



Contact Information

Mail completed form to:

Regular Mail: PO Box 219361, Kansas City, MO 64121-9361

Overnight Mail: 430 W 7th Street, Suite 219361, Kansas City, MO 64105-1407

Fax completed form to:

Traditional Life: (816) 502-4920

Variable Life: (816) 221-7036

Annuity: (816) 221-9674

Phone:

Traditional Life: (800) 628-1936

Variable Life or Annuity: (800) 541-0171

Section 1 - Required Fields

- Policy/Contract Number(s)
- Insured/Annuitant Name(s)
- Identification Code - will confirm identity of the Authorized Party
- Nature of Information
- Signature(s) of Owner(s)
- Signing Date

Section 2 - Required Fields

Signature requirements are based on the owner designation of the policy/contract. Examples are:

- **Individual Owner:** Print and sign your full name as it appears on the policy/contract.
- **Multiple Owners:** All owners must sign.
- **Partnership:** All partners must sign (unless Form OL4363 authorizing one partner to sign is on file with us).
- **Corporation:** Titled officer must sign. The company name and officer's title must also be indicated.

NOTE: In general, the insured/annuitant should not sign as officer. We ask that an additional titled officer sign if the signing officer is effecting a change for his or her personal benefit.

- **Trust:** The current trustee(s) must sign. The name and full date of the trust must also be indicated.

All forms must be dated in order to process your request.



Section 1 - Release Information

Regarding the following policy/contract number(s), I authorize the Company to release the non-medical information specified below to the individual or company. This is not an authorization to conduct policy/contract transactions on my behalf.

Table with 2 columns: Policy / Contract Number(s), Insured / Annuitant Name(s)

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Information may be provided by the Customer Care Center to the following individual or company:

Table with 2 columns: Name of Authorized Party, REQUIRED - Passcode (We will use this code to confirm the identity of the authorized party)

The above named is an [] Advisor, [] Insurance Institution or [] Insurance Service Organization.

The nature of the information to be disclosed is as follows: (If nothing checked, the section will default to Account Values.)

- [] ALL Non-medical Information
OR one or more of the following specific types of non-medical information
[] Title/Registration - owner/beneficiary designation, collateral assignment
[] Billing - premium amount/frequency, type of billing
[] Account Values - cash value, taxable gain, death benefit
[] Illustrations - projected values based on hypothetical scenarios

Section 2 - Signature(s)

This authorization is valid for three (3) years from the date signed. This authorization may be revoked at any time upon written request from the owner. This form revokes any prior authority given to this authorized party.

Owner

If the OWNER is an INDIVIDUAL, complete the following.

Table for individual owner signatures with columns: Name, Signature, Witness Signature, State Signed In, Date

Non-Individual Owner

If the OWNER is a NON-INDIVIDUAL, complete the following.

Form for non-individual owner signatures including fields for Full Name of Trust, Entity, Corporation or Other; Date of Trust; Signing in the capacity as; and signature table.