Employees Group Insurance Division

Application for Life Premium Waiver

Waiver of premium for all life coverage available to the active member and dependents is based upon proof of total disability. Premium waiver can be requested at any time after the person has been disabled for 30 consecutive days and, if approved, will become effective the first of the month following approval of this application. The accompanying Attending Physician's Statement must also be completed and received by the EGID before a waiver is effective. **SIGN THE ATTACHED AUTHORIZATION BEFORE SUBMITTING THE FORM TO YOUR PHYSICIAN.**

PART A – CLAIMANT'S STATEMENT OF DISABILITY

1. Employee name________________________________ SSN/Member ID ______________________________

   Home address ____

   Home phone ________________________________ Date of birth ______________________________

2. Duties ____

3. Date of injury/sickness ____

4. Name and address of treating physician ____

   ____

5. Were you admitted to a hospital as a result of this disability? ☐Yes ☐No

   If so, list dates. From____________________________To ______________________________

   Hospital name ____

   Hospital address ____

6. Last date at work ______________________________Date you could resume work __________________

Claimant's signature______________________________Date ______________________________

PART B – EMPLOYER'S STATEMENT

Occupation ____

Was the above person an employee at the time disability began? ☐Yes ☐No

Last date employee was at work ____

Has the employee returned to work? ☐Yes ☐No If so, on what date ______________________________

Name (please print) ____Official position __________________

Signature ____Date __________________________

Name of entity ____Phone __________________________

Physicians – Please return completed form to:
Employees Group Insurance Division
Attn: Health Care Management Unit
2401 N. Lincoln Blvd., Ste. 300
Oklahoma City, OK 73105

PART C – ATTENDING PHYSICIAN'S STATEMENT

Diagnosis and Concurrent Conditions (list medication) ______________________________

____

____

____

Briefly explain how patient's disability prevents this employee from working ______________________________

____

Date symptoms first appeared or accident happened ______________________________

Date patient first consulted you for this condition ______________________________

Is the patient still under your care for this condition? ☐Yes ☐No

Patient was continuously totally disabled (unable to work) From ______________ To ______________

If still disabled, date patient should be able to return to work______________________________

I declare under penalty of perjury that I have examined this physician's report and the statements contained herein to the best of my knowledge and belief is true, correct and complete.

Physician's name (please print)	Degree	Phone number

Physician's signature	Date

Street address	City	State	ZIP code

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