

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 thirty (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 Oklahoma State and Education Employees Group Insurance Board before a waiver is effective. **BE SURE THAT YOU HAVE SIGNED 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, what 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:
Oklahoma State and Education Employees Group Insurance Board
Health Care Management Division
3545 NW 58th, Ste. 110, Oklahoma City, OK 73112

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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.

(Please Print) Physician's Name Degree Phone Number

Physician's Signature Date

Street Address City State Zip Code

Physicians – Please return completed form to:

Oklahoma State and Education Employees Group Insurance Board
Health Care Management Division
3545 NW 58th, Ste. 110, Oklahoma City, OK 73112

Instructions for Authorization to Disclose Health Information

Please follow the instructions below when completing the Authorization form on the back of this page.

1. Enter the primary member's name, date of birth, and social security number.
2. If the authorization is for a dependent(s), enter the dependent's name(s).
3. Enter the name of the member, legal representative, spouse or dependent giving authorization to release information.
4. Enter the name of the provider or plan being given authorization to release the information. (Example: HealthChoice)
5. Enter the name, address, telephone number, and fax number (if applicable) of the person or entity receiving the information.
6. Enter the purpose for which the information is to be used. (Example: assists in making decisions)
7. Enter the specific information that is to be released. (Example: any and all information in regard to my coverage and claims with HealthChoice)
8. Enter the date, event, or condition that the authorization is to expire. (Example: upon termination of enrollment in HealthChoice)
9. Member, legal representative, spouse or dependent age 18 or over must sign and date the authorization form.

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

1. Primary Member Name: _____ Date of Birth: _____ SSN/Member ID# _____

2. Dependents: _____

3. I _____ hereby authorize
(Member, Legal Representative, Spouse or Dependent age 18 or over)

4. _____
(Name of Provider/Plan/or entity providing records)

to disclose specific health information from the file records of the above named member and/or dependents if applicable to:

5. _____
(Recipient Name/Address/Phone/Fax)

for the specific purpose(s):

6. _____

Specific information to be disclosed:

7. _____

I understand that this authorization will expire on the following date, event or condition:

8. _____

I also understand that I may revoke this authorization at any time and that I will be asked to sign the *Revocation Form*. I further understand that any action taken on this authorization prior to the rescinded date is legal and binding and that if this Authorization is used for OSEEGIB that no charge is paid to OSEEGIB for this Authorization.

I understand that my information may not be protected from re-disclosure by the requester of the information; however, if this information is protected by the Federal or State Substance Abuse Confidentiality Regulations, the recipient may not re-disclose such information without my further written authorization unless otherwise provided for by state or federal law. I understand the information authorized for release may include records which may indicate the presence of a communicable or venereal disease which may include, but are not limited to, diseases such as hepatitis, syphilis, gonorrhea and the human immunodeficiency virus, also known as Acquired Immune Deficiency Syndrome (AIDS).

I also understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment for services, or my eligibility for benefits; however, if a service is requested by a non-treatment provider (e.g., insurance company) for the sole purpose of creating health information (e.g., physical exam), service may be denied if authorization is not given. If treatment is research-related, treatment may be denied if authorization is not given.

By signing this form, I understand and agree that I am responsible for any fee charged for copies of the medical information or records by the providing entity, and OSEEGIB is not responsible for payment of any fee charged for copies of medical records, report or any other documentation.

I further understand that I may request a copy of this signed authorization.

Return to OSEEGIB, 3545 NW 58th, Suite 100, Oklahoma City, Oklahoma 73112

9. _____ Date _____

(Signature of Member, Legal Representative, Spouse or Dependent age 18 or over)