K·C·L GROUP BENEFITS

Application for Group Insurance
Dental Insurance

1. Legal Name of Applicant (Policyholder) | 2. Federal Tax I.D. No.

3. Nature of Business | Standard Industrial Classification (SIC) Code | Three Digit Plan No.

4. Street Address | City | State | Zip

5. Name of Subsidiaries, Divisions or Affiliates to be Covered

6. Name and Title of Plan Administrator (Corporate Officer) | Phone No.

7. Name and Title of Correspondent (Routine Accounting Matters) | Phone No.

8. Billing Address(es) - If Different From Street Address

9. Service of Legal Process Agent (If Different From Plan Administrator) | Phone No.

10. Street Address | City | State | Zip

11. Proposed Effective Date of Insurance

12. Advance Payment of $ _____ is submitted with this application to be applied by the Company on premiums for insurance when and if issued.

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

Carrier	Type of Coverage	Date to be Discontinued

This application must be accompanied by a copy of an in force certificate and benefit schedule, a current month's billing from the current carrier, as well as, proof of the effective date for each employee (and dependents, if insured).

Eligibility

14. Eligible Classes:

☐ All Full-Time Employees

☐ Other*_____

15. Are any individuals currently disabled?

☐ Yes ☐ No

If yes, provide:

Full Name	Social Security Number

16. Probationary Waiting Period:

Current Individuals_____

New Individuals_____

Coverage to be effective the first of the month following completion of probationary waiting period? ☐ Yes ☐ No

17. Are any former employees and/or dependents currently on continuation coverage provided by the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985?

☐ Yes ☐ No

If yes, list names of the enrollees, qualifying event and date of event on a separate sheet.

Coverage Applied For and Premium Contributions

18. Coverage applied for as quoted in proposal of _____, _____, Plan_____

(Please attach copy of the proposal)

Percentage of Employer Contribution* Employee_____% Dependents_____%

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

Verification of Eligibility and Enrollment

19. Participation requirements are a condition of coverage. These requirements will vary depending upon the plan selected. Statements may be used to contest a claim or the validity of the policy only if they are contained in the application. See the policy for further information. Please complete the following section to verify eligibility and enrollment.

1. Total number of employees on the payroll. _____
2. Total number of part-time employees including temporary or seasonal employees. (Employees working less than your group's definition of full-time; minimum of 30 hours per week.) _____
3. Total number of employees who have not completed the probationary waiting period. _____
4. Number of full-time employees (subtract #2 and #3 from #1). _____

If the employer pays 100% of the employee's cost, skip to number 8 below.

5. Are there other dental plans to be offered concurrently with your Kansas City Life group dental plan? ☐ Yes ☐ No
   If yes, how many employees are enrolled in your other dental plans? _____
6. Total number of employees who have waived because they are covered by their spouse's plan. _____
7. Number of eligible employees (subtract #5 and #6 from #4). _____
8. Number of enrolled employees. _____
9. Number of COBRA participants. _____

For Voluntary Dental Plan, waivers for coverage under another program are not considered in calculating participation. Participation requirements for voluntary dental programs are always calculated from the number of full-time employees (#4).

For Employer Sponsored Dental Plans requiring some employee contributions, participation requirements are calculated from #7. In no instance, will coverage be provided if more than 50% of full-time employees waive coverage. (#7 is less than 50% of #4)

Agreement and Signatures

20.

It is understood and agreed as follows:

1. No coverage is effective until approved by Kansas City Life Insurance Company at its Home Office in Kansas City, Missouri.
2. Insurance will be effective with regard to those individuals listed above in the Eligibility Section, on the latest of the following dates: (a) the effective date approved by the Company; (b) the date this application is signed; or (c) the date the first premium is paid in full.
3. No agent has the authority to waive any of the Company's rights or requirements, or to make or alter any contract or policy.
4. Any person who submits an application for files a claim containing a false or deceptive statement may be guilty of insurance fraud if there is intent to defraud or knowledge that fraud is being facilitated.

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

_____ _____
Signature of Writing Agent | Agent Code Officer's Signature

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

_____ _____
Signature of Other Agent(s) | Agent Code | Title

_____ _____
Agent(s) Business Address | City | State Zip | Agency | Agency Code