KANSAS CITY LIFE INSURANCE COMPANY

Application for Life Insurance

PERSONAL DATA

Proposed Insured Information

Full Name _____ ☐ Male ☐ Female Date of Birth ____/____/____
First Middle Last Month Day Year

State of Birth _____ SSN _____ ☐ Married ☐ Civil Union ☐ Divorced ☐ Single ☐ Separated ☐ Widowed

Former Full Name _____
First Middle Last

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 _____ ☐ Male ☐ Female Date of Birth ____/____/____
First Middle Last Month Day Year

State of Birth _____ SSN or Tax ID _____ Relationship to Insured _____

Street Address _____ City _____ State _____ Zip _____

Successor Owner _____ Relationship to Insured _____

(If there are multiple Successor Owners, show order and distribution in Special Requests.)

Applicant Information

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

Applicant _____ ☐ Male ☐ Female Relationship to Insured _____
First Middle Last

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**

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

☐ Accidental Death $ _____
☐ Assured Insurability $ _____
☐ Charitable Giving (Term)
☐ Children's Term _____ units
☐ Spouse's Term _____ units
☐ Waiver of Premium (Non-UL)
☐ Other _____

UL Only:
☐ Additional Life Insurance $ _____
☐ Cost of Living
☐ Disability Payment of Premium $_____
☐ Extra Protection $ _____
☐ Other Insured (complete information below)

UL Only:
☐ Automatic Growth
☐ Disability Continuance of Insurance
☐ Enhanced Living Benefits
☐ Living Benefits
☐ Monthly Benefit $_____
☐ Pension Increase
☐ Terminal Illness

Other Insureds (OI)

	Full Name (First, Middle, Last)		Marital/Civil Union Status	Specified Amount	
1st OI	_____	☐ Non-Smoker ☐ Smoker	_____	$_____	☐ ADB $_____
2nd OI	_____	☐ Non-Smoker ☐ Smoker	_____	$_____	☐ ADB $_____
3rd OI	_____	☐ Non-Smoker ☐ Smoker	_____	$_____	☐ ADB $_____
4th OI	_____	☐ Non-Smoker ☐ Smoker	_____	$_____	☐ ADB $_____
5th OI	_____	☐ Non-Smoker ☐ Smoker	_____	$_____	☐ 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	_____	(____) _____ ☐home ☐work	_____
2nd OI	_____	(____) _____ ☐home ☐work	_____
3rd OI	_____	(____) _____ ☐home ☐work	_____
4th OI	_____	(____) _____ ☐home ☐work	_____
5th OI	_____	(____) _____ ☐home ☐work	_____

BILLING INFORMATION

Premium Mode ☐ Ann ☐ SA ☐ Qtly ☐ 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 Other Financial Services $_____

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

Annual earned income (Include Salary, Bonus, Commissions)

☐ Proposed Insured $_____ ☐ Other Insured $_____

☐ Spouse or Civil Union Partner $_____ ☐ 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 (or Civil Union Partner's) Occupation _____

Amount of life insurance in force on Spouse (or Civil Union Partner) $_____

Complete For Business Insurance Sales

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

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 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) participated in parachute jumping, skydiving, rock climbing, scuba diving, hang gliding, rodeo events, auto/motorboat/motorcycle racing, any professional sport, or mountain climbing? (If **Yes**, complete the Avocation 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 (a)	(b)	Family History or Cause of Death	Age at Death (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
1) Do you take prescription medicine?		
2) Are you currently pregnant? Due date? _____		
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?		
4) Have you used any form of nicotine/tobacco in the last 12 months? If cigarettes, how many packs per day? _____		
5) Have you ever used heroin, cocaine, barbiturates, or other drugs, except as prescribed by a physician or other licensed practitioner?		
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?		
In the last 10 years, have you been diagnosed or treated by a member of the medical profession for any disease or disorder of:		
7) Brain and nervous system: Mental illness, epilepsy, seizures, stroke, paralysis?		
8) Sight or hearing?		
9) Blood: anemia or leukemia?		
10) Tumor or cancer?		
11) Heart/blood vessels: murmur, chest pain or pressure, palpitations, heart attack?		
12) Blood pressure?		
13) Thyroid or glandular trouble?		
14) Lungs: asthma, emphysema, tuberculosis?		
15) Digestive system: ulcer, intestines or rectum, polyps, colitis?		
16) Liver: elevated enzymes, cirrhosis, hepatitis?		
17) Diabetes, sugar in urine?		
18) Kidney, bladder or prostate: albumin, blood, or pus in urine?		
19) Muscles, bones, or joints (e.g. arthritis)?		
20) Breasts, uterus, or ovaries?		
21) Menstruation or pregnancy?		
Have you ever been diagnosed or treated by a member of the medical profession for:		
22) A sexually transmitted disease?		
23) Acquired Immune Deficiency Syndrome (AIDS) or AIDS-Related Complex (ARC)?		

*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.

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

Date and Reason Last Consulted

Clinic or VA Claim Number

Agreement

It is understood and agreed as follows:

1) To the best of my(our) knowledge and belief, 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)

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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 219428
Kansas City, MO 64121-9428

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. I authorize Kansas City Life Insurance Company, or its reinsurers, to make a brief report of my personal health information to MIB. "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 includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

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 or Civil Union Partner's Signature (if spouse or civil union partner 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)**

KANSAS CITY LIFE INSURANCE COMPANY

Pre-Authorized Check Plan (PAC)

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

Temporary Life Insurance Agreement (TIA)

Please read this agreement carefully. The information it contains is important to you. The maximum amount of coverage under this and all other agreements will not be more that $500,000 for any person to be insured. The maximum period of coverage under this agreement is 60 days.

Advance payment in the amount of $_____ * is made for life insurance on _____
Name of Proposed Insured

_____
Name of other Proposed Insureds (Spouse and Dependents)

***All premium checks must be make payable to Kansas City Life Insurance Company. Do not make check payable to the agent or leave the payee blank.**

TIA Health Questions

Has(have) the person(s) listed above as Proposed Insured(s):

1. within the **past 90 days**, been admitted to a hospital or other medical facility, been advised to be admitted, or had surgery performed or recommended? ..... ☐ Yes ☐ No
2. within the **past 2 years**, been treated for heart trouble, stroke, or cancer, or had such treatment recommended by a physician or other medical practitioner? ..... ☐ Yes ☐ No

If either of the above questions is answered **Yes** or **left blank** with respect to the Primary Insured, no agent of Kansas City Life Insurance Company is authorized to accept money and **no insurance** will take effect under the TIA. If either of the above questions is answered **Yes** with respect to any other Proposed Insured(s), no insurance will take effect under the TIA for that(those) individual(s).
Name(s) of individual(s) to which any **Yes** answer applies and who **do(does) not** qualify for temporary insurance:_____

Conditions For Temporary Insurance

Kansas City Life Insurance Company will provide limited temporary life insurance under the terms of this agreement if the money specified in this agreement has been paid to the agent in exchange for this agreement. Coverage will begin on the date of this agreement on those individuals proposed for insurance in the application, except for any person who answers **Yes** to any of the above TIA health questions.

Total Benefit Limitations

If the above conditions have been satisfied and any Proposed Insured dies while this temporary insurance is in effect, the Company will pay to the designated beneficiary who would have received payment under the policy applied for, the **LESSER** of (1) the amount of death benefits applied for on that Proposed Insured in the Plan Data Section of the application **INCLUDING** any accidental or supplemental death benefits; **LESS** any existing insurance with the Company that is being reissued, exchanged or converted in connection with this application or (2) $500,000. This total benefit limit applies to all insurance applied for under: (1) this and any other current applications to the Company and; (2) any other Temporary Insurance Agreements.

Date Insurance Terminates

Temporary life insurance terminates automatically on the earliest of the following dates:

1. 60 days from the date of this agreement;
2. the date coverage starts under the policy applied for;
3. the date a policy, other than as applied for, is accepted or rejected by the applicant; or
4. the date the Company mails notice of termination of insurance to the applicant.

Special Limitations

It is understood and agreed as follows:

1. No one is authorized to accept money on Proposed Insureds under 15 days of the age or over age 70 (last birthday) on the date of this agreement, nor will any insurance take effect.
2. Fraud or material misrepresentations in the application invalidate this agreement and the Company's only liability is for refund of any payment made.
3. If any Proposed Insured dies by suicide**, the Company's liability under this agreement is limited to a refund of any payment made.
4. No insurance will take effect under this agreement if the check or draft submitted as payment is not honored by the bank
5. No one but the President, Vice President, Secretary or Assistant Secretary of Kansas City Life may change or waive the terms of this agreement.
6. If the application is declined or withdrawn, the Company will immediately refund the advance payment shown above. In no event will insurance under this agreement and under the policy issued on the application be effective at the same time.
   **(In Missouri, the Company must prove intent.)

Agreement and Signatures

I(We) have received and read this agreement and declare that the answers to the TIA Health Questions are true and complete. I(We) understand and agree to all its terms.

Dated at _____ this _____ day of _____, _____

_____
Agent's Signature

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

_____
Applicant's Signature (if other than Primary Insured)

NOTICE: The Applicant should retain the copy of this agreement; the original will be retained by the Company. If you do not hear from the Company regarding the insurance applied for within 70 days from the date of this agreement, notify the Company at P.O. Box 219428, Kansas City, Missouri 64121-9428, Attention: New Business Department.

A133

KANSAS CITY LIFE INSURANCE COMPANY

Supplemental Information for Life Insurance and Annuities

This form must be submitted with any application for life insurance or annuity.

Applicant(s): Do you have any existing annuity contracts or life insurance policies? ____yes ____no

(If "yes", complete and sign *Important Notice: Replacement of Life Insurance or Annuities* below.)

(If "no", applicant and producer must sign and date below)

Important Notice: Replacement of Life Insurance or Annuities

This document must be signed by the applicant and the producer, if there is one, and a copy left with the applicant.

- You are contemplating the purchase of a life insurance policy or annuity contract. In some cases this purchase may involve discontinuing or changing an existing policy or contract. If so, a replacement is occurring. Financed purchases are also considered replacements.
- A replacement occurs when a new policy or contract is purchased and, in connection with the sale, you discontinue making premium payments on the existing policy or contract, or an existing policy or contract is surrendered, forfeited, assigned to the replacing insurer, or otherwise terminated or used in a financed purchase.
- A financed purchase occurs when the purchase of a new life insurance policy or an annuity contract involves the use of funds obtained by the withdrawal or surrender of or by borrowing some or all of the policy values, including accumulated dividends, of an existing policy to pay all or part of any premium or payment due on the new policy. A financed purchase is a replacement.
- You should carefully consider whether a replacement is in your best interest. You will pay acquisition costs and there may be surrender costs deducted from your policy or contract. You may be able to make changes to your existing policy or contract to meet your insurance needs at less cost. A financed purchase will reduce the value of your existing policy and may reduce the amount paid upon the death of the insured.
- We want you to understand the effects of replacements before you make your purchase decision and ask that you answer the following questions and consider the questions on the back of this form.

1. Are you considering discontinuing making premium payments, surrendering, forfeiting, assigning to the insurer, or otherwise terminating your existing policy or contract? _____ YES _____ NO
2. Are you considering using funds from your existing policies or contracts to pay premiums due on the new policy or contract? _____ YES _____NO

If you answered "yes" to either of the above questions, list each existing policy or contract you are contemplating replacing (include the name of the insurer, the insured or annuitant, and the policy or contract number if available) and whether each policy or contract will be replaced or used as a source of financing:

Insurer Name	***Contract or Policy #***	***Insured or Annuitant***	***Replaced (R) or Financing(F)***
1._____	_____	_____	_____
2._____	_____	_____	_____

Make sure you know the facts. Contact your existing company or its agent for information about the old policy or contract. (If you request one, an in-force illustration, policy summary or available disclosure documents must be sent to you by the existing insurer.) Ask for and retain all sales material used by the agent in the sales presentation. Be sure that you are making an informed decision.

The existing policy or contract is being replaced because (*Please describe in detail)*_____

_____

_____

I certify that the responses herein are, to the best of my knowledge, accurate:

_____

(Applicant's Signature) (Printed Name) (Date)

_____

(Producer's Signature) (Printed Name) (Date)

I do not want this notice read aloud to me._____*(Applicants must initial only if they do not want the notice read aloud.)*

I certify that I have used only company-approved sales materials and that all copies of all sales materials were left with the applicant._____*(Producer's initials)*

(Continued on Reverse Side)

A replacement may not be in your best interest, or your decision could be a good one. You should make a careful comparison of the costs and benefits of your existing policy or contract and the proposed policy or contract. One way to do this is to ask the company or agent that sold you your existing policy or contract to provide you with information concerning your existing policy or contract. This may include an illustration of how your existing policy or contract is working now and how it would perform in the future based on certain assumptions. Illustrations should not, however, be used as a sole basis to compare policies or contracts. You should discuss the following with your agent to determine whether replacement or financing your purchase makes sense:

PREMIUMS:

- Are they affordable?
- Could they change?
- You're older – are premiums higher for the proposed new policy?
- How long will you have to pay premiums on the new policy? On the old policy?

POLICY VALUES:

- New policies usually take longer to build cash values and to pay dividends.
- Acquisition costs for the old policy may have been paid; you will incur costs for the new one.
- What surrender charges do the policies have?
- What expense and sales charges will you pay on the new policy?
- Does the new policy provide more insurance coverage?

INSURABILITY:

- If your health has changed since you bought your old policy, the new one could cost you more, or you could be turned down.
- You may need a medical exam for a new policy.
- Claims on most new policies for up to the first two years can be denied based on inaccurate statements.
- Suicide limitations may begin anew on the new coverage.

IF YOU ARE KEEPING THE OLD POLICY AS WELL AS THE NEW POLICY:

- How are premiums for both policies being paid?
- How will the premiums on your existing policy be affected?
- Will a loan be deducted from death benefits?
- What values from the old policy are being used to pay premiums?

IF YOU ARE SURRENDERING AN ANNUITY OR INTEREST SENSITIVE LIFE PRODUCT:

- Will you pay surrender charges on your old contract?
- What are the interest rate guarantees for the new contract?
- Have you compared the contract charges or other policy expenses?

OTHER ISSUES TO CONSIDER FOR ALL TRANSACTIONS:

- What are the tax consequences of buying the new policy?
- Is this a tax-free exchange? (See your tax advisor.)
- Is there a benefit from favorable "grandfathered" treatment of the old policy under the federal tax code?
- Will the existing insurer be willing to modify the old policy?
- How does the quality and financial stability of the new company compare with your existing company?