

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

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Employee (Insured's) name	Social Security number				
Employer name	Policy number				
	is hereby requested that the beneficiary under the policy numbered as above usured, address, Social Security number and date of birth for each beneficiary)				
Contingent: (Include full name, relationship to the insured, addre					
	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.					
Insured unless unequal distribution percentages have been made	hyable at death will be paid equally to the named Beneficiaries surviving the e. When unequal distribution percentages are listed, a contingent Beneficiary e of unequal distributions are 60/40 or 50/25/25 or 60/20/20 etc.				
	re the Insured Individual if: the Beneficiary dies at the same time as or within not paid the proceeds to the Beneficiary within the 15-day period.				
If no Beneficiary survives, payment will be made according to the designations. The right to change the Beneficiary is reserved to the	ne terms of the policy. This designation revokes any and all previous the Insured.				
The amendment will be made when this notice is received and is <i>Please sign, date and return this form immediately to your Hi</i>	e e e e e e e e e e e e e e e e e e e				
XSignature	Date signed (MM/DD/YYYY)				
X Witness signature	_				
BELOW THIS I	LINE FOR HOME OFFICE USE ONLY				
Above Change of Beneficiary is recorded as part of the policy fi	ile this day of, 20				
Authorized Kansas City Life representative					

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