KANSAS CITY LIFE
GROUP BENEFITS

Kansas City Life Insurance Company
PO Box 219425
Kansas City, MO 64121-9425

VERIFICATION OF DEPENDENT ELIGIBILITY

DATE (MM/DD/YY) _____

EMPLOYER NAME | GROUP POLICY NO.

EMPLOYEE NAME (First, Middle Initial, Last)

SOCIAL SECURITY NO.

DEPENDENT(S) _____ Date of Birth _____
_____ Date of Birth _____
_____ Date of Birth _____
_____ Date of Birth _____

Please complete and sign the following questionnaire to verify coverage under the terms of your policy.

I certify that the dependent(s) listed above is/are (check one):

(1) My natural or adopted child/ren
(2) My step-child/ren
(3) My grandchild/ren*
(4) My foster child/ren
(5) Other* (please explain)

If you checked number 2, 3, 4 or 5 above, please complete numbers 6-10 below.

(6) The listed dependent lives with me in a parent-child relationship ☐ Yes ☐ No
(7) Date permanent residence began (MM/DD/YY) _____
(8) I provide more than half of the listed dependent's support ☐ Yes ☐ No
(9) The child is claimed as a tax exemption on my annual IRS tax report ☐ Yes ☐ No
(10) I or my spouse have legal custody ordered by a court of competent jurisdiction ☐ Yes ☐ No

Return this form and documentation within five working days to avoid delays in claim processing.

SIGNATURE

SIGNATURE_____ DATE SIGNED (MMDD/YYYY) _____

*Legal documentation is required for dependents as indicated.

AFTER YOU HAVE COMPLETED THIS FORM MAIL TO:

KCL Group Administration

P O Box 219425 Kansas City, MO 64121-9425

Telephone: (816) 753-7299 Ext. 8302

Toll Free: 1-877-266-6767