



**EMPLOYEE INFORMATION**

SSN or Member ID \_\_\_\_\_

Employee name \_\_\_\_\_  
(print)                                      First                                      MI                                      Last

Mailing address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP code \_\_\_\_\_

Email \_\_\_\_\_

Home phone \_\_\_\_\_ Mobile \_\_\_\_\_ Work \_\_\_\_\_

**DEPENDENT INFORMATION**

Dependent name \_\_\_\_\_  
(print)                                      First                                      MI                                      Last

Date of birth \_\_\_\_\_ SSN \_\_\_\_\_

Relationship     Son     Daughter     Other \_\_\_\_\_

Dependent resides     In home with member     In a nursing home     In separate housing

Other (explain) \_\_\_\_\_

Is this child unmarried and primarily supported by you?                       Yes                       No

Please check each that applies for the coverage you want:

Health     Dental     Vision    Dependent Life:  Premier Option     Standard Option     Low Option

**AUTHORIZATION (Please read before signing.)**

I authorize release of any and all information necessary to complete the review to determine if the above dependent is eligible to enroll or continue on my insurance through OMES Employees Group Insurance Division. I understand that any fee charged for this information is my responsibility as the member requesting coverage and is not eligible for payment, reimbursement or consideration by EGID. It is further understood and agreed that failure to provide complete and accurate information might affect my dependent's insurability and may constitute grounds for retroactive termination of coverage.

Member signature \_\_\_\_\_ | \_\_\_\_\_ Date \_\_\_\_\_

Dependent signature (if capable) \_\_\_\_\_ Date \_\_\_\_\_

**Note:** First-time applicants must attach a copy of your most recent income tax return reflecting support of the dependent. If you are requesting extended coverage for currently covered dependents, you must submit this form at least 30 days prior to the dependent's 26th birthday.



**ATTENDING PHYSICIAN MUST COMPLETE THIS SECTION**

The information you provide about the limitations and abilities of this patient will determine if coverage is approved, denied or continued under the member's policy. Please complete this section by checking all appropriate boxes. Provide additional information on an attached sheet.

**Note:** Documentation must confirm the disability occurred before the patient reached age 26.

Condition is  Mental  Physical Condition began \_\_\_\_\_

Diagnosis \_\_\_\_\_ ICD code(s) \_\_\_\_\_

**Note:** Diagnosis and current ICD codes must be completed in order for the assessment to be reviewed.

1. Mobility  Full  Partial  Total  
 Specify \_\_\_\_\_  
(Bedridden, wheelchair, etc.)

2. Paralysis  None  Partial  Total  
 Specify \_\_\_\_\_  
(Bedridden, wheelchair, etc.)

3. Mental  Irrational  Confused  Impulsive  Hallucinating  Delusional  
 Aggressive  Fearful  Withdrawn  Suicidal  Homicidal  
 Others – List \_\_\_\_\_

4. Medical  Seizures  Tremors  Epilepsy  Frailty  Swelling  
 Labored breathing  Cardiovascular disease  Respiratory disease  
 Others – List \_\_\_\_\_

5. Prognosis  Excellent  Good  Poor  Terminal

6. List any special needs of patient \_\_\_\_\_  
\_\_\_\_\_

7. Check the box that best applies to patient:  
 Patient is unable to live independently and is not capable of self-support.  
Provide details \_\_\_\_\_  
\_\_\_\_\_

Patient is able to live independently with monitoring and is capable of self-support.

Signature of attending physician \_\_\_\_\_ Date \_\_\_\_\_

**Return completed form to:**  
Employees Group Insurance Division  
Health Care Management Unit  
P.O. Box 11137  
Oklahoma City, Oklahoma 73136-9998