

**Gift of Life
Application**



Insured: (Please print)

Name		first	middle	last
Age	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Birthdate / /	Height	Weight
Social Security or Tax #		Birthplace (State)		

Residence:

No. & Street _____
 City _____ State _____ Zip _____

Plan: Gift of Life

Coverage Amount	Annual	Premium until Age 25		
		Semi-Annual	Quarterly	CB
<input type="checkbox"/> \$15,000	\$60.00	\$31.10	\$15.90	\$5.40
<input type="checkbox"/> \$30,000	\$90.00	\$46.20	\$23.70	\$7.95

Other Coverage: (Replacement)

Does the proposed insured intend to replace or change an existing life, health or annuity policy as a result of this application?
 Yes No If "Yes", provide company name and policy number(s) in Details below.

Health Questions:

- Has the above child ever had any insurance rated, declined or postponed?..... Yes No
- Has the above child ever been diagnosed or treated by a member of the medical profession for disorder of the heart or kidney, diabetes, seizures or epilepsy, anemia or rheumatic fever?..... Yes No
- Has the above child ever been diagnosed or treated by a member of the medical profession for an immune deficiency disorder?..... Yes No
- Has the above child received any medical or surgical advice or treatment not mentioned above within the last five years?..... Yes No
- Is there any reason to believe the above child is not in good health?..... Yes No

Give Details To Any "Yes" Answer To The Above Questions: (Attach a separate sheet if necessary.)

Usual Physician _____ Address _____

Owner: (Must be other than Insured Child)

Name _____
 No. & Street _____
 City _____ State _____ Zip _____
 Social Security or Tax # _____
 Successor Owner (In the event the owner predeceases the Insured) _____

Beneficiary:

Primary: _____
 No. & Street _____
 City _____ State _____ Zip _____
 Unless otherwise specified, all surviving primary beneficiaries will share equally and the right to change the beneficiary is reserved to the owner.
 Contingent: _____

It is understood and agreed as follows: (1) The statements and answers recorded in all parts of this application are true and complete; (2) No information regarding the Proposed Insured will be considered known by the Company unless explicitly set out in writing on this application; (3) No agent has the authority to waive any of the Company's rights or rules, or to make or change any contract; (4) The insurance applied for will take effect only after the following occur while the Proposed Insured is living and his/her health is as stated in this application: (A) the contract is delivered to the applicant; and (B) the first full premium is paid in cash. The only exception to this is provided in the Temporary Insurance Agreement if the agreement has been issued and the advance payment required by the agreement has been made. I have paid \$ _____* to the agent in exchange for the Temporary Insurance Agreement and I acknowledge that I fully understand and accept its terms.

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

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

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

Dated at _____ this _____ day of _____, _____
City State Month Year

Parent/Guardian Signature

Applicant's Signature (if other than Parent/Guardian)

Statement of Agent

I certify that the statements made on behalf of the Insured have been correctly recorded in this application and that any premium payment shown above has been collected by me and a Temporary Insurance Agreement given to the applicant.

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

Agent Code | Signature of Writing Agent

Agent Code | Signature of Other Agent(s) (if split case)

Agency Code | Agency
A153-C



**KANSAS CITY LIFE
INSURANCE COMPANY**

**NOTICE OF
INFORMATION PRACTICES**
Including Fair Credit Reporting Act Notice
and MIB, Inc. Notice

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

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

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

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

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

If you wish to have a more detailed description of our information practices, we will be pleased to furnish this information upon your written request to our New Business Department, Kansas City Life Insurance Company, PO Box 219428, Kansas City, MO 64121-9428.

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

Upon written request from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of the information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedure set forth in the Federal Fair Credit Reporting Act. The address of the Bureau's information office is PO Box 105, Essex Station, Boston, MA 02112. Telephone (617) 426-3660.

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

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