OKLAHOMA
Office of Management
& Enterprise Services

Employees Group Insurance Division
**Life Insurance Application**
**OPTION PERIOD/MIDYEAR COVERAGE**

**COORDINATOR MUST COMPLETE THIS SECTION BEFORE IT IS RETURNED TO EGID FOR PROCESSING**

***Please note:*** *All information including entity/agency name and address must be completed.*

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: ☐New hire/hire date _____ ☐Option Period
☐Rehire/rehire date _____ ☐Midyear change (answer 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 | ☐Male ☐Female

Last name | First name | MI

Mailing address (New address? ☐Yes ☐ 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 | $ | 0.00 |
| SUPPLEMENTAL LIFE IN EFFECT | $ | 0.00 |
| BASIC AND/OR SUPPLEMENTAL LIFE BEING REQUESTED | $ | 0.00 |
| **TOTAL COVERAGE DESIRED (Click in the amount to the right and hit F9 to reveal total →)** | $ | 0.00 |

## 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 for dependents to have Dependent Life coverage.

*** Refer to Page 2 for medical information ***

☐ ***I give my permission to receive notification by email.***

Employee signature | Date

**FOR HCMU REVIEW ONLY – DO NOT WRITE IN THIS SECTION**

**Approved** ☐ Reviewer: Date:

**Denied** ☐ Reviewer: Date:

**LIFE INSURANCE APPLICATION – PAGE 2 – MEDICAL INFORMATION. PLEASE PRINT CLEARLY.**

This form must be completed by the member requesting Employee Life coverage. If you need to list additional information pertinent to the consideration of this application, please use a separate sheet of paper. Both pages of this form must be returned to: EGID, Submit by FAX 405-717-8997.

| **MEMBER ID or SSN** | **AGE** | **SEX** | **WEIGHT** | **HEIGHT** |
|---|---|---|---|---|
| **MEMBER'S NAME** | | ☐ **M** ☐ **F** | | _____Feet ____Inches |

**Tobacco use?** ☐ Yes ☐ No ____Packs/Cigars per Day **Alcohol use?** ☐ Yes ☐ No _____Cans/Drinks per 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 YEAR** in which you received treatment. Treatment includes but is not limited to office visit, surgery, lab and medication.

| Year | | Year | |
|---|---|---|---|
| | Acromegaly, Gigantism | | Hemophilia |
| | Adrenal Disorder | | Hepatitis B / Hepatitis C |
| | Alzheimer's | | High Blood Pressure |
| | 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 |
| | Circulatory Disease / Disorder | | Meningitis |
| | Claudication (Leg pain when walking) | | Mental Disease / Disorder |
| | Closed Head Injury | | Intellectual Disability |
| | Coma | | Multiple Myeloma |
| | Within 5 years | | Multiple Sclerosis |
| | Congenital Deformity | | Muscular Dystrophy |
| | Congestive Heart Failure | | Myasthenia Gravis |
| | COPD / Emphysema | | Within 5 years |
| | Covid-19 (Long) | | 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 |
| | Type 1 Insulin Dependent | | Within 3 years |
| | Type 2 – Non-Insulin Dependent | | Greater than 3 years |
| | Must provide recent A1c results | | Parkinson's Disease |
| | Eating Disorder | | Peritonitis |
| | Embolism | | Pituitary Gland Dysfunction / Tumor |
| | Encephalitis | | Within 3 years |
| | Epilepsy / Convulsion / Seizure | | Greater than 3 years |
| | Factor V Leiden's Disorder | | Plasmacytoma |
| | Fistula | | Polycythemia |
| | Gastrectomy / Gastric resection / Gastric bypass | | Within 3 years |
| | Stapling / lap band / Sleeve | | Greater than 3 years |
| | Within 2 years | | Prostate Cancer |
| | Greater than 3 years | | Pulmonary Hypertension |
| | Glioma – Tumor | | Pulmonary Edema (Chronic) |
| | Glomerulonephritis / Nephritis | | Pyelonephritis |
| | Guillain Barre' | | Renal Failure / Insufficiency |
| | Within 3 years | | Rheumatic Fever |
| | Greater than 3 years | | Sarcoidosis |
| | Head Injury | | Schizophrenia |
| | Heart Disease / Disorder | | Sepsis |
| | Angioplasty | | Sickle Cell Anemia |
| | Arrhythmia | | Sleep Apnea |
| | Cardiomyopathy | | Spina Bifida |
| | Chest Pain / Angina | | Substance Use Disorder (Alcohol, Drug, Other) |
| | Congenital Heart Disease | | Syncope |
| | Coronary Artery Bypass | | Syphilis |
| | Within 5 years | | **T**ransplants |
| | Greater than 5 years | | Bone Marrow |
| | Coronary Artery Disease | | Heart |
| | Within 5 years | | Kidney |
| | Greater than 5 years | | Liver |
| | Myocardial Infarction / Heart Attack | | Lung |
| | Within 5 years | | Pancreas |
| | Greater than 5 years | | Tumor – Non-Malignant |
| | Myocarditis | | Must Provide Path Report |
| | Valve Replacement | | Ulcerative Colitis |
| | Valvular Heart Disease | | Uremia |
| | Within 5 years | | Vascular Disease |
| | Greater than 5 years | | Vomiting/Coughing Up Blood |
| | Other Cardiac Surgery | | Wegner's Granulomatosis / syndrome |
| | Hemiplegia / Paraplegia / Quadriplegia | | |
| | | | |

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.

List any medications you take regularly. Include the strength of the medication and frequency.
Example: Lipitor 20mg once/daily