OKLAHOMA
Employees Group Insurance Division

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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 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 EGID before a waiver is effective. **SIGN 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, list 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
Attn: Health Care Management Unit
2401 N. Lincoln Blvd., Ste. 300
Oklahoma City, OK 73105

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.

Physician's name (please print)	Degree	Phone number

Physician's signature	Date

Street address	City	State	ZIP code

Physicians – Please return completed form to:
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