



**Employees Group Insurance Division**

**Life Insurance Application**

**New Hire/Rehire Employee**

<b>COORDINATOR MUST COMPLETE THIS SECTION IN ITS ENTIRETY BEFORE EGID WILL PROCESS.</b>		
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 <input type="checkbox"/> New Hire/Hire date _____	<input type="checkbox"/> Rehire/Rehire date _____	
NEW HIRE'S ANNUAL SALARY \$ _____		
ANNUAL SALARY — Information <b>must</b> 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 _____	<input type="checkbox"/> Male <input type="checkbox"/> Female
Last name _____	First name _____	Middle initial _____	
Mailing address (New address? <input type="checkbox"/> Yes <input type="checkbox"/> 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.

<b>NEW HIRE/REHIRE EMPLOYEE COMPLETE THIS SECTION</b>	
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)	\$ _____
<b>TOTAL COVERAGE DESIRED</b> (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 _____
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**FOR HCMU REVIEW ONLY ----- DO NOT WRITE IN THIS SECTION**

APPROVED	<input type="checkbox"/>	REVIEWER _____	DATE _____
DENIED	<input type="checkbox"/>	REVIEWER _____	DATE _____

LIFE INSURANCE APPLICATION – PAGE 2 – MEDICAL INFORMATION. PLEASE PRINT CLEARLY.

This form must be completed by the member requesting Employee Life coverage. If you need to list additional information pertinent to the consideration of this application, please use a separate sheet of paper. Both pages of this form must be returned to: EGID, Submit by FAX 405-717-8997.

MEMBER ID or SSN _____	AGE _____	SEX D M    D F	WEIGHT _____	HEIGHT ____ Feet ____ Inches
Tobacco use?    D Yes    D No    ____ Packs/Cigars per Day	Alcohol use?    D Yes    D No		____ Cans/Drinks per week	

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		Hemophilia	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		Hepatitis B / Hepatitis C	
	Alzheimer's		High Blood Pressure	
	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	
	Circulatory Disease / Disorder		Meningitis	
	Claudication (Leg pain when walking)		Mental Disease / Disorder	
	Closed Head Injury		Intellectual Disability	
	Coma		Multiple Myeloma	
	Within 5 years		Multiple Sclerosis	
	Congenital Deformity		Muscular Dystrophy	
	Congestive Heart Failure		Myasthenia Gravis	
	COPD / Emphysema		Within 5 years	
	Covid-19 (Long)		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	
	Type 1 Insulin Dependent		Within 3 years	
	Type 2 – Non-Insulin Dependent		Greater than 3 years	
	Must provide recent A1c results		Parkinson's Disease	
	Eating Disorder		Peritonitis	
	Embolism		Pituitary Gland Dysfunction / Tumor	
	Encephalitis		Within 3 years	
	Epilepsy / Convulsion / Seizure		Greater than 3 years	
	Factor V Leiden's Disorder		Plasmacytoma	
	Fistula		Polycythemia	
	Gastrectomy / Gastric resection / Gastric bypass		Within 3 years	
	Stapling / lap band / Sleeve		Greater than 3 years	
	Within 2 years		Prostate Cancer	
	Greater than 3 years		Pulmonary Hypertension	
	Glioma – Tumor		Pulmonary Edema (Chronic)	
	Glomerulonephritis / Nephritis		Pyelonephritis	
	Guillain Barre'		Renal Failure / Insufficiency	
	Within 3 years		Rheumatic Fever	
	Greater than 3 years		Sarcoidosis	
	Head Injury		Schizophrenia	
	Heart Disease / Disorder		Sepsis	
	Angioplasty		Sickle Cell Anemia	
	Arrhythmia		Sleep Apnea	
	Cardiomyopathy		Spina Bifida	
	Chest Pain / Angina		Substance Use Disorder (Alcohol, Drug, Other)	
	Congenital Heart Disease		Syncope	
	Coronary Artery Bypass		Syphilis	
	Within 5 years		Transplants	
	Greater than 5 years		Bone Marrow	
	Coronary Artery Disease		Heart	
	Within 5 years		Kidney	
	Greater than 5 years		Liver	
	Myocardial Infarction / Heart Attack		Lung	
	Within 5 years		Pancreas	
	Greater than 5 years		Tumor – Non-Malignant	
	Myocarditis		Must Provide Path Report	
	Valve Replacement		Ulcerative Colitis	
	Valvular Heart Disease		Uremia	
	Within 5 years		Vascular Disease	
	Greater than 5 years		Vomiting/Coughing Up Blood	
	Other Cardiac Surgery		Wegner's Granulomatosis / syndrome	
	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.

List any medications you take regularly. Include the strength of the medication and frequency. Example: Lipitor 20mg once/daily