

<i>SERFF Tracking Number:</i>	<i>KCLF-127869004</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Kansas City Life Insurance Company</i>	<i>State Tracking Number:</i>	<i>50442</i>
<i>Company Tracking Number:</i>	<i>J160 HMS LEVEL 20</i>		
<i>TOI:</i>	<i>L04I Individual Life - Term</i>	<i>Sub-TOI:</i>	<i>L04I.103 Renewable - Single Life - Fixed/Indeterminate Premium</i>
<i>Product Name:</i>	<i>J160 HMS Level 20</i>		
<i>Project Name/Number:</i>	<i>J160 HMS Level 20/J160 HMS Level 20</i>		

Filing at a Glance

Company: Kansas City Life Insurance Company

Product Name: J160 HMS Level 20

TOI: L04I Individual Life - Term

Sub-TOI: L04I.103 Renewable - Single Life -
Fixed/Indeterminate Premium

Filing Type: Form

SERFF Tr Num: KCLF-127869004 State: Arkansas

SERFF Status: Closed-Approved-
Closed State Tr Num: 50442

Co Tr Num: J160 HMS LEVEL 20 State Status: Approved-Closed

Author: Bobby Stow

Date Submitted: 12/09/2011

Reviewer(s): Linda Bird

Disposition Date: 12/14/2011

Disposition Status: Approved-
Closed

Implementation Date Requested: On Approval

State Filing Description:

Implementation Date:

General Information

Project Name: J160 HMS Level 20

Project Number: J160 HMS Level 20

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Status of Filing in Domicile: Pending

Date Approved in Domicile:

Domicile Status Comments:

Market Type: Individual

Individual Market Type:

Filing Status Changed: 12/14/2011

State Status Changed: 12/14/2011

Created By: Bobby Stow

Corresponding Filing Tracking Number:

Deemer Date:

Submitted By: Bobby Stow

Filing Description:

With this filing, Kansas City Life Insurance Company is submitting for review and approval the enclosed schedule page J160 which provides an alternative option for issue of previously approved contract form J160, Adjustable Premium Renewable and Convertible Term Policy - Nonparticipating. The previous approval dates are on the attached cover letter on the supporting documents tab.

This schedule page will be issued with policies that have a minimum size of \$1,000,000. The contract provides a level death benefit to age 95 and level premiums during the initial term period of 20 years. The policy is annually renewable after the initial term period. Conversion privileges and requalification options are available, but no conversion credits

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 Product Name: J160 HMS Level 20
 Project Name/Number: J160 HMS Level 20/J160 HMS Level 20

apply when issuing this alternative Level 20 term option.

Company and Contact

Filing Contact Information

Bobby Stow, Compliance Analyst I bstow@kclife.com
 3520 Broadway St. 816-753-7299 [Phone] 8852 [Ext]
 Kansas City, MO 64111 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

Filing Fees

Fee Required? Yes
 Fee Amount: \$50.00
 Retaliatory? No
 Fee Explanation: One form. Filing fee \$50.00.
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Kansas City Life Insurance Company	\$50.00	12/09/2011	54400873

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Product Name: J160 HMS Level 20
Project Name/Number: J160 HMS Level 20/J160 HMS Level 20

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved- Closed	Linda Bird	12/14/2011	12/14/2011

SERFF Tracking Number: KCLF-127869004 *State:* Arkansas
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Fixed/Indeterminate Premium

Product Name: J160 HMS Level 20
Project Name/Number: J160 HMS Level 20/J160 HMS Level 20

Disposition

Disposition Date: 12/14/2011

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: KCLF-127869004 State: Arkansas
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 Product Name: J160 HMS Level 20
 Project Name/Number: J160 HMS Level 20/J160 HMS Level 20

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		Yes
Supporting Document	Life & Annuity - Acturial Memo		No
Supporting Document	Cover Letter		Yes
Supporting Document	Statement of Variability		Yes
Form	Level 20 Schedule Page Filing		Yes

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 Fixed/Indeterminate Premium
 Product Name: J160 HMS Level 20
 Project Name/Number: J160 HMS Level 20/J160 HMS Level 20

Form Schedule

Lead Form Number: J160-A

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	J160-A	Schedule Pages	Level 20 Schedule Page Filing	Initial		0.000	J160-A.pdf

Section 1: Policy Data

Beneficiary

As stated in the application or in any subsequent agreements, amendments, or endorsements.

Owner

[The Insured]

Issue Age

[35]

Sex

[Male]

Risk Classification

[Standard Non-tobacco]

Initial Term Period

20 Years

Requalification Expiration Date

[February 1, 2042]

Expiration Date

[February 1, 2072]

Final Conversion Date

[February 1, 2022]

Reserve Table

2001 Commissioners Standard Ordinary Smoker or Nonsmoker, Male or Female Select and Ultimate Mortality Table. Our calculations use continuous functions on an age nearest birthday basis.

Conversion Credit Percentage

<u>Policy Year</u>	<u>Percentage</u>
1+	0%

Policy Number

[1234567]

Insured

[John Doe]

Face Amount

[\$1,000,000]

Policy Date

[February 1, 2012]

Section 1: Policy Data (continued)

Date Prepared: [02/01/2012]

Insured
[John Doe]

Policy Number
[1234567]

<u>Form Number</u>	<u>Benefit Description</u>	<u>Amount of Insurance</u>	<u>Initial Annual Premium</u>	<u>Renewal Premiums Payable</u>
J160	Adjustable Premium Yearly Renewable and Convertible Term to 95 – 20 Year Level Premium – Nonparticipating	[\$1,000,000]	[\$1,200.00]	*To age 95
	Total Annual Premium		[\$1,200.00]	

Other Premium Option	Semi-Annually	Quarterly	Monthly	PAC
Amounts – First 20 years:	[\$612.50]	[\$312.50]	[\$108.50]	[\$102.30]

*The premiums shown above are based on our current premium scale and are guaranteed for the initial term period. Thereafter, the current renewal annual premiums for the policy may be increased or decreased according to Section 4.2, Amount and Frequency.

The premium shown above for any additional benefit provided by rider or endorsement is based on the current premium scale and guaranteed for the initial term period. Thereafter, the current renewal annual premium for any additional benefits will be changed only because the age of the Insured has changed.

This Policy Does Not Have Cash Values

Section 1: Policy Data (continued)

Date Prepared: [02/01/2012]

Insured
[John Doe]

Policy Number
[1234567]

Premium Schedule

<u>Policy Anniversary</u> <u>[February 1]</u>	<u>Age</u>	<u>Guaranteed Maximum Annual Premium</u>
[2012]	[35]	[1,200.00]
[2013]	[36]	[1,200.00]
[2014]	[37]	[1,200.00]
[2015]	[38]	[1,200.00]
[2016]	[39]	[1,200.00]
[2017]	[40]	[1,200.00]
[2018]	[41]	[1,200.00]
[2019]	[42]	[1,200.00]
[2020]	[43]	[1,200.00]
[2021]	[44]	[1,200.00]
[2022]	[45]	[1,200.00]
[2023]	[46]	[1,200.00]
[2024]	[47]	[1,200.00]
[2025]	[48]	[1,200.00]
[2026]	[49]	[1,200.00]
[2027]	[50]	[1,200.00]
[2028]	[51]	[1,200.00]
[2029]	[52]	[1,200.00]
[2030]	[53]	[1,200.00]
[2031]	[54]	[1,200.00]
[2032]	[55]	[12,920.00]
[2033]	[56]	[14,410.00]
[2034]	[57]	[16,010.00]
[2035]	[58]	[17,390.00]
[2036]	[59]	[18,970.00]
[2037]	[60]	[20,880.00]
[2038]	[61]	[23,210.00]
[2039]	[62]	[26,060.00]
[2040]	[63]	[29,250.00]
[2041]	[64]	[32,600.00]
[2042]	[65]	[36,150.00]
[2043]	[66]	[39,730.00]
[2044]	[67]	[43,370.00]
[2045]	[68]	[47,280.00]
[2046]	[69]	[51,340.00]
[2047]	[70]	[56,250.00]
[2048]	[71]	[61,750.00]
[2049]	[72]	[68,970.00]
[2050]	[73]	[76,590.00]
[2051]	[74]	[84,610.00]
[2052]	[75]	[93,370.00]
[2053]	[76]	[102,920.00]
[2054]	[77]	[114,010.00]
[2055]	[78]	[126,970.00]
[2056]	[79]	[141,930.00]

Section 1: Policy Data (continued)

Date Prepared: [02/01/2012]

Insured
[John Doe]

Policy Number
[1234567]

Premium Schedule

Policy Anniversary <u>[February 1]</u>	Age	Guaranteed Maximum Annual Premium
[2057]	[80]	[158,240.00]
[2058]	[81]	[176,810.00]
[2059]	[82]	[196,150.00]
[2060]	[83]	[217,000.00]
[2061]	[84]	[240,090.00]
[2062]	[85]	[265,880.00]
[2063]	[86]	[294,470.00]
[2064]	[87]	[325,690.00]
[2065]	[88]	[359,150.00]
[2066]	[89]	[394,450.00]
[2067]	[90]	[431,290.00]
[2068]	[91]	[465,940.00]
[2069]	[92]	[502,050.00]
[2070]	[93]	[540,150.00]
[2071]	[94]	[580,390.00]

The current renewal annual premium will never exceed the guaranteed maximum annual premium in the above table. Current renewal annual premiums are based on the premium scale in effect on the policy date and are not guaranteed. Premiums shown above include premium for any additional benefit provided by rider or endorsement. If any additional benefit provided by rider or endorsement terminates during a term period the premium will be decreased by the appropriate amount. The current annual premium for any additional benefits can be changed only on a renewal policy anniversary.

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 Project Name/Number: J160 HMS Level 20/J160 HMS Level 20

Supporting Document Schedules

Item Status: **Status Date:**

Satisfied - Item: Flesch Certification

Comments:

This is a schedule page filing.

Attachment:

CertificationReg19Reg49ACA2379138_AR.pdf

Item Status: **Status Date:**

Satisfied - Item: Application

Comments:

Attachment:

A160-AR.pdf

Item Status: **Status Date:**

Satisfied - Item: Life & Annuity - Actuarial Memo

Comments:

Actuarial Memo

Attachment:

B1000 Act Memo (2).pdf

Item Status: **Status Date:**

Satisfied - Item: Cover Letter

Comments:

Attachment:

AR_B1000.pdf

Item Status: **Status**

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Fixed/Indeterminate Premium

Product Name: J160 HMS Level 20
Project Name/Number: J160 HMS Level 20/J160 HMS Level 20

Date:

Satisfied - Item: Statement of Variability

Comments:

Attachment:

Statement of Variability - Generic.pdf

STATE OF ARKANSAS COMPLIANCE CERTIFICATION

COMPANY NAME: Kansas City Life Insurance Company

FORM TITLE(S): Schedule Pages for Level 20 Term Policy

FORM NUMBER(S): J160-A

I hereby certify that to the best of my knowledge and belief, the above form and submission is in compliance with Rule 19, Rule & Regulation 49 and ACA §23-79-138, as well as the other laws, rules and regulations of the State of Arkansas.

A handwritten signature in black ink that reads "Marc S. Bensing". The signature is written in a cursive style and is positioned above a horizontal line.

Marc Bensing
Assistant Vice President
Kansas City Life Insurance Company

Date: December 9, 2011



PERSONAL DATA

Proposed Insured Information

Full Name, Date of Birth, State of Birth, SSN, Former Full Name, Street Address, City, State, Zip, Home Phone, Work Phone, Cellular Phone, E-Mail Address, Driver's License No., State of Issue, Employer, Street Address, City, State, Zip, Occupation and Duties, Years Employed

If you have been employed at your current position less than two years, complete the following:

Former Employer, Occupation and Duties

Ownership Information

(The Insured will be the Owner unless otherwise stated.)

Primary Owner, Date of Birth, State of Birth, SSN or Tax ID, Relationship to Insured, Street Address, City, State, Zip, Successor Owner, Relationship to Insured

Applicant Information

(Complete the following information if the applicant is someone other than the Insured or the Owner.)

Applicant, Date of Birth, Relationship to Insured, Street Address, City, State, Zip

Beneficiary Information* (with right to change)

Primary Beneficiary (First and Last Name), Relationship to Insured, Contingent Beneficiary (First and Last Name), Relationship to Insured

*Unless otherwise stated, benefits are payable equally to the named beneficiaries or to the surviving beneficiaries.

Special Requests (Policy date, alternate or additional policy, existing PAC or CB number, etc.) **Home Office Endorsements**

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PLAN DATA

Life Insurance

Plan Name _____ Specified/Face Amount \$ _____ UL Coverage Option
 A B C (if available)

Planned/Annual Premium \$ _____ DEFRA Compliance Guideline Premium Test (GLP)
 Cash Value Accumulation Test (CVAT)

Special Class Premium \$ _____ Reason for Special Class Premium _____

Proposed Risk Class _____ Automatic Premium Loan Yes No

Riders/Benefits

<input type="checkbox"/> Accidental Death \$ _____ <input type="checkbox"/> Assured Insurability \$ _____ <input type="checkbox"/> Charitable Giving (Term) <input type="checkbox"/> Children's Term _____ units <input type="checkbox"/> Spouse's Term _____ units <input type="checkbox"/> Waiver of Premium (Non-UL) <input type="checkbox"/> Other _____	<p>UL Only:</p> <input type="checkbox"/> Additional Life Insurance \$ _____ <input type="checkbox"/> Cost of Living <input type="checkbox"/> Disability Payment of Premium \$ _____ <input type="checkbox"/> Extra Protection \$ _____ <input type="checkbox"/> Other Insured (complete information below)	<p>UL Only:</p> <input type="checkbox"/> Automatic Growth <input type="checkbox"/> Disability Continuance of Insurance <input type="checkbox"/> Enhanced Living Benefits <input type="checkbox"/> Living Benefits <input type="checkbox"/> Monthly Benefit \$ _____ <input type="checkbox"/> Pension Increase <input type="checkbox"/> Terminal Illness
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Other Insureds (OI)

	Marital Status	Specified Amount	
1st OI _____	<input type="checkbox"/> Non-Smoker <input type="checkbox"/> Smoker	\$ _____	<input type="checkbox"/> ADB \$ _____
2nd OI _____	<input type="checkbox"/> Non-Smoker <input type="checkbox"/> Smoker	\$ _____	<input type="checkbox"/> ADB \$ _____
3rd OI _____	<input type="checkbox"/> Non-Smoker <input type="checkbox"/> Smoker	\$ _____	<input type="checkbox"/> ADB \$ _____
4th OI _____	<input type="checkbox"/> Non-Smoker <input type="checkbox"/> Smoker	\$ _____	<input type="checkbox"/> ADB \$ _____
5th OI _____	<input type="checkbox"/> Non-Smoker <input type="checkbox"/> Smoker	\$ _____	<input type="checkbox"/> ADB \$ _____

Complete the following for all Other Insureds. If years employed is less than **two years**, specify the prior occupation in Special Requests. If any information is identical to the Primary Insured's, write **Same**.

	Social Security Number	State of Birth	Occupations and Exact Duties	Employer's Name and Address	Years Emp.
1st OI	_____	_____	_____	_____	_____
2nd OI	_____	_____	_____	_____	_____
3rd OI	_____	_____	_____	_____	_____
4th OI	_____	_____	_____	_____	_____
5th OI	_____	_____	_____	_____	_____

	Street Address, City, State, Zip	Telephone Number	Driver's License Number and State of Issue
1st OI	_____	(____) _____ <input type="checkbox"/> home <input type="checkbox"/> work	_____
2nd OI	_____	(____) _____ <input type="checkbox"/> home <input type="checkbox"/> work	_____
3rd OI	_____	(____) _____ <input type="checkbox"/> home <input type="checkbox"/> work	_____
4th OI	_____	(____) _____ <input type="checkbox"/> home <input type="checkbox"/> work	_____
5th OI	_____	(____) _____ <input type="checkbox"/> home <input type="checkbox"/> work	_____

BILLING INFORMATION

Premium Mode Ann SA Qtlly Mo * EPA GA CB FAP Single Other _____

* I request Kansas City Life to withdraw the **initial** monthly premium from my checking account to pay the premium on this policy. **(The initial draft will be drafted immediately on approval for a standard or better rate class. The Temporary Life Insurance Agreement, A133, is required.)**

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

Modal Premium Amount for _____ Branch of _____
 Other Financial Services \$ _____ 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?..... Yes No
 If **Yes**, provide name of company(ies) or amount(s) _____
- 3) Will the proposed policy be part of an Internal Revenue Code Section 1035 Exchange?..... Yes No

EVIDENCE OF INSURABILITY

Insurance History

Do any of the proposed Insureds currently have life insurance coverage? Yes No
 (If **Yes**, fill out the table below; if **No**, proceed to question 1 directly below the table.)

Proposed Insured(s)	Company	Year Issued	Insurance Amount	ADB Amount
_____	_____	_____	\$ _____	\$ _____
_____	_____	_____	\$ _____	\$ _____
_____	_____	_____	\$ _____	\$ _____
_____	_____	_____	\$ _____	\$ _____

- 1) In the **last three years**, have any of the proposed Insureds applied for life or health insurance or reinstatement thereof without receiving it exactly as requested? Yes No
- 2) Do any of the proposed Insureds have an application for life or health insurance pending at any other insurance company or intend to apply for such insurance within the next 10 days?..... Yes No

Provide details to all **Yes** answers. _____

FINANCIAL INFORMATION

Complete For Personal Insurance Sales

Purpose of insurance Family Income Protection Estate Planning College Savings Other _____
 (Check all that apply) Mortgage Protection Retirement Savings Final Expenses

Annual earned income (Include Salary, Bonus, Commissions)

Proposed Insured \$ _____ Other Insured \$ _____

Spouse \$ _____ Family net worth \$ _____
 (Total assets minus total liabilities)

Has(Have) the proposed Insured(s) ever filed for bankruptcy? Yes No

If **Yes**, please provide type (Chapter 7, 11, 13) and date closed. _____

Spouse's Occupation _____ Amount of life insurance in force on Spouse \$ _____

Complete For Business Insurance Sales

Purpose of insurance Key Person Buy/Sell Other _____
 (Check all that apply) Deferred Compensation Creditor

For the option(s) checked, how was the amount of insurance determined? _____
 (Please provide documentation)

Annual earned 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 \$ _____

Net worth 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) Do any of the family members listed on this application live outside the Primary Insured's household?..... Yes No
- 2) Are any proposed Insureds not a U.S. citizen? Yes No
 If **Yes**, how long has(have) the proposed Insured(s) been in the United States? _____
 Visa type? _____ Visa number? _____
- 3) Have any of the proposed Insureds in the last 12 months, or do any of the proposed Insureds within the next 24 months, intend to travel or reside outside the continental U.S. or Canada? If **Yes**, explain below. Yes No
- 4) In the **last three years**, has any proposed Insured:
 - a) been cited or convicted for any moving motor vehicle violations? If **Yes**, explain below. Yes No
 - b) had a driver's license suspended or revoked? If **Yes**, explain below. Yes No
 - c) flown as a pilot, co-pilot, or crew member of an aircraft? If **Yes**, complete the Aviation Questionnaire. Yes No
 - d) engaged in sky or scuba diving, hang gliding, racing or any other hazardous sport or hobby? If **Yes**, complete the Avocations Questionnaire. Yes No
- 5) Has any proposed Insured ever been convicted of a felony? If **Yes**, explain below. Yes No
- 6) For proposed Insured (a) and Other Insureds (b), is there any **family history** of diabetes, cancer, high blood pressure, heart or kidney disease, mental illness, suicide, or stroke? If **Yes**, explain below..... Yes No

Relationship	Age if Living		Family History or Cause of Death	Age at Death	
	(a)	(b)		(a)	(b)
Father					
Mother					
Brothers and Sisters					

*Provide details to all **Yes** answers. _____

JUVENILE INSURANCE (AGE 0-17)

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

HEALTH STATEMENT

Print full names of all to be insured.	Relationship to Primary Insured	Birthdate			Age	Sex	Build			*Weight Change in the Past Year	
		Month	Day	Year			Ft.	In.	Lb.	Gain	Loss
1) Primary Insured	X	X	X	X	X	X					
2)											
3)											
4)											
5)											
6)											

Questions apply to all proposed Insureds*

	YES	NO	*Provide details to all Yes answers. Identify proposed Insured(s), question, specify conditions, severity, dates, duration, after-effects, weight gain or loss, and names and addresses of all attending physicians and medical facilities.
1) Do you take prescription medicine?.....	<input type="checkbox"/>	<input type="checkbox"/>	
2) Are you currently pregnant? Due date? _____	<input type="checkbox"/>	<input type="checkbox"/>	
3) Have you ever received treatment from a physician or counselor regarding the use of alcohol, or for the use of drugs except for medicinal purposes, or received treatment or advice from an organization that assists those who have an alcohol or drug problem?.....	<input type="checkbox"/>	<input type="checkbox"/>	
4) Have you used any form of nicotine/tobacco in the last 12 months (e.g. cigar, pipe, smokeless tobacco, cigarettes, etc.)?..... If cigarettes, how many packs per day? _____	<input type="checkbox"/>	<input type="checkbox"/>	
5) Have you ever used heroin, cocaine, barbiturates, or other drugs, except as prescribed by a physician or other licensed practitioner?.....	<input type="checkbox"/>	<input type="checkbox"/>	
6) During the last five years, have you been hospitalized or had medical advice, diagnostic tests recommended, or treatment by a physician or other medical practitioner?.....	<input type="checkbox"/>	<input type="checkbox"/>	
In the last 10 years, have you been diagnosed or treated for any disease or disorder of:			
7) Brain and nervous system: Mental illness, epilepsy, seizures, stroke, paralysis?	<input type="checkbox"/>	<input type="checkbox"/>	
8) Sight or hearing?	<input type="checkbox"/>	<input type="checkbox"/>	
9) Blood: anemia or leukemia?	<input type="checkbox"/>	<input type="checkbox"/>	
10) Tumor or cancer?	<input type="checkbox"/>	<input type="checkbox"/>	
11) Heart/blood vessels: murmur, chest pain or pressure, palpitations, heart attack?	<input type="checkbox"/>	<input type="checkbox"/>	
12) Blood pressure?.....	<input type="checkbox"/>	<input type="checkbox"/>	
13) Thyroid or glandular trouble?	<input type="checkbox"/>	<input type="checkbox"/>	
14) Lungs: asthma, emphysema, tuberculosis?	<input type="checkbox"/>	<input type="checkbox"/>	
15) Digestive system: ulcer, intestines or rectum, polyps, colitis?	<input type="checkbox"/>	<input type="checkbox"/>	
16) Liver: elevated enzymes, cirrhosis, hepatitis?.....	<input type="checkbox"/>	<input type="checkbox"/>	
17) Diabetes, sugar in urine?.....	<input type="checkbox"/>	<input type="checkbox"/>	
18) Kidney, bladder or prostate: albumin, blood, or pus in urine?.....	<input type="checkbox"/>	<input type="checkbox"/>	
19) Muscles, bones, or joints (e.g. arthritis)?	<input type="checkbox"/>	<input type="checkbox"/>	
20) Breasts, uterus, or ovaries?	<input type="checkbox"/>	<input type="checkbox"/>	
21) Menstruation or pregnancy?	<input type="checkbox"/>	<input type="checkbox"/>	
Have you ever been diagnosed or treated for:			
22) A sexually transmitted disease?	<input type="checkbox"/>	<input type="checkbox"/>	
23) Acquired Immune Deficiency Syndrome (AIDS) or tested HIV positive?.....	<input type="checkbox"/>	<input type="checkbox"/>	

Names, addresses, and phone numbers of personal or family physicians. (If none, list last physician, clinic, or hospital consulted.)

<u>Date and Reason</u>	<u>Clinic or VA</u>
<u>Last Consulted</u>	<u>Claim Number</u>

Civilian Aviation Questionnaire

Name of proposed Insured _____

As a pilot or student pilot, indicate the number of hours flown in command _____ Date of last flight _____

Type of license currently held Commercial Student Private

Do you hold a valid instrument rating? Yes No

Number of hours flown in the last 12 months _____ Number of hours flown in the last 12-24 months _____ Number of flying hours contemplated in next 12 months _____

Purpose of present and future flying Pleasure Personal Business Commercial Other (specify) _____

Type and class of aircraft flown Propeller Glider Home-Built Jet Balloon Ultralite Helicopter Hang Glider

Do you expect to engage in any of the following types of flying within the next 12 months? If **Yes**, state which and number of hours.

	<u>Hours</u>		<u>Hours</u>	
<input type="checkbox"/> Scheduled Airlines	_____	<input type="checkbox"/> Pipeline Inspection	_____	
<input type="checkbox"/> Nonscheduled Airlines	_____	<input type="checkbox"/> Air Taxi or Sight Seeing	_____	
<input type="checkbox"/> Employer Owned Aircraft	_____	<input type="checkbox"/> Photography	_____	
<input type="checkbox"/> Crop Dusting	_____	<input type="checkbox"/> Mapping	_____	
<input type="checkbox"/> Water Bombing	_____	<input type="checkbox"/> Test or Inspection Flying	_____	
<input type="checkbox"/> Student Instruction	_____	<input type="checkbox"/> Aerobatics	_____	
<input type="checkbox"/> Charter Flying	_____	<input type="checkbox"/> Racing	_____	
<input type="checkbox"/> Freight or Mail Carrying	_____	<input type="checkbox"/> Any Other for Pay Flying	_____	Type _____

Have you ever:

- a) been in an aircraft accident? Yes No
 - b) been grounded? Yes No
 - c) been fined or reprimanded? Yes No
- If **Yes** to a, b, or c, explain below in Additional Details.

Do you have any operational limitations on your medical certificate? Yes No If **Yes**, explain below in Additional Details.

Do you contemplate flying in Alaska? Yes No

Do you contemplate flying outside the continental United States? Yes No If **Yes**, explain below in Additional Details.

If aviation required an extra premium or exclusion rider, which would you prefer? Extra Premium Exclusion Rider

Additional Details

Avocations Questionnaire

Name of proposed Insured _____

UNDERWATER DIVING

Frequency (Days) _____ Average Depth _____ Average Time (minutes) _____ Last 12 Months _____ 1 to 2 Years Ago _____ Estimated Next 12 Months _____

0-65 ft.
66-100 ft.
101-150 ft.
Over 150 ft.

Type Scuba
 Skin or snorkel

Purpose

Recreation Wreck/Salvage/Retrieval Commercial
 Search/Rescue Instructor Other _____

Certification (Check highest certificate attained.)

Basic Open-Water Advanced Open Water Dive Master/Instructor No Certificate

Locations

Lakes Rivers Oceans
 Quarries Pools Other _____

Do you use the "buddy system"? Yes No Do you engage in ice diving? Yes No

Do you engage in cave diving? Yes No Date of last dive _____

PARACHUTING OR SKYDIVING

Amateur Professional Association or club member Yes No
Number of years _____ Date of last jump _____ Average number of jumps per year _____
Do you compete for record attempts? Yes No Do you use experimental equipment? Yes No

AUTOMOBILE RACING

Type of vehicle used in races? _____ What is the maximum speed attained? _____ What is the average speed attained? _____

Purposes of racing Amateur Both (provide details)
 Professional

How many races did you enter in the last 12 months? _____ How many races did you enter in the last 13-24 months? _____ How many races do you contemplate in the next 12 months? _____

Championship (Indy Cars)
 Demolition
 Drag Racing (Circle those that apply: Funny Car, Top Fuel, Pro Stock, Modified Production, Modified Super Stock, Pure Stock)
 Formula Racing (Circle those that apply: Formula One, Supervee, Vee, Ford)
 Midget Car Racing
 Sports Car Racing (Circle those that apply: CanAm, TransAm, Production, A, B, C, All American GT, Showroom Stock, Vintage Sports)
 Stock Car (Circle those that apply: NASCAR Winston Cup Division, Winston Division, NASCAR Busch Grand National Division, NASCAR Modified Division, USAC Super Modified Division, Amateur, Street Stock, Hobby Division)
 Racing not covered above (provide type and details). _____

OTHER AVOCATIONS

(Please provide details in Remarks section.)

Ballooning Mountain or Rock Climbing Bungee Jumping
 Hang Gliding Motorboat or Powerboat Racing White Water Rafting
 Ultralite Flying Motorcycle Racing Other

Remarks

Military Questionnaire

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 _____

Have you or your unit been alerted 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, 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.) _____

Agreement

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 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 the applicant; and (2) the first full premium is paid in cash. The only exception to this is provided in the Temporary Life Insurance Agreement if the agreement has been issued and the advance payment required by the agreement has been made.
- 6) Any changes or additions made by the Company in "Home Office Endorsements" will be ratified by the applicant's acceptance of any life insurance policy issued on this application. However, any change in the classification, amount of insurance, issue age, plan of insurance or any benefits will not be effective unless accepted in writing by me(us).
- 7) I(We) have received the Notice of Information Practices which explains my(our) rights under the Fair Credit Reporting Act.
- 8) I(We) have paid \$_____ * to the agent in exchange for the Temporary Life Insurance Agreement 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.**

(Continued on next page)

(Continued from previous page)

Authorization for the Release of Medical Information
To obtain a copy of or to revoke this authorization, contact:
New Business Department
Kansas City Life Insurance Company
PO Box 219371
Kansas City, MO 64121-7073

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 protected health information concerning me to Kansas City Life Insurance Company or any person acting on behalf of Kansas City Life Insurance Company. "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 36 months following the date of my signature below, and a copy of this authorization is as valid as the original. 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 or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

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

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

Applicant'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)

Third Other Insured's Signature (if over age 18)

Fourth Other Insured's Signature (if over age 18)

Fifth Other Insured's Signature (if over age 18)

Statement of Agent

I certify that the statements of the Primary Insured, applicant and any other proposed Insured(s) have been correctly recorded in this application and that any premium payment shown in item 8 under Agreement on page 9 has been collected by me and that a Temporary Life Insurance Agreement has been given to the applicant.

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
Agency Code	Agency

Agent Code	Signature of Other Agent(s) (if split case)
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PAC Instructions

- 1) This form is to be used to request the establishment of a new PAC plan or change banks or accounts under an existing PAC plan. Do not use this form to add a policy to an existing PAC plan. Instead, simply provide the existing PAC plan number in the Special Requests section of the application.
- 2) **Attach a personalized sample check from the account to be used.**
- 3) The total monthly premium on all policies in a PAC plan must be at least \$10.

Request for PAC: I request Kansas City Life Insurance Company to make monthly withdrawals from my checking account to pay premiums on this policy applied for or to make monthly withdrawals from my checking account to pay premiums on the following additional pending applications. (Include name of proposed Insured(s) and policy number if available.) _____

Draft Date: I request Kansas City Life Insurance Company to draw the PAC check or debit entry on or after the _____* day of the month.
* Available draft days are the 1st through the 28th.

Account Information

Payor's Name _____

Bank Name _____ Branch Name (if any) _____

Checking Savings Account Number _____ Bank Transit Number _____

Bank's Address where Account is Maintained _____
Street City State Zip

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 Temporary Life Insurance Agreement.
- 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) Withdrawals will be made on or about the premium draft date shown above.
- 4) No premium notices or receipts will be sent. Debit entries or checks, when paid, will constitute receipts for premiums.
- 5) 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.
- 6) The Company's rights in respect to each check and/or debit entry will be the same as if I signed it personally.
- 7) 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.
- 8) 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.

Date _____ Signature of Premium Payor _____



KANSAS CITY LIFE
INSURANCE COMPANY

To obtain further information contact:
New Business Department
Kansas City Life Insurance Company
PO Box 219371
Kansas City, MO 64121-7073

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. 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 219371, Kansas City, MO 64121-7073.

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 (TTY 866-346-3642). 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.



**KANSAS CITY LIFE
INSURANCE COMPANY**

Broadway at Armour / Box 219139 / Kansas City, Missouri 64121-9139
Telephone: (816) 753-7000

December 6, 2011

Arkansas Insurance Department
1200 West Third Street
Little Rock, Arkansas 72201-1904

RE: Kansas City Life Insurance Company
NAIC: 65129-588
FEIN: 44-0308260
Informational Filing: Schedule Page for high min Level 20

Dear Sir or Madam:

With this filing, Kansas City Life Insurance Company is submitting for review and approval the enclosed schedule page J160-A which provides an alternative option for issue of previously approved contract form J160-A, Adjustable Premium Renewable and Convertible Term Policy - Nonparticipating. This contract form was approved by the Arkansas Insurance Department on March 11, 2003.

This schedule page will be issued with policies that have a minimum size of \$1,000,000. The contract provides a level death benefit to age 95 and level premiums during the initial term period of 20 years. The policy is annually renewable after the initial term period. Conversion privileges and requalification options are available, but no conversion credits apply when issuing this alternative Level 20 term option.

Please direct all inquiries regarding this filing to me at the address, phone number or email address contained in the file.

Your favorable consideration of this filing is respectfully requested.

Sincerely,

Bobby Stow

Bobby Stow
Compliance Analyst I
Kansas City Life Insurance Company
3520 Broadway
Kansas City, Missouri 64111
816.753.7299, ext. 8852
Fax: 816.753.3018
bstow@kclife.com

Statement of Variability for J160

Any use of variability shall be administered in a uniform and non-discriminatory manner and shall not result in unfair discrimination.

1. Insured: the Insured's name
2. Policy Number: a seven-digit number unique to each policy issued
3. Face Amount: The amount payable upon the death of the Insured.
4. Owner: the Owner's name
5. Issue Age: the Insured's age at issue
ages 20-65
6. Sex: the Owner's sex (Male/Female)
7. Risk Classification:
 - Preferred Elite Non-Tobacco (PENT)
 - Preferred Non-Tobacco (PNT)
 - Standard Select Non-Tobacco (SSNT)
 - Standard Non-Tobacco (SNT)
 - Preferred Tobacco (PT)
 - Standard Tobacco (ST)
8. Requalification Expiration Date: The date the Insured is no longer able to requalify for coverage. The Insured may requalify after the 10th policy year, but before age 65.
9. Expiration Date: The date the policy expires, the policy is renewable to age 95.
10. Final Conversion Date: is the earlier of the policy anniversary nearest the Insured's 65th birthday or the 10th policy anniversary
11. Policy Date: the date the policy was issued
12. Amount of Insurance: equal to the face amount
13. Initial Annual Premium: the annual premium during the first 20 years of the policy
14. Other Premium Option Amounts: the schedule of premium payment options
15. Date Prepared: the date the policy was prepared
16. Policy Anniversary: the date of the policy's anniversary corresponding to the Premium Schedule table
17. Age: age of the Insured corresponding to the Premium Schedule table
18. Guaranteed Maximum Annual Premium: The maximum premium charged corresponding to the year and age listed in the Premium Schedule table.