



Employees Group Insurance Division

Life Insurance Application

OPTION PERIOD/MIDYEAR COVERAGE CHANGE

COORDINATOR MUST COMPLETE THIS SECTION BEFORE IT IS RETURNED TO EGID FOR PROCESSING <i>Please Note: All information including entity/agency name and address must be completed.</i>		
Coordinator's Signature _____	Date _____	Entity/Agency Phone Number _____
Entity/Agency Name _____	Group # _____	Division # _____
Entity/Agency Mailing Address _____	City, State _____	ZIP Code _____
Please Check Employee's Status: <input type="checkbox"/> Option Period <input type="checkbox"/> Midyear Change (See Next Line) Reason for Midyear Change: _____		

SECTION 1. EMPLOYEE INFORMATION ONLY -- PLEASE PRINT NEATLY AND CLEARLY

Member ID or SSN (NOT Employee ID) _____	Date of Birth _____	Email Address _____	<input type="checkbox"/> Male	<input type="checkbox"/> Female
Last Name _____	First Name _____	Middle Initial _____		
Mailing Address (New Address? <input type="checkbox"/> Yes <input type="checkbox"/> No) _____	City _____	State _____	ZIP Code _____	

SECTION 2. EMPLOYEE COVERAGE BEING REQUESTED (IN EVEN \$20,000 UNITS ONLY)

DO NOT TURN IN THIS FORM IF EITHER OF THESE TWO ITEMS PERTAINS TO YOU: (1) You are a new hire and want only Basic Life and the Guaranteed Issue amount of Supplemental Life Insurance (Guaranteed Issue equals 2 times your annual salary at time of employment) or (2) You terminated and are being rehired within 24 months and want only the same amount of life insurance you had when you left.

OPTION PERIOD/MIDYEAR COVERAGE CHANGE COMPLETE THIS SECTION	
Amounts should be listed in even \$20,000 units. DO NOT LIST premium cost.	
BASIC LIFE IN EFFECT	\$ _____
SUPPLEMENTAL LIFE IN EFFECT	\$ _____
BASIC AND/OR SUPPLEMENTAL LIFE BEING REQUESTED	\$ _____
TOTAL COVERAGE DESIRED (Click in the amount to the right and Hit F9 to reveal total →)	\$ _____

SECTION 3. AUTHORIZATION (READ BEFORE SIGNING THIS FORM).

It is understood and agreed that all statements and answers given on this form are true and complete, and they are the basis on which the group life insurance requested by me is issued. I authorize EGID to request any additional information from any source as may be deemed necessary. I agree EGID may request that I submit to an examination by a physician selected by EGID, at my expense, if EGID deems it necessary. It is further understood and agreed that failure to provide complete and accurate information might affect my insurability and may constitute grounds for retroactive termination of coverage. If member coverage is retroactively terminated and dependents are enrolled with life coverage, the dependent life coverage will also be terminated. The member must be enrolled in Basic Life coverage in order for dependents to have Dependent Life coverage. *** SEE PAGE 2 FOR MEDICAL INFORMATION ***

I give my permission to receive notification by email.

EMPLOYEE SIGNATURE _____	DATE SIGNED _____
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FOR HCMU REVIEW ONLY ----- DO NOT WRITE IN THIS SECTION

APPROVED	<input type="checkbox"/>	REVIEWER: _____	DATE _____
DENIED	<input type="checkbox"/>	REVIEWER: _____	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 or fax to 405-717-8997.

MEMBER ID or SSN		AGE	SEX	WEIGHT	HEIGHT
Member's name			M F		Feet Inches
Nicotine Use? Yes No Amount per day		Alcohol Use? Yes No		Amount per day	
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 YEAR in which you received treatment. Treatment includes but is not limited to office visit, surgery, lab and medication.					
Year	Year			List any conditions or surgeries you have had that are not already given on this form. Include the last year you were treated for the condition/surgery.	
	Acromegaly, Gigantism		Hemiplegia / Paraplegia / Quadriplegia		
	Adrenal Disorder		Hemophilia		
	Alcohol Abuse		Hepatitis B / Hepatitis C		
	Alzheimer's		High Blood Pressure / High Cholesterol		
	Amputation (Disease Related)		HIV / AIDS / ARC		
	Amyotrophic Lateral Sclerosis (ALS)		Hodgkin's Disease		
	Anemia		Hydrocephalus		
	Aneurysm		Kidney Disease / Disorder		
	Arthritis - Rheumatoid		Leukemia / Lymphoma		
	Asthma		Liver Disease		
	Bipolar Disorder		Lupus		
	Blood Disease / Disorder		Discoid		
	Cancer (Other than skin)		Systemic		
	Cardiac Defibrillator Implantable		Malaria		
	Cardiomyopathy		Melanoma Cancer		
	Cerebral Palsy		Must Provide Path Report		
	Chronic Fatigue Syndrome		Meningitis		
	Circulatory Disease / Disorder		Mental Disease / Disorder		
	Claudication (Leg pain when walking)		Mental Retardation		
	Closed Head Injury		Multiple Myeloma		
	Coma		Multiple Sclerosis		
	within 5 years		Muscular Dystrophy		
	Congenital Deformity		Myasthenia Gravis		
	Congestive Heart Failure		Within 5 years		
	COPD / Emphysema		Greater than 5 years		
	Crohn's Disease		Myositis		
	Cystic Fibrosis		Neuromuscular Disease / Disorder		
	CVA - TIA (stroke)		Organic Brain Syndrome		
	Dementia / Senility		Osteogenesis Imperfecta		
	Depression		Osteomyelitis		
	Diabetes		Pancreatitis		List any medications you take on a regular basis. Include the strength of the medication and frequency. Example: Lipitor 20mg once/daily.
	Type 1 - Insulin Dependent		Within 3 years		
	Type 2 - Non-Insulin Dependent		Greater than 3 years		
	Must provide A1C results w/in 6 months		Parkinson's Disease		
	Drug Abuse		Peritonitis		
	Eating Disorder		Pituitary Gland Dysfunction / Tumor		
	Embolism		Within 3 years		
	Encephalitis		Greater than 3 years		
	Epilepsy / Convulsion / Seizures		Plasmacytoma		
	Factor V Leidens Disorder		Polycythemia		
	Fibromyalgia		Within 3 years		
	Fistula		Greater than 3 years		
	Gastrectomy / Gastric Resection		Prostate Disorder		
	Gastric Bypass/Stapling/Lapband		Pulmonary Hypertension		
	Within 5 years		Pulmonary Edema		
	Greater than 5 years		Pyelonephritis		
	Glioma - Tumor		Renal Failure / Insufficiency		
	Glomerulonephritis / Nephritis		Rheumatic Fever		
	Guillain - Barre		Sarcoidosis		
	Within 3 years		Schizophrenia		
	Greater than 3 years		Sepsis		
	Head Injury		Sickle Cell Anemia		
	Heart Disease / Disorder		Sleep Apnea		
	Angioplasty		Spina Bifida		
	Arrhythmia		Syncope		
	Cardiomyopathy		Syphilis		
	Chest Pain / Angina		Transplants		
	Congenital Heart Disease		Bone Marrow		
	Coronary Artery Bypass		Heart		
	Within 5 years		Kidney		
	Greater than 5 years		Liver		
	Coronary Artery Disease		Lung		
	Within 5 years		Pancreas		
	Greater than 5 years		Tuberculosis		
	Myocardial Infarction / Heart Attack		Tumor - Non Magignant		
	Within 5 years		Must Provide Path Report		
	Greater than 5 years		Ulcerative Colitis		
	Myocarditis		Uremia		
	Valve Replacement		Vascular Disease		
	Valvular Heart Disease		Vomiting/Coughing Up Blood		
	Within 5 years		Wegner's Granulomatosis / syndrome		
	Greater than 5 years				
	Other Cardiac Surgery				
	includes pacemaker or defibrillator				