

# KANSAS CITY LIFE INSURANCE COMPANY

## Restricted Life Insurance Beneficiary Designation Form

Policy Number: \_\_\_\_\_ Owner: \_\_\_\_\_

**Primary Beneficiary:** \_\_\_\_\_ SSN/TIN: \_\_\_\_\_

Relationship: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

Street City State Zip

Percentage of Benefit: \_\_\_\_\_ Restricted: Yes or No (circle one)

Please pay \_\_\_\_\_% or \$\_\_\_\_\_ immediately with the balance paid as stated below.

Please remove the restriction on \_\_\_\_\_% of the beneficiary's remaining portion at the later of age \_\_\_\_\_ or \_\_\_\_\_ years following the Insured's death.

### Annuitization

Specified Period of \_\_\_\_\_ years (minimum of 3 years). Proceeds will be paid in equal installments.

Specified Amount of \$\_\_\_\_\_ until balance is fully paid.

Life with \_\_\_\_\_ year period certain.\*

Pay proceeds monthly, quarterly, semi-annually, annually (Please circle one)

**Beneficiary #2** (Primary or Contingent) \_\_\_\_\_ SSN/TIN: \_\_\_\_\_

Relationship: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

Street City State ZIP

Percentage of Benefit: \_\_\_\_\_ Restricted: Yes or No (circle one)

Please pay \_\_\_\_\_% or \$\_\_\_\_\_ immediately with the balance paid as stated below.

Please remove the restriction on \_\_\_\_\_% of the beneficiary's remaining portion at the later of age \_\_\_\_\_ or \_\_\_\_\_ years following the Insured's death.

### Annuitization

Specified Period of \_\_\_\_\_ years (minimum of 3 years). Proceeds will be paid in equal installments.

Specified Amount of \$\_\_\_\_\_ until balance is fully paid.

Life with \_\_\_\_\_ year period certain.\*

Pay proceeds monthly, quarterly, semi-annually, annually (Please circle one)

**Beneficiary #3** (Primary or Contingent) \_\_\_\_\_ SSN/TIN: \_\_\_\_\_

Relationship: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

Street City State ZIP

Percentage of Benefit: \_\_\_\_\_ Restricted: Yes or No (circle one)

Please pay \_\_\_\_\_% or \$\_\_\_\_\_ immediately with the balance paid as stated below.

Please remove the restriction on \_\_\_\_\_% of the beneficiary's remaining portion at the later of age \_\_\_\_\_ or \_\_\_\_\_ years following the Insured's death.

### Annuitization

Specified Period of \_\_\_\_\_ years (minimum of 3 years). Proceeds will be paid in equal installments.

Specified Amount of \$\_\_\_\_\_ until balance is fully paid.

Life with \_\_\_\_\_ year period certain.\*

Pay proceeds monthly, quarterly, semi-annually, annually (Please circle one)

Once distributions commence payments may not be modified or commuted. Please make additional copies of this form if necessary. Payments must be at least \$50. Should a payment schedule result in a distribution of less than \$50 the payment schedule will be modified. Ex. \$25 monthly will be changed to \$75 quarterly. The only exception would be for an annual payment.

\_\_\_\_\_  
(Owner's signature) Date \_\_\_\_\_

\_\_\_\_\_  
(Witness's signature) Date \_\_\_\_\_

=====HOME OFFICE USE ONLY=====

The above change of beneficiary is recorded as part of the policy file this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_. A letter of notification will be sent to the policyowner at the address of record upon completion of the change.

AUTHORIZED KANSAS CITY LIFE REPRESENTATIVE \_\_\_\_\_