Employees Group Insurance Division | **Life Insurance Application** | **New Hire/Rehire Employee**

COORDINATOR MUST COMPLETE THIS SECTION IN ITS ENTIRETY BEFORE EGID WILL PROCESS.

Coordinator's signature | Date | Entity/Agency phone number

Entity/Agency name | Group # | Division #

Entity/Agency mailing address | City, State | ZIP code

Check employee's status ☐New Hire/Hire date _____ ☐Rehire/Rehire date _____

NEW HIRE'S ANNUAL SALARY $_____

ANNUAL SALARY — Information **must** be included for new hires. Life summary sheet may be attached.

SECTION 1. EMPLOYEE INFORMATION ONLY – PLEASE PRINT CLEAR

Member ID or SSN (Not employee ID) | Date of birth | Email address | ☐Male ☐Female

Last name | First name | Middle initial

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.

NEW HIRE/REHIRE EMPLOYEE COMPLETE THIS SECTION	
Amounts should be listed in even $20,000 units. DO NOT LIST premium cost.	
Basic Life (Basic Life is $20,000)	$
Guaranteed Issue (2 X annual salary at time of employment)	$
Supplemental Life (maximum available, including your guaranteed issue, is $500,000)	$
TOTAL COVERAGE DESIRED (Click in the amount to the right and hit F9 to update/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.

*** Refer to page 2 for Medical Information ***

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

Employee signature | Date signed

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 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		
	Acromegaly, Gigantism		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.
	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 Maglignant	
	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 defibillator			