KANSAS CITY LIFE INSURANCE COMPANY

PENNSYLVANIA – ICC17A194

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, Assured Insurability, Children's Term Rider, Additional Life Insurance, Disability Payment of Premium, Additional Term Coverage, Enhanced Living Benefits, or Monthly Benefit, a Rider Amount must be entered on the application.
- If applying for Enhanced Living Benefits (ELB), Living Benefits (LBR), Terminal Illness (TIR) rider, or Chronic Illness Rider please include the appropriate disclosure as noted in the Other Forms/Supplements section below.

General Forms Required With Application (included in this packet)

- ICC17A192 Conditional Receipt || If money collected or PAC premium mode box marked on application.
- 990 Illustration Waiver
- M216 Notice and Consent for AIDS Virus (HIV) Testing
- M705 Notice Regarding Replacement of Life Insurance and Annuities

State Forms Required With Application (included in this packet)

- There are no Pennsylvania specific forms required at application.

Other Forms / Supplements (not included in this packet)

These are coverage specific forms & supplements that may not be required with all applications. If this application requires any of the following forms, please access the form(s) via kclic.net (Sales & Marketing Center >> Sales Forms), the Forms Wizard on www.ikclife.com, or Supply and include with the submission.

- ICC17M723 Accelerated Death Benefit Riders Disclosure || TIR for UL & Value Assured; LBR for Cashback & Gift of Life; Chronic Illness for Value Assured & UL
- M508-F How the Rider Providing Acceleration of Term Policy Death Benefits Works || TIR for Term
- M626-PA How the Terminal Illness Accelerated Death Benefit Rider Works || TIR for VUL
- ICC17A165 Enhanced Living Benefits Rider Supplement to Application || ELB for UL & VUL
- M595-PA How the Acceleration of Death Proceeds Rider Works || ELB for VUL
- M596-PA How the Acceleration of Death Proceeds Rider Works || ELB for UL products
- M700 Indexed Universal Life Premium Allocation Form || EquiFlex IUL, required.
- ICC16M716 Indexed Universal Life Premium Allocation Form || Compass Elite IUL, required.
- ICC17A163 Designation of Death Benefit Payout Endorsement Supplement to Application || All, if applicable.
- ICC17A179 Additional Owner Information Supplement to Application for Life Insurance || All, required if multiple Owners.
- ICC17A185 Military Questionnaire Supplement to Application for Life Insurance || All, if applicable.
- ICC17A186 Avocations Questionnaire Supplement to Application for Life Insurance || All, if applicable.
- ICC17A187 Civilian Aviation Questionnaire Supplement to Application for Life Insurance || All, if applicable.
- ICC17A188 Motor Sport Racing Questionnaire Supplement to Application for Life Insurance || All, if applicable.
- ICC17A189 Variable Universal Life Supplement to Application for Life Insurance || VUL, required.
- ICC17A190 Senior Questionnaire Supplement to Application for Life Insurance || Age 71+ and specified/face amount of $50,000 to $99,999.
- M511 Portfolio of Funds for Variable Contracts || VUL, required.
- 1035C Request and Agreement for the Exchange of Insurance Policies Under IRS Section 1035
- 7230 Modified Endowment Contract Consent (MEC)
- 7577 Request to Discount Premiums || Term or Value Assured only.
- NB100 Request to Terminate Coverage and Rollover/Transfer Policy Value

Paramedical Vendors

ExamOne	www.examone.com	877-933-9261
Examination Management Services, Inc. (EMSI)	www.emsinet.com	800-872-9674
Portamedic	www.portamedic.com	800-782-7373
APPS	www.appsnational.com	800-PARA999 / (800-727-2999)

KANSAS CITY LIFE INSURANCE COMPANY

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

Application for Individual Life Insurance

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 ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

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

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	Driver's License No.	State of Issue

Street Address	City	State	Zip
Mailing Address (if different)	City	State	Zip

Home Phone ( )	Cellular Phone ( )	Email

Employer	Street Address	
City	State	Zip

Occupation and Duties	Years Employed

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. If there are multiple Successor Owners, show order and distribution in Special Requests.)

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

Successor Owner	Relationship to Insured	Email

Trust Information (If trust is Owner and/or Beneficiary, please provide the following additional information.)

Exact Name of Trust	Trust Tax ID #
Current Trustee(s)	Date of Trust

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.

Special Requests (Policy date, additional policy, existing PAC or CB number, etc.)

PLAN DATA

Life Insurance

Plan Name*	Specified / Face Amount $	UL Coverage Option ☐ A ☐ B ☐ C (if available)
Risk Class / Special Class Table Rating:		DEFRA Compliance: ☐ Guideline Premium Test (GPT) ☐ Cash Value Accumulation Test (CVAT)
Planned / Annual Premium $		
Projected 1035 Exchange Amount: $		Automatic Premium Loan ☐ Yes ☐ No

**If VUL, please complete Supplement to Application for Variable Universal Life.*
**If IUL, please complete Premium Allocation Form.*

Riders/Benefits

- ☐ Accidental Death $_____
- ☐ Assured Insurability $_____
- ☐ Charitable Giving (Term)
- ☐ Children's Term _____ units
- ☐ Living Benefits
- ☐ Waiver of Premium (Non-UL)
- ☐ Accelerated Death Benefit for Terminal Illness
- ☐ Accelerated Death Benefit for Chronic Illness
- ☐ Other _____

UL Only:

- ☐ Additional Life Insurance $_____
- ☐ Disability Continuance of Insurance
- ☐ Disability Payment of Premium $_____
- ☐ Enhanced Living Benefits $_____
- ☐ Other Insured (complete information below)
- ☐ Monthly Benefit $_____
- ☐ Additional Term Coverage (IUL only) $_____

Other Insureds (OI) If any information is identical to the Primary Insured's, write Same.

1st OI

Full Name (First, Middle, Last)	☐ Non-Tobacco ☐ Tobacco	☐ Male ☐ Female	Marital Status	Specified Amount $
Social Security Number	State of Birth	Driver's License Number and State of Issue		☐ ADB $
Street Address, City, State, Zip			Telephone Number ( )	
Occupation and duties	Employer's Name and Address			Years Employed

2nd OI

Full Name (First, Middle, Last)	☐ Non-Tobacco ☐ Tobacco	☐ Male ☐ Female	Marital Status	Specified Amount $
Social Security Number	State of Birth	Driver's License Number and State of Issue		☐ ADB $
Street Address, City, State, Zip			Telephone Number ( )	
Occupation and duties	Employer's Name and Address			Years Employed

BILLING INFORMATION

Premium Mode ☐ Ann ☐ SA ☐ Qtly ☐ Mo ☐* PAC ☐ GA ☐ CB ☐ Single ☐ Other _____

Premium Notices Delivered To: ☐ Owner ☐ Primary Insured ☐ Other (provide name and address)

Branch of Service for GA	Payor's SSN for Government Allotment

REPLACEMENT

1) Will any existing life or annuity contract be lapsed, reissued, surrendered, or converted (to reduce amount, premium, or period of coverage, including surrender options) if the proposed policy is issued?	☐ Yes ☐ No
2) Will the proposed policy be financed by loans from this or any other policy or annuity? If Yes, provide name of company(ies) or amount(s):	☐ Yes ☐ No
3) Will the proposed policy be part of an Internal Revenue Code Section 1035 Exchange?	☐ Yes ☐ No
Provide details to all Yes answers.	

EVIDENCE OF INSURABILITY

Insurance History

1) Do any of the proposed Insureds currently have life insurance coverage or annuity contract(s)?	☐ Yes ☐ No

(If Yes, fill out the table below for life insurance coverage; if No, proceed to question 2) directly below the table.)
Please indicate the Type of coverage: Personal (P); Business (B); or Key Person (K)

Proposed Insured(s)	Company	Insurance Amount	Year Issued	Type	Replacement
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No

2) Is this policy being funded via a premium financing loan or with funds borrowed, advanced, or paid from another person or entity? (If Yes, provide further information in the space provided.)	☐ Yes ☐ No
3) Have you ever applied for life, health, or disability insurance and been declined, postponed, rated, modified or charged an increased premium? (If Yes, provide further information in the space provided.)	☐ Yes ☐ No
4) Do any of the proposed Insureds have an application for life, health, or disability insurance currently pending at any other insurance company or intend to apply for such insurance?	☐ Yes ☐ No
5) What is the total amount of life insurance coverage that will be placed in force with all companies including this application?	$
Provide details to all Yes answers.	

OTHER COVERAGE INFORMATION

1) Has any party to the application been offered or received compensation, inducement, or other consideration for obtaining this policy?	☐ Yes ☐ No
2) Do you intend to sell, transfer ownership, or permanently assign 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
Provide details to all Yes answers.	

FINANCIAL INFORMATION

Complete For Personal Insurance Sales

Purpose of insurance (Check all that apply) ☐ Family Income Protection ☐ Estate Planning ☐ College Savings ☐ Mortgage Protection ☐ Retirement Savings ☐ Final Expenses ☐ Other:		
☐ Annual Gross Income (Include Salary, Bonus, Commissions) $	☐ Family net worth $	☐ Spouse $
Amount of life insurance in force on Spouse? $	Spouse Occupation	
Has(Have) the proposed Insured(s) ever filed for bankruptcy? ☐ Yes ☐ No	If Yes, please provide type (Chapter ☐ 7, ☐ 11, ☐ 13) and date closed.	

Complete For Business Insurance Sales

Purpose of insurance (Check all that apply) ☐ Key Person ☐ Buy/Sell ☐ Deferred Compensation ☐ Creditor ☐ Other:	How long has the business been established?
Annual Gross income of proposed Insured $	Proposed Insured's ownership of company %
Are other owners, officers, or key persons being insured? ☐ Yes ☐ No	If No, please explain.
Total assets of company $	Total liabilities of company $
Fair Market Value of company $	Net income of company after taxes last fiscal year $
Has company ever filed bankruptcy? ☐ Yes ☐ No	If Yes, please provide type (Chapter ☐ 7, ☐ 11, ☐ 13) and date closed.

NON-MEDICAL UNDERWRITING QUESTIONS

Questions apply to all proposed Insureds*

1)	For Children's Term Rider only: Do any of the children listed for this coverage live outside the Primary Insured's household?	☐ Yes ☐ No
2)	Do any of the proposed Insureds plan to travel or reside outside the U.S. or Canada within the next 2 years? If Yes, explain below.	☐ Yes ☐ No
3) A)	In the last 3 years, has any proposed Insured been convicted of or pleaded guilty to any moving motor vehicle violation or had a driver's license suspended or revoked? If Yes, explain below.	☐ Yes ☐ No
B)	In the last 5 years, has any proposed Insured been convicted of or pleaded guilty to driving under the influence of alcohol or other drugs, or to careless, or reckless driving? If Yes, explain below.	☐ Yes ☐ No
4) A)	In the last 3 years, has any proposed Insured flown as a pilot, student pilot, crew member, or other than a passenger on regularly scheduled commercial airlines? If Yes, complete the Civilian Aviation Questionnaire.	☐ Yes ☐ No
B)	Is there any intent to do so within the next year? If Yes, complete the Civilian Aviation Questionnaire.	☐ Yes ☐ No
5)	In the last 3 years, has any proposed Insured participated in or plan, in the next 2 years, to participate in skydiving, parachuting, hang-gliding, ultra-light flying, scuba diving, vehicle racing, mountain or rock climbing, white water rafting, bungee jumping or ice climbing? If Yes, complete the Avocations Questionnaire and/or the Motor Sport Racing Questionnaire.	☐ Yes ☐ No
6)	Are you a member of the armed forces? ☐ Yes ☐ No If Yes, please complete the Military Questionnaire.	☐ Yes ☐ No
7)	Has any proposed Insured ever been convicted of or pleaded guilty to a felony or misdemeanor? If Yes, explain below.	☐ Yes ☐ No
8)	Family History – Have parents or siblings been diagnosed or treated by a member of the medical profession for diabetes, cancer, heart or kidney disease, melanoma, or stroke? If Yes, please indicate below.	☐ Yes ☐ No

Relationship	Age if Living	Diagnosis or Cause of Death	Age at Diagnosis	Age at Death
Father				
Mother				
Brothers and Sisters				

*Provide details to all Yes answers. _____

_____

_____

_____

JUVENILE INSURANCE (AGE 0-17)

1)	For any proposed Insured(s) less than one year old, what was birth weight?
2)	For any proposed Insured(s) age 5-15, what is grade in school?
3)	Are all children insured equally? ☐ Yes ☐ No If No, please explain.
4)	Amount of insurance in force or applied for on father: $
5)	Amount of insurance in force or applied for on mother: $

HEALTH STATEMENT

Print full names of all to be insured, excluding the Primary Insured.	Relationship	Birthdate			Age	Sex	Build			Weight change in the last 12 months	
		Month	Day	Year			Ft.	In.	Lb.	Gain	Loss
1)											
2)											
3)											
4)											

1) Primary Physician (provide name and address; if none, indicate none):

2) Physician last consulted (provide name, specialty, address, date last seen, and reason and results of last visit):

Questions apply to all proposed Insureds	
3) Do you currently take prescription, non-prescription, or herbal medication?	☐ Yes ☐ No
4) Have you used any form of nicotine/tobacco products in the last 5 years? If Yes, provide date of last use.	☐ Yes ☐ No
5) Do you consume alcoholic beverages? If Yes, provide type and number of drinks per day or week.	☐ Yes ☐ No
6) Have you ever used (except as prescribed by a physician) or received treatment or counseling for the use of marijuana, heroin, cocaine, amphetamines, barbiturates, hallucinogenic agents, controlled substances, or opium or its derivatives?	☐ Yes ☐ No
7) Have you sought advice, been counseled, or treated for, advised to limit, or arrested for the use of alcohol?	☐ Yes ☐ No
Have you ever been diagnosed, treated, or been given advice by any member of the medical profession for:	
8) Depression, anxiety, bipolar disorder, psychosis, schizophrenia, suicidal thoughts, eating disorder, or other nervous, mental, or emotional disorder?	☐ Yes ☐ No
9) High blood pressure, high cholesterol, heart murmur, chest pain or pressure, heart attack, irregular heart rhythm, peripheral vascular disease, palpitations, aneurysm, or any other heart or vascular disorder?	☐ Yes ☐ No
10) Anemia, blood clots, bleeding, leukemia, immune deficiency, or any other blood or immune disorder (excluding HIV)?	☐ Yes ☐ No
11) Cancer, melanoma, tumor, or other malignancy?	☐ Yes ☐ No
12) Diabetes, elevated blood sugar, or any other disorder of the thyroid or pituitary gland or the endocrine system?	☐ Yes ☐ No
13) Asthma, COPD, emphysema, bronchitis, shortness of breath, sleep apnea, tuberculosis, or any other disorder of the lungs or respiratory system?	☐ Yes ☐ No
14) Hepatitis, cirrhosis, ulcer, internal bleeding, polyps, colitis, Crohn's disease, acid reflux (GERD), or any other disorder of the stomach, liver, colon, pancreas, or digestive system?	☐ Yes ☐ No
15) A disorder of the brain, spinal cord, or nervous system, including stroke, TIA (transient ischemic attack), seizures, multiple sclerosis (MS), paralysis, tremors, fainting, chronic headaches, or loss of consciousness?	☐ Yes ☐ No
16) Protein, sugar, or blood in urine or any other disorder of the bladder or kidneys?	☐ Yes ☐ No
17) Arthritis, deformity, or any injury to or disorder of the bones, joints, muscles, back, neck, or spine?	☐ Yes ☐ No
18) Any disorder of the breasts, uterus, ovaries, cervix, prostate, or reproductive organs?	☐ Yes ☐ No
19) Menstruation, pregnancy, or complications from pregnancy?	☐ Yes ☐ No
20) Are you currently pregnant? If yes, provide due date.	☐ Yes ☐ No
21) Any sexually transmitted disease or disorder?	☐ Yes ☐ No
22) Acquired Immune Deficiency Syndrome (AIDS), "AIDS" Related Complex (ARC), or tested HIV positive?	☐ Yes ☐ No
23) In the last 5 years, have you had surgery, biopsy, an electrocardiogram, x-ray, blood test, or other diagnostic testing for any reason, except those related to the Human Immunodeficiency Virus (AIDS Virus), other than what you have already stated?	☐ Yes ☐ No
24) In the last 5 years, have you been advised or referred by a medical professional for surgery, biopsy, medical treatment, or diagnostic testing for any reason, except those related to the Human Immunodeficiency Virus (AIDS Virus), other than what you have already stated?	☐ Yes ☐ No

*Provide details to all Yes answers. Identify question, specify conditions, dates, treatment (if any), and results.

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 Conditional Receipt 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 7 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 (if under 15, parent/guardian 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 _____ (City/State) this _____ day of _____ (Month), 20____ (Year).

_____
Primary Insured's Signature (if under 15, parent/guardian signature)

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

_____
Spouse's Signature (if spouse coverage applied for)

_____
First Other Insured's Signature (if over age 18)

_____
Second Other Insured's Signature (if over age 18)

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 6 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.)

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, ICC17A192, is required in all cases.

☐ Draft my account for the first premium. Please draft subsequent premiums on the _____ of each month. (The initial draft will be drafted immediately on approval for a standard or better rate class.)

☐ 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

Must fill in all boxes and start with a 0, 1, 2, or 3.

Routing Number | | | | | | | | | | 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.
3) No premium notices or receipts will be sent. Debit entries or checks, when paid, will constitute receipts for premiums.
4) 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.
5) The Company's rights in respect to each check and/or debit entry will be the same as if I signed it personally.
6) 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.
7) 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.

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

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.

No one is authorized to accept money on proposed Insureds under 15 days of age or over age 70 (last birthday). No coverage will be effective under this Conditional Receipt for a proposed Insured under 15 days of age or over age 70 (last birthday).

Benefit

The benefit under this Receipt is an amount equal to the lesser of the Specified/Face Amount applied for on the proposed Insured in the application or $500,000. 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 $500,000;
(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 _____, 20_____.
City/ State Month Year

Agent's Signature: _____

ICC17A192 Original Copy

Instructions to Agent
Original Copy must be given to the Owner.
Forward the Company Copy to the Home Office.

KANSAS CITY LIFE INSURANCE COMPANY
P.O. Box 219139 Kansas City, MO 64121-9139

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.

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(1) the maximum total coverage provided under all Conditional Receipts of the Company in effect on the proposed Insured is limited to $500,000;
(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;
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(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 _____, 20_____.
City/ State Month Year

Agent's Signature: _____

ICC17A192 Company Copy

Instructions to Agent
Original Copy must be given to the Owner.
Forward the Company Copy to the Home Office.

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

Illustration Waiver

Complete this section if no illustration conforming to the policy applied for was provided.

I certify that no illustration conforming to the policy applied for was shown or provided to _____

_____.

Agent Signature **Date**

I acknowledge that no illustration of future nonguaranteed values conforming to the life insurance policy applied for was provided. I understand that an illustration conforming to the policy as issued will be provided no later than at the time of policy delivery.

Owner/Trustee Signature **Date**

Complete this section if illustration was viewed on computer screen and no paper copy was provided.

I certify that I displayed a computer screen illustration for _____ that complies with state requirements and for which no paper copy was furnished.

The illustration was based on the following personal and policy information:

Male, Female, or Unisex	Age or Date of Birth	Risk Class	Product Name	Initial Death Benefit

Agent Signature **Date**

I acknowledge that I viewed a computer screen illustration based on the information as stated above. No paper copy of the illustration was furnished. I understand that an illustration conforming to the policy as issued will be provided to me no later than at the time the policy is delivered.

Owner/Trustee Signature **Date**

Submit completed form with policy 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

Insurer: Kansas City Life Insurance Company

Address: P.O. Box 219139, Kansas City, Missouri 64121-9139

Notice And Consent For AIDS Virus (HIV) Testing

To evaluate your insurability, the insurer named above has requested that you provide a sample of your blood or oral fluid for testing and analysis to determine the presence of human immunodeficiency virus (HIV) antibodies. By signing and dating this form, you agree that this test may be done and that underwriting decisions will be based on the test result. A series of tests will be performed by a certified laboratory through a medically accepted procedure.

Pre-Testing Considerations

Many public health organizations have recommended that before taking an AIDS Virus (HIV) test, a person seek counseling to become informed concerning the implications of such a test. You may wish to consider counseling, at your expense, prior to being tested.

Meaning of Positive Test Results

The test is not a test for AIDS. It is a test for antibodies to the HIV virus, the causative agent for AIDS and shows whether you have been exposed to the virus. A positive test result does not mean that you have AIDS but that you are at significantly increased risk of developing problems with your immune system. The test for HIV antibodies is very sensitive. Errors are rare, but they do occur. Your private physician, a public health clinic, or an AIDS information organization in your city might provide you with further information on the medical implications of a positive test.

Positive HIV antibody test results will adversely affect your application for insurance.

Confidentiality of Test Results

All test results are required to be treated confidentially. They will be reported by the laboratory to the insurer. The test results may be disclosed as required by law or may be disclosed to employees of the insurer who have the responsibility to make underwriting decisions on behalf of the insurer or to outside legal counsel who needs such information to effectively represent the insurer in regard to your application. The results may be disclosed to a reinsurer, if the reinsurer is involved in the underwriting process. The test may be released to an insurance medical information exchange under procedures that are designed to assure confidentiality, including the use of general codes that also cover results of tests for other diseases or conditions not related to AIDS, or for the preparation of statistical reports that do not disclose the identity of any particular person.

HIV-Related Testing and Counseling Information

You can obtain information on HIV testing and counseling sites by calling the Pennsylvania Health Department at (717) 783-0479.

Notification of Test Result

A positive test result will be disclosed to a physician you designate or to the Pennsylvania Health Department in lieu of your personal physician.

Name of physician or organization to receive positive test result:

_____

Address: _____

Negative test results will not be mailed to the person or organization you have designated unless you check the box below.

☐ Yes, I want negative results to be sent to the person or organization I've designated.

Consent

I have read and I understand this Notice and Consent for AIDS Virus (HIV) Testing. I voluntarily consent to the collection of blood or oral fluid from me, the testing of that blood or oral fluid, and the disclosure of the test results as described above. I understand that I have the right to request and receive a copy of this authorization. A photocopy of this form will be as valid as the original.

_____

Signature of Proposed Insured or Parent/Guardian Date Signed

_____

Name of Proposed Insured (Please Print)

_____

Address of Proposed Insured (Please Print)

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