

# 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 Employees Group Insurance Division 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:**  
Employees Group Insurance Division  
Health Care Management Division  
3545 NW 58, 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 EGID that no charge is paid to EGID 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 EGID 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 EGID, 3545 NW 58<sup>th</sup>, Suite 100, Oklahoma City, Oklahoma 73112

9. \_\_\_\_\_ Date \_\_\_\_\_

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