Office of Management and Enterprise Services

Employees Group Insurance Division

Life Insurance Claim Form

An original or certified copy of the Death Certificate must accompany this form.

Member Name:
Member ID/SSN:
Full Name of Deceased:
Date of Death:
Immediate Cause of Death:
Death Resulted From: ☐ Natural Causes ☐ Suicide* ☐ Homicide* ☐ Accident* *If death was caused as a result of suicide, homicide, or accident, a copy of the official police report must be submitted before claim payment can be made.

To Whom It May Concern:

Upon the request of the Office of Management and Enterprise Services Employees (OMES) Group Insurance Division (EGID), please furnish to EGID or its representative all information you may have and a copy of your records concerning the treatment and history of and prescription for the above-named subject. You may honor a photocopy of this authorization.

I (we) the undersigned beneficiary(ies) understand that any underpayment of premiums may be deducted from the available life insurance benefits. We agree to the deduction of any money should premiums be underpaid.

Signature(s) of Beneficiary(ies)

Name (please print): _____

Signature: _____ Age: _____

Social Security #:_____ Relationship: _____

Address: _____

Street City State Zip Code

Phone: (___) _____

Name (please print): _____

Signature: _____ Age: _____

Social Security #:_____ Relationship: _____

Address: _____

Street City State Zip Code

Phone: (___) _____

Name (please print): _____

Signature: _____ Age: _____

Social Security #:_____ Relationship: _____

Address: _____

Street City State Zip Code

Phone: (___) _____

Return this form along with original signatures and original or certified copy of the Death Certificate to:

HP Administrative Services, LLC.
Attn: Life Benefits Coordinator
P.O. Box 24110
Oklahoma City, OK 73124
Phone: 1-405-416-1800 or 1-800-782-5218 TDD: 1-405-416-1525 or 1-800-941-2160