

## 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

## **GROUP BENEFITS**

Employee (Insured's) name	Social Security number
Employer name	Policy number
	t is hereby requested that the beneficiary under the policy numbered as above insured, address, Social Security number and date of birth for each beneficiary)
Contingent: (Include full name, relationship to the insured, add	dress, Social Security number and date of birth for each beneficiary)
	SIGNATURE
	e numbered Group Policy or Policies. The provisions listed below are accepted. f the above policy(ies) be paid equally to all surviving Beneficiaries.
Insured unless unequal distribution percentages have been made	payable at death will be paid equally to the named Beneficiaries surviving the de. When unequal distribution percentages are listed, a contingent Beneficiary ple of unequal distributions are 60/40 or 50/25/25 or 60/20/20 etc.
	fore the Insured Individual if: the Beneficiary dies at the same time as or within as not paid the proceeds to the Beneficiary within the 15-day period.
If no Beneficiary survives, payment will be made according to designations. The right to change the Beneficiary is reserved to	the terms of the policy. This designation revokes any and all previous the Insured.
The amendment will be made when this notice is received and Please sign, date and return this form immediately to your in	e e e e e e e e e e e e e e e e e e e
XSignature	X Date signed (MM/DD/YYYY)
X Witness signature	_
BELOW THIS	S 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	

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