KANSAS CITY LIFE

GROUP BENEFITS

Group Number _____

Policyholder _____

Health Statement

Kansas City Life Insurance Company
3520 Broadway
Kansas City, Missouri 64111

A separate form must be completed for each proposed Insured.

Please complete this form in its entirety. Incomplete forms will delay processing. No coverage for which evidence of insurability is required will be effective until the first day of the month following the date your health statement is approved.

Print Full Name of Proposed Insured	Name of Primary Insured	Relationship to Primary Insured
Date of Birth (Month/Day/Year) / /	Age	Sex ☐ Male ☐ Female
Occupation	Phone Number*	Email Address*

**Required in the event questions arise from responses on the health statement.*

Build	Feet	Inches	Pounds	**Weight change in the past year**	Gain	Loss

Details are required for all questions answered as 'Yes'. Please complete the chart on page 2 to address any 'Yes' responses.

1.	During the **last 5 years**, has the proposed Insured been hospitalized, been given medical advice, had diagnostic tests recommended, or had treatment by a physician or other medical practitioner?	☐ Yes ☐ No
2.	Has the proposed Insured used any nicotine products in the **last 12 months**?	☐ Yes ☐ No
3.	During the **last 10 years**, has the proposed Insured been diagnosed with or been treated (including medication), hospitalized, or given advice by any member of the medical profession for any of the following:	
A.	cancer, including cancer of the bone marrow, leukemia, lymphoma, or melanoma, but excluding localized non-melanoma skin cancer?	☐ Yes ☐ No
B.	coronary artery disease, heart attack, coronary artery bypass surgery, angioplasty, stent placement, valvular heart disease with repair or replacement, cardiomyopathy, congestive heart failure, congenital heart disease, pacemaker/implantable cardioverter defibrillator, abnormal heart rhythm, or aortic or thoracic aneurysm?	☐ Yes ☐ No
C.	hypertension? A blood pressure reading in the last 12 months exceeding 149 systolic or 94 diastolic (149/94)? If yes, most recent reading was: _____	☐ Yes ☐ No
D.	organ transplant or recommendation for or placement on a transplant list (excluding cornea)?	☐ Yes ☐ No
E.	chronic liver disease, including cirrhosis, chronic hepatitis C, chronic hepatitis B, or carrier state?	☐ Yes ☐ No
F.	chronic lung disease (except mild asthma), including chronic obstructive pulmonary disease (COPD), chronic bronchitis, emphysema, sarcoidosis, or cystic fibrosis?	☐ Yes ☐ No
G.	chronic kidney disease, including end-stage renal disease with dialysis?	☐ Yes ☐ No
H.	stroke, including transient ischemic attack (TIA), or cerebral aneurysm?	☐ Yes ☐ No
I.	any disorder of the endocrine system, including thyroid disorder, diabetes (except during a pregnancy), and complications such as retinopathy (eye), nephropathy (kidney), neuropathy (nerve), peripheral vascular disease (PVD or PAD)?	☐ Yes ☐ No
J.	Acquired Immunodeficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV)?	☐ Yes ☐ No
K.	any disorder of the immune system, including systemic lupus, scleroderma, rheumatoid arthritis, Crohn's disease or ulcerative colitis, or stomach, digestive, or bladder condition/disease?	☐ Yes ☐ No
L.	a chronic or progressive eye or ear disorder (excluding correctable, age-related vision or hearing changes)?	☐ Yes ☐ No
M.	any condition that causes blood clots or abnormal bleeding?	☐ Yes ☐ No
N.	a sexually transmitted disease (STD)?	☐ Yes ☐ No
O.	psychosis, bipolar depression, schizophrenia, anxiety, mood disorder, post-traumatic stress disorder (PTSD), obsessive-compulsive disorder (OCD), anorexia nervosa, or stress adjustment disorder?	☐ Yes ☐ No
P.	Alzheimer's disease, dementia, Parkinson's disease, sickle cell anemia, Lou Gehrig's Disease (ALS), muscular dystrophy, demyelinating disease including multiple sclerosis, Huntington's disease, hydrocephalus, quadriplegia, paraplegia, Down's syndrome, autism, mental incapacity, or any disease of the central nervous system?	☐ Yes ☐ No
Q.	any disorder of the musculoskeletal system, including bone, joint, muscle, back, or spine?	☐ Yes ☐ No
R.	Epilepsy (grand mal, petite mal, focal/partial), seizures, or paralysis? If yes, date of last event was: ____/____/____	☐ Yes ☐ No

4. Does the proposed Insured currently take prescription medication? If yes, please indicate the medication, the frequency, the dosage, and the diagnosis for use. _____ _____	☐ Yes ☐ No
5. Is the proposed Insured currently pregnant? If yes, due date: ____/____/____	☐ Yes ☐ No
6. In the **last 2 years**, has the proposed Insured:	
A. had an abnormal test, including blood test, urinalysis, pap smear, mammogram, x-ray, MRI, CT scan, ultrasound, cardiac stress test, including echocardiogram, not normalized or for which a medical diagnosis has not yet been made?	☐ Yes ☐ No
B. had any cyst, growth, lump, or any mole or freckle that has bled, become painful, changed color, or increased in size that has not been medically diagnosed as benign?	☐ Yes ☐ No
C. had new onset of chest pain, shortness of breath, persistent dizziness, unexplained weight loss, or abnormal fatigue that has not been evaluated by a medical doctor?	☐ Yes ☐ No
D. been advised to have or have scheduled a consultation, surgery, or test which has not been completed, or which has been completed and results are pending?	☐ Yes ☐ No
7. In the **last 5 years**, has the proposed Insured taken non-prescription drugs or illicit substances such as marijuana, heroin, cocaine, amphetamines, barbiturates, hallucinogenic agents, or opium or its derivatives?	☐ Yes ☐ No
8. In the **last 5 years**, has the proposed Insured received medical treatment or counseling for or been advised by a physician to discontinue the use of alcohol or prescribed or non-prescribed drugs?	☐ Yes ☐ No
9. In the **last 5 years**, has the proposed Insured been convicted of driving under the influence of drugs or alcohol, been convicted of reckless driving, or been convicted of three or more moving violations?	☐ Yes ☐ No

If any preceding question(s) were answered 'YES', please provide details in the chart below.

Question Number	Doctor/Hospital Name and Address	Condition, Injury, Test, or Operation	Duration of Symptoms, Treatment, and Degree of Recovery	Dates of Onset and Recovery

AUTHORIZATION FOR MIB, LLC

I authorize MIB, LLC 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, LLC.

A photographic copy of this authorization shall be as valid as the original.

_____

Proposed Insured's Signature (if under age 18, parent/guardian signature)

AGREEMENTS

By signing below, I acknowledge that the following are understood and agreed:

1. I represent that, to the best of my knowledge and belief, the statements and answers given on all pages of this application are true, complete, and correctly recorded.
2. No information regarding any proposed Insured will be considered known by the Company unless explicitly set out in writing in this application.
3. This application and the answers to any required medical exam will become a part of any insurance 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. I have received the Notice of Information Practices which explains my rights under the Fair Credit Reporting Act.

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
P.O. Box 219428
Kansas City, MO 64121-9428

This authorization applies to all persons whose signatures appear below. The proposed Insured 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"); insurers; reinsurers; government agencies; consumer reporting agencies; health information exchanges; 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. "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; 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"); insurers; reinsurers; government agencies; consumer reporting agencies; health information exchanges; 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. 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.

I have read and understand the above Agreements and Authorization. I understand that failure to disclose a proposed Insured person's true health condition may void the coverage. I understand that no person to be insured is also covered by any Title XIX program (Medicaid or any similar name). (Not applicable to residents of AZ, MO, NC, OR, or SC.)

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) (Day) (Month) (Year)

_____
Proposed Insured's Signature (if under age 18, parent/guardian signature)

EMPLOYER SECTION:

Reason for Submitting Health Statement:

☐ Late Applicant ☐ Adding Coverage ☐ Other _____

☐ Late Dependent ☐ Increasing Coverage _____

Coverage Type and Amount Applying For:

☐ Life $_____ ☐ WDI $_____

☐ Supplemental Life $_____ ☐ LTD $_____

☐ Dependent Life: Spouse _____ Child _____

_____ _____ _____

Information Provided By Phone Number Date

HOME OFFICE USE ONLY:

Basic Max._____ EOI _____

Supp. Max _____ EOI _____

Combined Max. _____ EOI _____

WDI Max. _____

LTD Max. _____

Notes: _____

_____

_____

Amount to be Approved Basic _____

Supp. _____

Total _____

Underwriting Action:

Approved ☐

Declined ☐

Withdrawn ☐

UND. | Decision Date

Notes:

_____

_____

_____

_____

_____

_____

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

NOTICE OF INFORMATION PRACTICES

Including Fair Credit Reporting Act Notice and MIB, LLC 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, P.O. Box 219428, Kansas City, MO 64121-9428.

MIB, LLC 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 MIB, LLC, 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 or go to its website at www.mib.com to request disclosure online. 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.