KANSAS CITY LIFE

GROUP BENEFITS

KANSAS CITY LIFE INSURANCE COMPANY BENEFICIARY FORM

Kansas City Life Group Benefits
P.O. Box 219425
Kansas City, MO 64121-9425
Phone: 877-266-6767, ext. 8302
Fax: 816-753-2964
Email: *afi@kclife.com*
www.kclgroupbenefits.com

Employee (Insured's) name	Social Security number
Employer name	Policy number

To Kansas City Life Insurance Company, Kansas City, MO. It is hereby requested that the beneficiary under the policy numbered as above be changed to primary: *(Include full name, relationship to the insured, address, Social Security number and date of birth for each beneficiary)*

Contingent: *(Include full name, relationship to the insured, address, Social Security number and date of birth for each beneficiary)*

SIGNATURE

This change will apply to any product in force under the above numbered Group Policy or Policies. The provisions listed below are accepted. Unless specified otherwise, I request that the death proceeds of the above policy(ies) be paid equally to all surviving Beneficiaries.

If two or more primary Beneficiaries are named, the proceeds payable at death will be paid equally to the named Beneficiaries surviving the Insured unless unequal distribution percentages have been made. When unequal distribution percentages are listed, a contingent Beneficiary must be provided for each primary Beneficiary named. (Example of unequal distributions are 60/40 or 50/25/25 or 60/20/20 etc.

Death proceeds will be paid as though the Beneficiary died before the Insured Individual if: the Beneficiary dies at the same time as or within 15 days of the Insured Individual's death and the Company has not paid the proceeds to the Beneficiary within the 15-day period.

If no Beneficiary survives, payment will be made according to the terms of the policy. This designation revokes any and all previous designations. The right to change the Beneficiary is reserved to the Insured.

The amendment will be made when this notice is received and is effective the date it was signed.
Please sign, date and return this form immediately to your HR department.

X _____ Signature

X _____ Date signed (MM/DD/YYYY)

X _____ Witness signature

BELOW THIS LINE FOR HOME OFFICE USE ONLY

Above Change of Beneficiary is recorded as part of the policy file this _____ day of _____, 20_____.

Authorized Kansas City Life representative