

Office of Management and Enterprise Services Employees Group Insurance Division Life Insurance Application

	Life Insuran	ice Application	n	
COORDINATOR MUST CO		_		
PLEASE NOTE: All	information including entity/	agency name ar	nd address must be com	pleted.
Coordinator's Signature		Date	() Fntity/Ac	jency Phone Number
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Entity/Agency Name		Grou	p #	Division #
Entitu/Agangu Mailing Address			C:4.	ZIP Code
Entity/Agency Mailing Address			City	ZIP Code
Please Check Employee's Status:	New Hire/Hire DateRehire/Rehire Date		☐ Option Period ☐ Midyear Change (S	See Next Line)
Reason for Midyear Change:				,
NEW HIRE'S ANNUAL SALARY	3	(SAI	ARY MUST BE COMPL	ETED FOR NEW HIRES)
ANNUAL SALARY Info	rmation Must Be Included fo	or New Hires (Life	e Summary Sheet May B	se Attached)
SECTION 1. EMPLO	YEE INFORMATION O	NLY PLEAS	SE PRINT NEATLY	AND CLEARLY
				☐ Male ☐ Female
Member ID or SSN (NOT Employee ID)	Date of Birth	Email Addr	ess	I Maic I chiaic
Last Name	First Nam	е		Middle Initial
Mailing Address (New Address?	Yes No)	City	State	ZIP Code
• • •	,	·		
SECTION 2. EMPLOYE				_
DO NOT TURN IN THIS FORM IF EITH the Guaranteed Issue amount of Supple				
(2) You terminated and are being rehired				
NEW HIRE/REHIRE		OPTIO	N PERIOD/MIDYEAR CO	
COMPLETE THIS : Amounts should be listed in		Amou	COMPLETE THIS S nts should be listed in	SECTION oven \$20,000 units
DO NOT LIST prem	-	Amou	DO NOT LIST prem	•
BASIC LIFE (Basic Life is \$20,000)	\$ 20,000.00	BASIC LIFE	IN EFFECT	\$
GUARANTEED ISSUE (2 x annual salary at time of employment)	\$	SUPPLEME	NTAL LIFE IN EFFECT	\$
SUPPLEMENTAL LIFE (maximum available, including your guaranteed issue, is \$500,000)	\$		OR SUPPLEMENTAL REQUESTED	\$
TOTAL COVERAGE DESIRED	\$	TOTAL CO	VERAGE DESIRED	\$
SECTION 3.	AUTHORIZATION (RE	EAD BEFORE	SIGNING THIS FO	RM).
It is understood and agreed that all state life insurance requested by me is issued. agree EGID may request that I submit further understood and agreed that failur for retroactive termination of coverage. dependent life coverage will also be term Life coverage.	I authorize EGID to request a to an examination by a physici re to provide complete and acre of member coverage is retrospinated. The member must be a term of the member and the member must be a term of the member and the member must be a term of the member and	this form are true a any additional infor ian selected by E curate information actively terminated enrolled in Basic I	and complete, and they are mation from any source as GID, at my expense, if EG might affect my insurability and dependents are enlife coverage in order for definitions.	the basis on which the ground may be deemed necessary. BID deems it necessary. It yes and may constitute ground molled with life coverage, the
EMPLOYEE SIG	GNATURE		DATE	SIGNED
FOR HCM	IU REVIEW ONLY	DO NOT WRI	TE IN THIS SECTION	
APPROVED REVIEWER:			DATE	

DENIED

REVIEWER:

Page 1 Revised 8/12/2014

DATE

LIFE INSURANCE APPLICATION -- PAGE 2 -- MEDICAL INFORMATION. PLEASE PRINT CLEARLY.

This form must be completed by the member who is requesting Employee Life coverage. If you need to list additional information you feel is pertinent to the consideration of this application, please use a separate sheet of paper. Both pages of this form must be returned to: EGID, HCMU, P O BOX 57830, Oklahoma City, OK 73157-7830. Fax # 1-405-717-8997

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MEMBER ID or SSN		AGE	9	SEX	WEIGHT	HEIGHT					
MEMBER'S NAM	1E					М	F		Feet	Inches	
Tobacco Use?	Yes	Nο	Packs/Cigars per Day	Alco	hol Use?	Yes	Nο	Cans/Drinks p	er week		

Please CIRCLE all conditions below that you have received any type of treatment for. On the line in front of the condition, list the

LAST VEAR in which you received treatment	Treatment includes but is not limited to office visit, surgery, lab, and medication	

Acromegaly, Gigantism	Year Heminlegia /	Paraplegia / Quadriplegia	List any conditions or surgeries you have had that are not alread
Adrenal Disorder		rarapiegia / Quadripiegia	given on this form. Include the last year you were treated for th
	Hemophilia	Languiria O	condition/surgery.
Alcohol Abuse	Hepatitis B /	Hepatitis C	4
Alzheimer's		ressure / High Cholesterol	
Amputation (Disease Related)	HIV / AIDS /		
Amyotrophic Lateral Sclerosis (ALS)	Hodgkin's Dis		
Anemia	Hydrocephalu		
Aneurysm	Kidney Disea		
Arthritis - Rheumatoid	Leukemia / L		
Asthma	Liver Disease)	
Bipolar Disorder	Lupus		
Blood Disease / Disorder	Discoid		
Cancer (Other than skin)	Systemi	С	
Cardiac Defibrillator Implantable	Malaria		
Cardiomyopathy	Melanoma Ca		
Cerebral Palsy	Must	Provide Path Report	
Chronic Fatigue Syndrome	Meningitis		
Circulatory Disease / Disorder	Mental Disea	se / Disorder	
Claudication (Leg pain when walking)	Mental Retar	dation	
Closed Head Injury	Multiple Myel	oma	
Coma	Multiple Scle	rosis	
within 5 years	Muscular Dys		1
Congenital Deformity	Myasthenia C		
Congestive Heart Failure		Within 5 years	1
COPD / Emphysema		Greater than 5 years	
Crohn's Disease	Myositis	,	1
Cystic Fibrosis		ar Disease / Disorder	
CVA - TIA (stroke)	Organic Brain		1
Dementia / Senility	Osteogenesis		
Depression Depression	Osteomyelitis		1
Diabetes	Pancreatitis		List any modications you take an a regular besite. Institute the
Type 1 - Insulin Dependent		Within 3 years	List any medications you take on a regular basis. Include the streng
Type 2 - Non-Insulin Dependent		Greater than 3 years	of the medication and frequency. Example: Lipitor 20mg once/daily
Must provide A1C results w/in 6	Parkinson's [·	1
Drug Abuse	Peritonitis	7100400	1
Eating Disorder		d Dysfunction / Tumor	
Embolism		Within 3 years	1
Encephalitis		Greater than 3 years	
Epilepsy / Convulsion / Seizures	Plasmacytom	·	-
Factor V Leidens Disorder			
Fibromyalgia	Polycythemia	Within 3 years	1
		•	
Fistula		Greater than 3 years	4
Gastrectomy / Gastric Resection	Prostate Disc		
Gastric Bypass / Stapling	Pulmonary H		4
Within 5 years	Pulmonary E		
Greater than 5 years	Pyelonephriti		
Glioma - Tumor		/ Insufficiency	
Glomerulonephritis / Nephritis	Rheumatic Fo	ever	4
Guillain - Barre	Sarcoidosis		
Within 3 years	Schizophreni	a	1
Greater than 3 years	Sepsis		
Head Injury	Sickle Cell A	nemia	4
Heart Disease / Disorder	Sleep Apnea		
Angioplasty	Spina Bifida		1
Arrhythmia	Syncope		
Cardiomyopathy	Syphilis		
Chest Pain / Angina	Transplants		
Congenital Heart Disease	Bone	Marrow	
Coronary Artery Bypass	Hear		<u>1</u>
Within 5 years	Kidne		
Greater than 5 years	Liver	•	1
Coronary Artery Disease	Lung		
Within 5 years	Panc		1
Greater than 5 years	Tuberculosis		
		Malignant	1
Myocardial Infarction / Heart Attack	Tumor - Non	•	
Within 5 years		Provide Path Report	1
Greater than 5 years	Ulcerative Co	olitis	
Myocarditis	Uremia		
Valve Replacement	Vascular Dise	ease	
			1
Valvular Heart Disease		ahina IIn Blood	
Valvular Heart Disease		ghing Up Blood	4
Valvular Heart Disease Within 5 years Greater than 5 years		ghing Up Blood anulomatosis / syndrome	