMPANY

Pre-Authorized Check Plan (PAC)

PAC Instructions – Please select only one option. Include a copy of a voided check for bank draft.

Available draft days are the 1st through the 28th. Withdrawals will be made on or about the premium draft date shown.

The Conditional Receipt, page 9, is required.

☐ Draft my account for the first premium. Please draft subsequent premiums on the _____ of each month. **(The initial draft will be drafted on the draft day following approval.)**

☐ Delay my first draft until: _____. All subsequent drafts will occur on this same day each month.

☐ The initial premium is attached, please draft subsequent premiums on the _____ of each month.

Account Information

Bank Name			
Address	City	State	Zip

Routing Number **Must fill in all boxes and start with a 0, 1, 2, or 3.** | | | | | | | | | | | Account Number ☐ Checking ☐ Savings

Agreement for Automatic Premium Payments and Authorization to Honor Checks Drawn by the Company

It is agreed that:

1) This PAC plan does not change any policy provisions. The payor's authorization is not in lieu of payment in cash of the first premium and does not constitute advance payment required by the Conditional Receipt.
2) Upon 30 days written notice, this PAC plan may be stopped or changed at any time by: the owner of any policy under this PAC plan, the Company, or the payor. No premium notices or receipts will be sent. Debit entries or checks, when paid, will constitute receipts for premiums.
3) The privilege of paying premiums under this PAC plan may be revoked by the Company if any check or debit entry is not paid upon presentation.
4) The Company's rights in respect to each check and/or debit entry will be the same as if I signed it personally.
5) If any debit or check entry is dishonored, the Company will be under no liability whatsoever, even if such dishonor results in forfeiture of insurance.
6) I authorize the Company to pay and charge to my(our) account, debit entries or checks drawn by and payable to the order of the Company, provided there are sufficient collected funds present to pay same upon presentation. This authorization will remain in effect until revoked by me in writing, a copy of which will be sent to the Company. Until the Company receives such notice, I agree that the Company will be fully protected in honoring any such debit.

Print Premium Payor's Name: _____

Signature of Premium Payor: _____

Date_____

PLEASE TAPE A VOIDED CHECK IN THIS BOX.

Conditional Receipt

If the proposed Insured in this application dies before coverage under this Receipt terminates, we will pay the Receipt benefit described below to the beneficiary named in the application, subject to the Conditions.

Please read this Receipt carefully. No coverage is in force other than as stated in this Receipt. No agent may change the terms of this Receipt. No coverage will be effective under this Conditional Receipt if advance payment is not made by check or Pre-Authorized Check Plan (PAC).

Conditions

If the amount received by check or Pre-Authorized Check Plan with the application is at least one month's premium for the policy applied for, the coverage will be in effect as of the date of this Receipt, BUT ONLY IF the proposed Insured is hereafter determined by the Company according to the underwriting standards of the Company then in effect to be insurable for the policy exactly as applied for.

Fraud or material misrepresentations invalidate this Receipt and the company's only liability is for refund of any payment made. All parts of the application must be completed and received by the Company.

Benefit

The benefit under this Receipt is an amount equal to the lesser of the Face Amount applied for on the proposed Insured in the application or $100,000. The benefit provided by this Receipt is further limited as follows:

(1) the maximum total coverage provided under all Conditional Receipts of the Company in effect on the proposed Insured is limited to $100,000;

(2) for death due to suicide, the Company's liability is limited to return of any amount paid with the application;

(3) this Receipt is not effective as to any rider or supplemental benefits to the policy;

(4) if payment is made by check or draft, coverage is effective only if the check or draft is honored on first presentation for payment;

(5) in no event may this Receipt and the policy applied for provide coverage at the same time.

Date Coverage Terminates

The coverage provided by this Receipt will end on the earliest of:

(1) the date coverage becomes effective under the policy applied for;

(2) the date the Company mails notice of termination of coverage to the Owner;

(3) 60 days from the date of this Receipt; or

(4) the date the Owner withdraws the application for insurance.

If the application is declined or withdrawn, the Company will immediately refund any amount paid with this application.

All premium checks must be payable to Kansas City Life Insurance Company. Do not make check payable to the agent or leave the payee blank.

Name of Proposed Insured: _____

Payment Amount: _____

Dated at: _____ **this** _____ **day of** _____, _____.
City, State Date Month Year

Agent's Signature: _____

KANSAS CITY LIFE INSURANCE COMPANY

To obtain further information contact:
New Business Department
Kansas City Life Insurance Company
PO Box 219428
Kansas City, MO 64121-9428

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. We may also order a credit report.

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 219428, Kansas City, MO 64121-9428.

MIB, Inc. Notice

Information regarding your insurability will be treated as confidential. Kansas City Life Insurance Company or its reinsurers may, however, make a brief report thereon to the MIB, Inc., formerly known as Medical Information Bureau, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information about you in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at 866-692-6901. If you question the accuracy of the information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.

Kansas City Life Insurance Company, 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.

This page remains with the applicant.

KANSAS CITY LIFE INSURANCE COMPANY
3520 Broadway, P.O. Box 219428
Kansas City, MO 64121-9428

Authorization for Release of Information to Insurance Agent or Agency

I authorize Kansas City Life Insurance Company, or its authorized third-party vendor, to disclose personal and medical information about me to the insurance agent and/or agency stated in my application for life insurance.

Information that Kansas City Life Insurance Company or its authorized third-party vendor may disclose includes medical information and other personal information as it relates to actions Kansas City Life Insurance Company may have taken based on this information, such as charging me a higher premium for my insurance, changing benefits to something other than I applied for, or declining my application for insurance.

The information will be used to help me with the insurance application process or to find other insurance coverage options.

I understand that if the person or entity that receives the above information is not covered by federal privacy regulations, the information described above may be re-disclosed by such person or entity and will likely no longer be protected by the federal privacy regulations.

I understand that I may refuse to sign this authorization. If I refuse to sign, it will not affect the issuance of the insurance for which I am applying.

Unless revoked earlier, this authorization will remain in effect for 24 months from the date I sign it. I understand that I may revoke this authorization at any time, by written notice to: Kansas City Life Insurance Company, New Business Department, P.O. Box 219428, Kansas City, Missouri 64121-9428.

I realize that my right to revoke this authorization is limited to the extent that Kansas City Life Insurance Company, or its authorized third-party vendor, has taken action in reliance on the authorization.

I understand that I will receive a copy of the authorization.

Proposed Insured's signature: _____

Date: _____

M720 Company Copy

Instructions to Agent
Client Copy must be given to the proposed Insured.
Forward the Company Copy to the Home Office.

KANSAS CITY LIFE INSURANCE COMPANY

Accelerated Death Benefit Riders Disclosure

THIS DISCLOSURE IS A BRIEF DESCRIPTION OF THE ACCELERATED DEATH BENEFIT RIDERS AND THE EFFECTS ON YOUR POLICY. THIS DISCLOSURE IS NOT AN INSURANCE CONTRACT, BUT ONLY A SUMMARY OF THE COVERAGE PROVIDED BY THE RIDERS. THERE IS NO PREMIUM CHARGE FOR THE RIDERS.

THE BENEFITS RECEIVED UNDER ANY ACCELERATED DEATH BENEFIT RIDER MAY BE TAXABLE AND MAY ADVERSELY AFFECT YOUR ELIGIBILITY FOR MEDICAID OR OTHER GOVERNMENT BENEFITS OR ENTITLEMENTS. YOU SHOULD CONSULT YOUR PERSONAL TAX ADVISOR REGARDING THE TAX TREATMENT OF ACCELERATED BENEFITS. YOU SHOULD CONTACT A QUALIFIED ADVISOR OR THE APPLICABLE GOVERNMENT AGENCY (SUCH AS THE LOCAL STATE MEDICAID OFFICE) FOR ADVICE REGARDING ELIGIBILITY FOR MEDICAID OR OTHER GOVERNMENT BENEFITS OR ENTITLEMENTS BEFORE REQUESTING THIS BENEFIT.

ACCELERATED BENEFITS DO NOT AND ARE NOT INTENDED TO QUALIFY AS LONG-TERM CARE INSURANCE. BENEFIT PAYMENTS UNDER AN ACCELERATED DEATH BENEFIT RIDER ARE INTENDED TO QUALIFY FOR FAVORABLE TAX TREATMENT.

BENEFIT DESCRIPTION – ACCELERATED DEATH BENEFIT FOR CHRONIC ILLNESS RIDER

If the insured is diagnosed as being Chronically Ill while the policy is in force, you may request to receive an accelerated death benefit.

Chronically Ill means that within the last 12 months a physician has certified that for a continuous period of at least 90 days, the insured is:

1. unable to perform (without substantial assistance from another person) at least two activities of daily living; or
2. requires substantial supervision to protect himself or herself from threats to health and safety due to severe cognitive impairment.

Each requested acceleration may not exceed the per diem allowance permitted by section 101(g)(3) of the Internal Revenue Code multiplied by the number of days in the current calendar year that the insured is expected to be Chronically Ill. The Internal Revenue Service announces the per diem limit for each calendar year.

We will reduce the Chronic Illness benefit by an amount equal to the requested acceleration multiplied by an actuarial present value factor, the present value of expected future unpaid premiums, and a $100 charge. If the policy has indebtedness, we will deduct a portion of the Chronic Illness benefit and apply this portion to reduce indebtedness.

BENEFIT DESCRIPTION – ACCELERATED DEATH BENEFIT FOR CRITICAL ILLNESS RIDER

If the insured is diagnosed as being Critically Ill while the policy is in force, you may request to receive an accelerated death benefit.

Critically Ill means that within the last 12 months a physician had certified that the insured one or more of the following conditions: End Stage Renal Failure (Kidney Failure), Life Threatening (Invasive) Cancer, Major Organ Failure, Myocardial Infarction (Heart Attack), or Stroke (Cerebrovascular Accident).

We will reduce the Critical Illness Benefit by an amount equal to the requested acceleration multiplied by an actuarial present value factor, the present value of expected future unpaid premiums, and a $100 charge. If the policy has indebtedness, we will deduct a portion of the Critical Illness Benefit and apply this portion to reduce indebtedness.

Instructions to Agent

A copy must be given to applicant no later than at the time of application.

BENEFIT DESCRIPTION - ACCELERATED DEATH BENEFIT FOR TERMINAL ILLNESS RIDER

If the insured is diagnosed as having a Terminal Illness while the policy is in force, you may make a one-time request to receive an accelerated death benefit up to 80% of the policy's death benefit.

A Terminal Illness is a medical condition that, within a reasonable degree of medical certainty, will result in the insured's death within 12 months or less from the date a physician signs the statement of proof of Terminal Illness.

We will reduce the Terminal Illness benefit by an actuarial discount rate and a $100 charge. If the policy has indebtedness, we will deduct a portion of the Terminal Illness benefit and apply this portion to reduce indebtedness.

REQUESTING AN ACCELERATION

You may request to receive the Chronic Illness or Critical Illness benefit more than once, and there must be at least 12 months between acceleration requests. In contrast, you may request to receive the Terminal Illness benefit only once. If you request to receive the Terminal Illness benefit, the Chronic Illness and Critical Illness benefits are no longer available.

The minimum requested acceleration is the lesser of $10,000 or 10% of the policy face amount under any rider. The maximum sum of all accelerated death benefit payments, for the policy to which this rider is attached, cannot exceed 80% of the policy's face amount as of the policy issue date, and can never exceed $250,000. The issue date and face amount are shown in the policy.

EFFECT OF THE ACCELERATED DEATH BENEFIT ON THE POLICY

When we pay the accelerated death benefit, the policy will continue with a reduced face amount, reduced Guaranteed Values, and a reduced premium.

The benefit amount paid will always be less than the requested acceleration and, in some cases, could be zero. You will be notified of the amount payable as a result of your acceleration request and will have the opportunity to accept that amount, revise your requested acceleration, or withdraw your request acceleration request.

ACKNOWLEDGMENT

I acknowledge receipt of this disclosure form.

Owner Signature _____ Date _____

Proposed Insured Signature (if other than Owner) _____ Date _____

I have provided this disclosure form to the applicant.

Licensed KCL Agent Signature _____ Date _____

Agent Code _____

Instructions to Agent
A copy must be given to applicant no later than at the time of application.

KANSAS CITY LIFE
INSURANCE COMPANY
Broadway at Armour / Box 219139 / Kansas City, Missouri 64121-9139
Telephone: (816) 753-7000
Web Site: www.kclife.com

APPENDIX A

NOTICE REGARDING REPLACEMENT OF LIFE INSURANCE AND ANNUITIES

You have indicated that you intend to replace existing life insurance or annuity coverage in connection with the purchase of our life insurance or annuity policy. As a result, we are required to send you this notice. Please read it carefully.

Whether it is to your advantage to replace your existing insurance or annuity coverage, only you can decide. It is in your best interest, however, to have adequate information before a decision to replace your present coverage becomes final so that you may understand the essential features of the proposed policy and your existing insurance or annuity coverage.

You may want to contact your existing life insurance or annuity company or its agent for additional information and advice or discuss your purchase with other advisors. Your existing company will provide this information to you. The information you receive should be of value to you in reaching a final decision.

If either the proposed coverage or the existing coverage you intend to replace is participating, you should be aware that dividends may materially reduce the cost of insurance and are an important factor to consider. Dividends, however, are not guaranteed.

You should recognize that a policy which has been in existence for a period of time may have certain advantages to you over a new policy. If the policy coverages are basically similar, the premiums for a new policy may be higher because rates increase as your age increases. Under your existing policy, the period of time during which the issuing company could contest the policy because of a material misrepresentation or omission concerning the medical information requested in your application, or deny coverage for death caused by suicide may have expired or may expire earlier than it will under the proposed policy. Your existing policy may have options which are not available under the policy being proposed to you or may not come into effect under the proposed policy until a later time during your life. Also, your proposed policy's cash values and dividends, if any, may grow slower initially because the company will incur the cost of issuing your new policy. On the other hand, the proposed policy may offer advantages which are more important to you.

If you are considering borrowing against your existing policy to pay the premiums on the proposed policy, you should understand that in the event of your death, the amount of any unpaid loan, including unpaid interest, will be deducted from the benefits of your existing policy thereby reducing your total insurance coverage.

After we have issued your policy, you will have 20 days from the date the new policy is received by you to notify us you are canceling the policy issued on your application and you will receive back all payments you made to us.

You are urged not to take action to terminate or alter your existing life insurance or annuity coverage until you have been issued the new policy, examined it, and have found it acceptable to you.

Applicant's Signature	Date	Agent's Signature

KANSAS CITY LIFE INSURANCE COMPANY

Military Questionnaire
Supplement to Application for Life Insurance

Name of proposed Insured _____

Permanent Address (non-military residence) _____

STATUS

Branch of Service _____

Date entered active service _____ Present pay grade _____

Name and location of present unit _____

Are you a member of the National Guard or Reserves? ☐ Yes ☐ No

Have you or your unit been alerted or volunteered for overseas assignment? ☐ Yes ☐ No

If **Yes**, where? _____

Usual duty assignment (e.g., Tank Mechanic, Cook, Radar Operator, etc.) _____

Do you qualify for hazardous duty pay? ☐ Yes ☐ No

If **Yes**, why? (e.g., flying duty, submarine duty, demolition, scuba, etc.). _____

Have you any reason to believe you will, within the next 90 days, be transferred, or have you any knowledge of any change in activities? ☐ Yes ☐ No

If **Yes**, provide details _____

MILITARY AVIATION

How many total hours have you accumulated as a pilot or as a crew member? _____

Hours estimated in the next 12 months as a pilot or as a crew member? _____

Job title _____ Aviation activity and duties _____

Do you fly for proficiency only? ☐ Yes ☐ No

If **Yes**, specify hours flown and provide full details _____

Duty assignment (MAC, SAC, TAC, etc.) _____

Aircraft in which duties are performed (F4, B52, T28, HO-1, etc.) _____

By signing below you understand and agree that the information recorded above will form a part of the policy to which this Supplement is attached.

Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

Proposed Insured's signature: _____

Date: _____

KANSAS CITY LIFE
INSURANCE COMPANY

DESIGNATION OF DEATH BENEFIT PAYOUT ENDORSEMENT
SUPPLEMENT TO APPLICATION

This application is for the election of the Designation of Death Benefit Payout Endorsement.

Name of Insured: _____ Policy Number* _____

*Complete only if this supplement is for an inforce policy.

Please indicate your desired death benefit payout elections:

Specified Amount: *$*_____

Lump Sum Benefit Amount: *$*_____

Installment Benefit:

*$*_____ _____ *for* _____ *Years*

Installment Benefit Amount (min. amount of $100)

Installment Benefit Mode (Annually, Semi-Annually) Quarterly, Monthly)

Installment Benefit Period (min. period of 5 years, max. period of 30 years)

Any variation in death proceeds payable from the Specified Amount will first be applied as an adjustment to the Lump Sum Benefit Amount. Any remaining adjustment needed will be applied to the present value of the Installment Benefit and will reduce the Installment Benefit Amount in the same proportion as the reduction in the present value of the Installment Benefit.

By signing below you understand and agree that the information recorded above will form a part of the policy to which this Supplement is attached.

Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

Dated at _____ this _____ day of _____, 20_____
City/State Day Month Year

_____ _____ _____
Owner's Signature **Agent Code** **Agent Signature**

KANSAS CITY LIFE

REQUEST TO DISCOUNT PREMIUMS

I, _____ request that Kansas City Life Insurance Company accept an advance payment in the sum of $ _____, on the policy applied for in the accompanying application (or if already issued, on Policy No. _____on the life of _____ _____). The sum represents the present value of a total of _____ annual premiums. The first such premium is due on the first anniversary of any policy issued on said application (or if already issued, on the _____ day of _____, 20_____) and if said request is granted and said payment accepted, I agree that it shall be upon the following express terms and conditions:

The said sum of money shall be held by the Company in an advance premium fund for the purpose of paying said annual premiums as they fall due under the contract. In the event of the death of the Insured, the then present value at the date of death of any such advance premiums as shall not have become due shall be paid in one lump sum to the payee entitled to receive the proceeds of the policy. If there is more than one payee, each payee shall receive a share of the said lump sum in the same proportion that he or she shares in the proceeds of the policy. The calculation of the present value of each premium shall be at the rate of interest used in calculating prepayment of such premium.

The Company shall permit, on any anniversary of the effective date of the policy, withdrawal of the value of all of said premiums as shall not by then have become due. The value of such premiums withdrawn shall be the discounted amount originally paid in respect to such unearned premiums, without interest added thereon. Upon withdrawal, all premiums not due and paid on or before the date of withdrawal shall be due and payable in accordance with the terms of the above policy. Upon withdrawal of the advance premium fund, the receipt and agreement covering the same shall terminate and become void.

Dated at _____, the _____ day of _____, 20_____.

_____ _____

Signature of Applicant-Insured Signature of Owner

_____ _____

Social Security Number Social Security Number

LEAVE
WITH
CLIENT

COMPLETE THE FOLLOWING FORMS AND
LEAVE THESE COPIES WITH THE OWNER.

KANSAS CITY LIFE INSURANCE COMPANY
3520 Broadway, P.O. Box 219428
Kansas City, MO 64121-9428

Authorization for Release of Information to Insurance Agent or Agency

I authorize Kansas City Life Insurance Company, or its authorized third-party vendor, to disclose personal and medical information about me to the insurance agent and/or agency stated in my application for life insurance.

Information that Kansas City Life Insurance Company or its authorized third-party vendor may disclose includes medical information and other personal information as it relates to actions Kansas City Life Insurance Company may have taken based on this information, such as charging me a higher premium for my insurance, changing benefits to something other than I applied for, or declining my application for insurance.

The information will be used to help me with the insurance application process or to find other insurance coverage options.

I understand that if the person or entity that receives the above information is not covered by federal privacy regulations, the information described above may be re-disclosed by such person or entity and will likely no longer be protected by the federal privacy regulations.

I understand that I may refuse to sign this authorization. If I refuse to sign, it will not affect the issuance of the insurance for which I am applying.

Unless revoked earlier, this authorization will remain in effect for 24 months from the date I sign it. I understand that I may revoke this authorization at any time, by written notice to: Kansas City Life Insurance Company, New Business Department, P.O. Box 219428, Kansas City, Missouri 64121-9428.

I realize that my right to revoke this authorization is limited to the extent that Kansas City Life Insurance Company, or its authorized third-party vendor, has taken action in reliance on the authorization.

I understand that I will receive a copy of the authorization.

Proposed Insured's signature: _____

Date: _____

M720 Client Copy

Instructions to Agent
Client Copy must be given to the proposed Insured.
Forward the Company Copy to the Home Office.

KANSAS CITY LIFE INSURANCE COMPANY

Accelerated Death Benefit Riders Disclosure

THIS DISCLOSURE IS A BRIEF DESCRIPTION OF THE ACCELERATED DEATH BENEFIT RIDERS AND THE EFFECTS ON YOUR POLICY. THIS DISCLOSURE IS NOT AN INSURANCE CONTRACT, BUT ONLY A SUMMARY OF THE COVERAGE PROVIDED BY THE RIDERS. THERE IS NO PREMIUM CHARGE FOR THE RIDERS.

THE BENEFITS RECEIVED UNDER ANY ACCELERATED DEATH BENEFIT RIDER MAY BE TAXABLE AND MAY ADVERSELY AFFECT YOUR ELIGIBILITY FOR MEDICAID OR OTHER GOVERNMENT BENEFITS OR ENTITLEMENTS. YOU SHOULD CONSULT YOUR PERSONAL TAX ADVISOR REGARDING THE TAX TREATMENT OF ACCELERATED BENEFITS. YOU SHOULD CONTACT A QUALIFIED ADVISOR OR THE APPLICABLE GOVERNMENT AGENCY (SUCH AS THE LOCAL STATE MEDICAID OFFICE) FOR ADVICE REGARDING ELIGIBILITY FOR MEDICAID OR OTHER GOVERNMENT BENEFITS OR ENTITLEMENTS BEFORE REQUESTING THIS BENEFIT.

ACCELERATED BENEFITS DO NOT AND ARE NOT INTENDED TO QUALIFY AS LONG-TERM CARE INSURANCE. BENEFIT PAYMENTS UNDER AN ACCELERATED DEATH BENEFIT RIDER ARE INTENDED TO QUALIFY FOR FAVORABLE TAX TREATMENT.

BENEFIT DESCRIPTION – ACCELERATED DEATH BENEFIT FOR CHRONIC ILLNESS RIDER

If the insured is diagnosed as being Chronically Ill while the policy is in force, you may request to receive an accelerated death benefit.

Chronically Ill means that within the last 12 months a physician has certified that for a continuous period of at least 90 days, the insured is:

1. unable to perform (without substantial assistance from another person) at least two activities of daily living; or
2. requires substantial supervision to protect himself or herself from threats to health and safety due to severe cognitive impairment.

Each requested acceleration may not exceed the per diem allowance permitted by section 101(g)(3) of the Internal Revenue Code multiplied by the number of days in the current calendar year that the insured is expected to be Chronically Ill. The Internal Revenue Service announces the per diem limit for each calendar year.

We will reduce the Chronic Illness benefit by an amount equal to the requested acceleration multiplied by an actuarial present value factor, the present value of expected future unpaid premiums, and a $100 charge. If the policy has indebtedness, we will deduct a portion of the Chronic Illness benefit and apply this portion to reduce indebtedness.

BENEFIT DESCRIPTION – ACCELERATED DEATH BENEFIT FOR CRITICAL ILLNESS RIDER

If the insured is diagnosed as being Critically Ill while the policy is in force, you may request to receive an accelerated death benefit.

Critically Ill means that within the last 12 months a physician had certified that the insured one or more of the following conditions: End Stage Renal Failure (Kidney Failure), Life Threatening (Invasive) Cancer, Major Organ Failure, Myocardial Infarction (Heart Attack), or Stroke (Cerebrovascular Accident).

We will reduce the Critical Illness Benefit by an amount equal to the requested acceleration multiplied by an actuarial present value factor, the present value of expected future unpaid premiums, and a $100 charge. If the policy has indebtedness, we will deduct a portion of the Critical Illness Benefit and apply this portion to reduce indebtedness.

Instructions to Agent

A copy must be given to applicant no later than at the time of application.

BENEFIT DESCRIPTION - ACCELERATED DEATH BENEFIT FOR TERMINAL ILLNESS RIDER

If the insured is diagnosed as having a Terminal Illness while the policy is in force, you may make a one-time request to receive an accelerated death benefit up to 80% of the policy's death benefit.

A Terminal Illness is a medical condition that, within a reasonable degree of medical certainty, will result in the insured's death within 12 months or less from the date a physician signs the statement of proof of Terminal Illness.

We will reduce the Terminal Illness benefit by an actuarial discount rate and a $100 charge. If the policy has indebtedness, we will deduct a portion of the Terminal Illness benefit and apply this portion to reduce indebtedness.

REQUESTING AN ACCELERATION

You may request to receive the Chronic Illness or Critical Illness benefit more than once, and there must be at least 12 months between acceleration requests. In contrast, you may request to receive the Terminal Illness benefit only once. If you request to receive the Terminal Illness benefit, the Chronic Illness and Critical Illness benefits are no longer available.

The minimum requested acceleration is the lesser of $10,000 or 10% of the policy face amount under any rider. The maximum sum of all accelerated death benefit payments, for the policy to which this rider is attached, cannot exceed 80% of the policy's face amount as of the policy issue date, and can never exceed $250,000. The issue date and face amount are shown in the policy.

EFFECT OF THE ACCELERATED DEATH BENEFIT ON THE POLICY

When we pay the accelerated death benefit, the policy will continue with a reduced face amount, reduced Guaranteed Values, and a reduced premium.

The benefit amount paid will always be less than the requested acceleration and, in some cases, could be zero. You will be notified of the amount payable as a result of your acceleration request and will have the opportunity to accept that amount, revise your requested acceleration, or withdraw your request acceleration request.

ACKNOWLEDGMENT

I acknowledge receipt of this disclosure form.

Owner Signature _____ Date _____

Proposed Insured Signature (if other than Owner) _____ Date _____

I have provided this disclosure form to the applicant.

Licensed KCL Agent Signature _____ Date _____

Agent Code _____

Instructions to Agent
A copy must be given to applicant no later than at the time of application.

Conditional Receipt

If the proposed Insured in this application dies before coverage under this Receipt terminates, we will pay the Receipt benefit described below to the beneficiary named in the application, subject to the Conditions.

Please read this Receipt carefully. No coverage is in force other than as stated in this Receipt. No agent may change the terms of this Receipt. No coverage will be effective under this Conditional Receipt if advance payment is not made by check or Pre-Authorized Check Plan (PAC).

Conditions

If the amount received by check or Pre-Authorized Check Plan with the application is at least one month's premium for the policy applied for, the coverage will be in effect as of the date of this Receipt, BUT ONLY IF the proposed Insured is hereafter determined by the Company according to the underwriting standards of the Company then in effect to be insurable for the policy exactly as applied for.

Fraud or material misrepresentations invalidate this Receipt and the company's only liability is for refund of any payment made. All parts of the application must be completed and received by the Company.

Benefit

The benefit under this Receipt is an amount equal to the lesser of the Face Amount applied for on the proposed Insured in the application or $100,000. The benefit provided by this Receipt is further limited as follows:

(1) the maximum total coverage provided under all Conditional Receipts of the Company in effect on the proposed Insured is limited to $100,000;

(2) for death due to suicide, the Company's liability is limited to return of any amount paid with the application;

(3) this Receipt is not effective as to any rider or supplemental benefits to the policy;

(4) if payment is made by check or draft, coverage is effective only if the check or draft is honored on first presentation for payment;

(5) in no event may this Receipt and the policy applied for provide coverage at the same time.

Date Coverage Terminates

The coverage provided by this Receipt will end on the earliest of:

(1) the date coverage becomes effective under the policy applied for;

(2) the date the Company mails notice of termination of coverage to the Owner;

(3) 60 days from the date of this Receipt; or

(4) the date the Owner withdraws the application for insurance.

If the application is declined or withdrawn, the Company will immediately refund any amount paid with this application.

All premium checks must be payable to Kansas City Life Insurance Company. Do not make check payable to the agent or leave the payee blank.

Name of Proposed Insured: _____

Payment Amount: _____

Dated at: _____ **this** _____ **day of** _____, _____.
City, State Date Month Year

Agent's Signature: _____

KANSAS CITY LIFE INSURANCE COMPANY

To obtain further information contact:
New Business Department
Kansas City Life Insurance Company
PO Box 219428
Kansas City, MO 64121-9428

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. We may also order a credit report.

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 219428, Kansas City, MO 64121-9428.

MIB, Inc. Notice

Information regarding your insurability will be treated as confidential. Kansas City Life Insurance Company or its reinsurers may, however, make a brief report thereon to the MIB, Inc., formerly known as Medical Information Bureau, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information about you in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at 866-692-6901. If you question the accuracy of the information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.

Kansas City Life Insurance Company, 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.

This page remains with the applicant.