

|                                 |   |                               |   |
|---------------------------------|---|-------------------------------|---|
| <i>SERFF Tracking Number:</i>   | <i>KCLF-125912902</i>                     | <i>State:</i>                 | <i>Arkansas</i>   |
| <i>Filing Company:</i>          | <i>Kansas City Life Insurance Company</i> | <i>State Tracking Number:</i> | <i>41056</i>  |
| <i>Company Tracking Number:</i> | <i>GA173-AR</i>                           |                               |   |
| <i>TOI:</i>                     | <i>L04G Group Life - Term</i>             | <i>Sub-TOI:</i>               | <i>L04G.103 Renewable - Single Life -<br/>Fixed/Indeterminate Premium</i> |
| <i>Product Name:</i>            | <i>GA173-AR</i>                           |                               |   |
| <i>Project Name/Number:</i>     | <i>Group Enrollment Forms/GA173-AR</i>    |                               |   |

## Filing at a Glance

Company: Kansas City Life Insurance Company

|  |                               |                               |
|--|-------------------------------|-------------------------------|
| Product Name: GA173-AR   | SERFF Tr Num: KCLF-125912902  | State: ArkansasLH             |
| TOI: L04G Group Life - Term  | SERFF Status: Closed          | State Tr Num: 41056           |
| Sub-TOI: L04G.103 Renewable - Single Life -<br>Fixed/Indeterminate Premium | Co Tr Num: GA173-AR           | State Status: Approved-Closed |
| Filing Type: Form  | Co Status: Pending            | Reviewer(s): Linda Bird       |
|  | Author: Dieter Foster-Redmond | Disposition Date: 12/11/2008  |
|  | Date Submitted: 12/08/2008    | Disposition Status: Approved  |
| Implementation Date Requested: On Approval                                 |                               | Implementation Date:          |

State Filing Description:

## General Information

|   |                                       |
|---|---------------------------------------|
| Project Name: Group Enrollment Forms  | Status of Filing in Domicile: Pending |
| Project Number: GA173-AR  | Date Approved in Domicile:            |
| Requested Filing Mode: Review & Approval  | Domicile Status Comments:             |
| Explanation for Combination/Other:  | Market Type: Group                    |
| Submission Type: New Submission   | Group Market Size: Small              |
| Overall Rate Impact:  | Group Market Type: Employer           |
| Filing Status Changed: 12/11/2008   | Deemer Date:                          |
| State Status Changed: 12/11/2008  |                                       |
| Corresponding Filing Tracking Number: GA173-AR  |                                       |
| Filing Description:   |                                       |
| Kansas City Life Insurance has updated it's procedure for obtaining authorization to collect medical information from the Medical Information Bureau on our Group Enrollment Cards. |                                       |

We have added this authorization to our enrollment forms:

I(we) authorize the following to give information (defined below) to Kansas City Life Insurance Company or any person

|                                 |   |                               |   |
|---------------------------------|---|-------------------------------|---|
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| <i>Filing Company:</i>          | <i>Kansas City Life Insurance Company</i> | <i>State Tracking Number:</i> | <i>41056</i>  |
| <i>Company Tracking Number:</i> | <i>GA173-AR</i>                           |                               |   |
| <i>TOI:</i>                     | <i>L04G Group Life - Term</i>             | <i>Sub-TOI:</i>               | <i>L04G.103 Renewable - Single Life -<br/>Fixed/Indeterminate Premium</i> |
| <i>Product Name:</i>            | <i>GA173-AR</i>                           |                               |   |
| <i>Project Name/Number:</i>     | <i>Group Enrollment Forms/GA173-AR</i>    |                               |   |

or group acting on the part of Kansas City Life Insurance Company: 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 regarding my physical or mental condition; employment; other insurance coverage; or any other non-medical facts. I(we) understand that this information will be used by Kansas City Life Insurance Company to determine eligibility for insurance. I(we) agree this Authorization is valid for two and one-half years from the date signed. I (we) know that I(we) have a right to receive a copy of this Authorization upon request. I(we) agree that a photographic copy of this Authorization is as valid as the original.

Because of this change I have given the form a new number GA166-AR was approved in Arkansas on 04/15/2008 state tracking number 38613 the new form number is GA173-AR.

Once this new form is approved. It will replace the previously approved forms.

## Company and Contact

### Filing Contact Information

|  |                            |
|--|----------------------------|
| Dietter Foster-Redmond, Compliance Analyst | dfoster-redmond@kclife.com |
| P O Box 219139                             | (800) 821-5529 [Phone]     |
| Kansas City, MO 64121-9139                 | (816) 753-3018[FAX]        |

### Filing Company Information

|                                    |                         |                             |
|------------------------------------|-------------------------|-----------------------------|
| Kansas City Life Insurance Company | CoCode: 65129           | State of Domicile: Missouri |
| P O Box 219139                     | Group Code: 588         | Company Type: Life          |
| Kansas City, MO 64121-9139         | Group Name:             | State ID Number:            |
| (800) 821-5529 ext. [Phone]        | FEIN Number: 44-0308260 |                             |

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## Filing Fees

|                  |         |
|------------------|---------|
| Fee Required?    | Yes     |
| Fee Amount:      | \$50.00 |
| Retaliatory?     | Yes     |
| Fee Explanation: |         |

*SERFF Tracking Number:* KCLF-125912902      *State:* Arkansas  
*Filing Company:* Kansas City Life Insurance Company      *State Tracking Number:* 41056  
*Company Tracking Number:* GA173-AR  
*TOI:* L04G Group Life - Term      *Sub-TOI:* L04G.103 Renewable - Single Life -  
Fixed/Indeterminate Premium  
  
*Product Name:* GA173-AR  
*Project Name/Number:* Group Enrollment Forms/GA173-AR  
  
**Per Company:** No

SERFF Tracking Number: KCLF-125912902 State: Arkansas  
Filing Company: Kansas City Life Insurance Company State Tracking Number: 41056  
Company Tracking Number: GA173-AR  
TOI: L04G Group Life - Term Sub-TOI: L04G.103 Renewable - Single Life -  
Fixed/Indeterminate Premium  
Product Name: GA173-AR  
Project Name/Number: Group Enrollment Forms/GA173-AR

| COMPANY                            | AMOUNT  | DATE PROCESSED | TRANSACTION # |
|------------------------------------|---------|----------------|---------------|
| Kansas City Life Insurance Company | \$50.00 | 12/08/2008     | 24384995      |

SERFF Tracking Number: KCLF-125912902 State: Arkansas  
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Product Name: GA173-AR  
Project Name/Number: Group Enrollment Forms/GA173-AR

## Correspondence Summary

### Dispositions

| Status   | Created By | Created On | Date Submitted |
|----------|------------|------------|----------------|
| Approved | Linda Bird | 12/11/2008 | 12/11/2008     |

*SERFF Tracking Number:* KCLF-125912902      *State:* Arkansas  
*Filing Company:* Kansas City Life Insurance Company      *State Tracking Number:* 41056  
*Company Tracking Number:* GA173-AR  
*TOI:* L04G Group Life - Term      *Sub-TOI:* L04G.103 Renewable - Single Life -  
Fixed/Indeterminate Premium  
  
*Product Name:* GA173-AR  
*Project Name/Number:* Group Enrollment Forms/GA173-AR

## **Disposition**

Disposition Date: 12/11/2008

Implementation Date:

Status: Approved

Comment:

Rate data does NOT apply to filing.







**COMPLETED BY EMPLOYER**

|                              |                |   |                    |
|------------------------------|----------------|---|--------------------|
| 1. Employer                  |                | 2. Location   |                    |
| 3. Full-time employment date | 4. Occupation  | 5. Hours worked/week  | 6. Annual earnings |
| 7. Coverage class            | 8. Rehire date | 9. This enrollment is: (check all that apply)<br><input type="checkbox"/> Initial enrollment <input type="checkbox"/> Late entrant <input type="checkbox"/> New hire <input type="checkbox"/> Change <input type="checkbox"/> Other _____ |                    |

**COMPLETED BY EMPLOYEE**

|   |   |                           |  |
|---|---|---------------------------|--|
| 10. Last Name, First Name, Middle Initial |   |                           |  |
| 11. Home Address, City, State and Zip     |   |                           |  |
| 12. Social Security Number                | 13. <input type="checkbox"/> Male <input type="checkbox"/> Female | 14. Date of Birth (M/D/Y) | 15. <input type="checkbox"/> Single <input type="checkbox"/> Married |

To apply for coverage(s), complete the following section and sign below. Indicate only those products available through your employer/plan sponsor.

|   |   |
|---|---|
| 16. Coverage(s) for Employee:<br><input type="checkbox"/> Basic Life & AD&D <input type="checkbox"/> Voluntary/Supplemental Life Amount: _____<br><input type="checkbox"/> Dental If Applicable: <input type="checkbox"/> Low Plan <input type="checkbox"/> High Plan<br><input type="checkbox"/> Short-Term Disability <input type="checkbox"/> Voluntary STD If Applicable: Amount: _____<br><input type="checkbox"/> Long-Term Disability <input type="checkbox"/> Voluntary LTD If Applicable: Amount: _____<br><input type="checkbox"/> Vision | 17. Coverage(s) for Dependents (Employee coverage required)<br><input type="checkbox"/> Dependent Life<br><input type="checkbox"/> Spouse Voluntary/Supplemental Life Amount: _____<br><input type="checkbox"/> Child/ren Voluntary/Supplemental Life Amount: _____<br>Dental: <input type="checkbox"/> Spouse <input type="checkbox"/> Child/ren<br>Vision: <input type="checkbox"/> Spouse <input type="checkbox"/> Child/ren |
|---|---|

18. If COBRA continuee, please supply qualifying event and date: \_\_\_\_\_

19. Full Name of Primary Beneficiary and Relationship to you (applicable to life insurance only): \_\_\_\_\_

20. Full Name of Contingent Beneficiary and Relationship to you (applicable to life insurance only): \_\_\_\_\_

For Dependent Coverage: List each dependent you wish to insure.

| 21. Name (show last name if different from employee) | Gender | Relationship | Date of Birth | [Other Dental Coverage] |   |
|--|--------|--------------|---------------|-------------------------|---|
| Spouse   |        | N/A          |               | Y                       | N |
| Child  |        |              |               | Y                       | N |
| Child  |        |              |               | Y                       | N |
| Child  |        |              |               | Y                       | N |
| Child  |        |              |               | Y                       | N |

By signing below, I acknowledge I have read and I agree to the terms of the Provisions of Coverage contained on the reverse side of this Enrollment Form.

22. Signature of Employee: \_\_\_\_\_ Date: \_\_\_\_\_

(To decline any coverages, complete "Declination of Coverage" on page 2.)

**PLEASE DO NOT FILL IN SHADED AREA BELOW – HOME OFFICE USE ONLY**

| Group No. _____           | Effective Date (M/D/Y) | Class | Coverage Amount |
|---------------------------|------------------------|-------|-----------------|
| Loc/Div _____             |                        |       |                 |
| Cert. # _____             |                        |       |                 |
| ___ Approved as requested | Basic Life& AD&D       |       |                 |
| ___ Approved with changes | Basic Dep. Life        |       |                 |
| Employee _____            | Vol/Supp Life EE       |       |                 |
| Spouse _____              | Vol/Supp Life SP       |       |                 |
| Child/ren _____           | Vol/Supp Life Child    |       |                 |
| By: _____                 | STD                    |       |                 |
| Date: _____               | LTD                    |       |                 |
|                           | Dental                 |       |                 |
|                           | Vision                 |       |                 |

**\*PROVISIONS OF COVERAGE**

- I hereby apply to Kansas City Life Insurance Company for Group Insurance as presented to me and authorize my employer to make any necessary deduction from my wages to pay the premium when my insurance becomes effective.
- I represent I am not presently disabled and I am performing the material and substantial duties of my occupation for at least the number of hours as shown in column 5.
- Any person who knowingly presents a false for fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of crime and may be subject to fines and confinement in prison.
- I understand any material misstatement on this enrollment form may result in a denial of a claim and/or discontinuance of coverage.
- I have made a copy of this application for my records.

**DECLINATION OF COVERAGE**

To refuse coverage(s) for which you are required to pay a portion of the premium, please complete the following section:

|                                       |          |
|---------------------------------------|----------|
| Last Name, First Name, Middle Initial | Employer |
|---------------------------------------|----------|

Indicate Coverage(s) Declined Below:

|  |  |
|--|--|
| Coverage(s) for Employee:<br><input type="checkbox"/> Basic Life & AD&D] <input type="checkbox"/> Voluntary/Supplemental Life]<br><input type="checkbox"/> Dental] <input type="checkbox"/> Voluntary STD]<br><input type="checkbox"/> Short-Term Disability] <input type="checkbox"/> Voluntary LTD]<br><input type="checkbox"/> Long-Term Disability] <input type="checkbox"/> Vision] | Coverage(s) for Dependents (Employee coverage required):<br>[Life: <input type="checkbox"/> Spouse <input type="checkbox"/> Child/ren]<br>[Dental: <input type="checkbox"/> Spouse <input type="checkbox"/> Child/ren]<br>[Vision: <input type="checkbox"/> Spouse <input type="checkbox"/> Child/ren] |
|--|--|

Reason for refusing coverage: \_\_\_\_\_

I have been given an opportunity to participate in the group insurance plan offered by my employer. I am refusing the coverage indicated. I fully understand by this refusal, I and/or my dependents will not be entitled to any benefits under these coverages marked. If I and/or my Spouse or Child(ren) desire to participate at a later date, coverage(s) may be limited and proof of insurability may be required at my own expense.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**If requested to do so by Kansas City Life Insurance Company, please complete the following items.**

|   |     |        |        |        |  |
|---|-----|--------|--------|--------|--|
| Name of Employee:                           | Age | Gender | Height | Weight | Weight change in last year (gain/loss) |
| Name of Spouse of Employee (if applicable): | Age | Gender | Height | Weight | Weight change in last year (gain/loss) |

During the past five years, have you (or anyone proposed for coverage) been diagnosed or treated by a member of the medical profession for any of the following: heart condition (including high blood pressure)\*; cancer or tumor; chronic/recurrent respiratory disease; diabetes; kidney or liver disease; arthritis or any other disease of the joints, including neck and back disorders; any mental, emotional or nervous disorder; any disorder of the brain, nervous, digestive or reproductive system; muscle or connective tissue disorder; alcohol or drug abuse; or Acquired Immune Deficiency Syndrome (AIDS) or AIDS-Related Complex (ARC)?

Employee: Yes No      Spouse (life coverage only): Yes No

During the past five years, have you been declined coverage for any life or disability insurance?

Employee: Yes No      Spouse (life coverage only): Yes No

For female, disability applicants only: Are you currently pregnant? Yes No

Please supply full details to "Yes" answers. List date(s) of onset, last occurrence, types of treatment including medication. \*For high blood pressure, give date and last reading. If you require additional space, please attach separate sheet.

I(we) authorize the following to give information (defined below) to Kansas City Life Insurance Company or any person or group acting on the part of Kansas City Life Insurance Company: 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 regarding my physical or mental condition; employment; other insurance coverage; or any other non-medical facts. I(we) understand that this information will be used by Kansas City Life Insurance Company to determine eligibility for insurance. I(we) agree this Authorization is valid for two and one-half years from the date signed. I (we) know that I(we) have a right to receive a copy of this Authorization upon request. I(we) agree that a photographic copy of this Authorization is as valid as the original.

**I hereby represent that the above answers are complete and true to the best of my knowledge and belief concerning the past and present state of health and medical history of the person(s) to whom the answers relate. I agree that this document and all its contents shall form a part of my enrollment request for group benefits.**

Signature of Employee: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Spouse: \_\_\_\_\_ Date: \_\_\_\_\_

*SERFF Tracking Number:*      *KCLF-125912902*                      *State:*                      *Arkansas*  
*Filing Company:*              *Kansas City Life Insurance Company*              *State Tracking Number:*      *41056*  
*Company Tracking Number:*      *GA173-AR*  
*TOI:*                      *L04G Group Life - Term*                      *Sub-TOI:*                      *L04G.103 Renewable - Single Life -  
Fixed/Indeterminate Premium*

*Product Name:*              *GA173-AR*  
*Project Name/Number:*      *Group Enrollment Forms/GA173-AR*

## **Rate Information**

Rate data does NOT apply to filing.

SERFF Tracking Number: KCLF-125912902 State: Arkansas  
Filing Company: Kansas City Life Insurance Company State Tracking Number: 41056  
Company Tracking Number: GA173-AR  
TOI: L04G Group Life - Term Sub-TOI: L04G.103 Renewable - Single Life -  
Fixed/Indeterminate Premium  
Product Name: GA173-AR  
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## Supporting Document Schedules

### Review Status:

**Satisfied -Name:** Certification/Notice

11/20/2008

**Comments:**

**Attachment:**

ArCert - Reg. 19.pdf

**STATE OF ARKANSAS  
COMPLIANCE CERTIFICATION**

COMPANY NAME: Kansas City Life Insurance

FORM TITLES: Enrollment Form for Group  
Life insurance

FORM NUMBER(S): GA173-AR

I hereby certify that to the best of my knowledge and belief, the above form and submission is in compliance with Regulation 19, as well as the other laws, rules and regulations of the State of Arkansas.

A handwritten signature in black ink, appearing to read "Jill Paul", written in a cursive style.

Assistant Vice President

Date: December 8, 2008