

# APPLICATION FOR WAIVER OF LIFE PREMIUM

Please complete the "Patient Information" section of this form in its entirety and have your treating physician complete the remainder of the form and return it along with a copy of your SDRS or Social Security letter of disability approval to:

Health Management Partners  
2301 West Russell Street  
Sioux Falls, SD 57105

**\*\*Failure to submit the required documentation may result in a delay in processing. Waiver of Life Premiums are contingent on medical records received and approved by HMP.\*\***

## Patient Information

Patient Name: \_\_\_\_\_ SSN or Alternative ID#: \_\_\_\_\_

Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

*I hereby authorize any hospital, physician, or any workers compensation carrier, or other person who has attended me or examined me to furnish to the Bureau of Human Resources, or its authorized representative, any and all information with respect to any illness or injury, worker's compensation claim, medical history, consultation, prescription or treatment, and copies of all hospital and medical records. If requested, I will undergo an independent medical evaluation at the State's expense. Failure to comply may result in loss of benefits. A copy or facsimile of this authorization shall be considered as effective and valid as the original.*

Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Employee Signature \_\_\_\_\_

## Injury/Illness Treatment

Date of this examination: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

Treatment & Medications: \_\_\_\_\_

Re-evaluation/Follow-up on: \_\_\_\_\_

## Return to Work Status

- Return to work with no restrictions
- Unable to return to work for \_\_\_\_\_ days
- Modified light duty for \_\_\_\_\_ days
- Unable to return to work – permanent disability\*

*\*As used in this provision, totally disabled means the Employee is permanently and continuously disabled by injury or disease to the extent he cannot work for pay or profit and is not able to take part in any business or occupation.*

## Provider Information

Provider name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone number: \_\_\_\_\_

Provider signature: \_\_\_\_\_

Date signed: \_\_\_\_\_

As a totally disabled Employee, your Basic and Supplemental Life Coverage will continue during the period of total disability. In addition, your Supplemental Life Coverage contributions may be waived as indicated below, up to age 65.

Totally disabled means you are permanently and continuously disabled by injury or disease to the extent you cannot work for pay or profit and are not able to take part in any business or occupation.

To be eligible for the Waiver of Life Premium, you must submit proof of disability within one year after you stop working because of the disability. Proof of disability shall consist of written certification from your physician or from the Social Security Administration. Your physician must complete the front of this form. When approved, contributions will be waived once you are no longer listed as an active Employee on the payroll system. Waiving of contributions will continue for one year while you remain totally disabled. From then on, contributions will be waived for successive one-year periods while you remain totally disabled, if due proof is received by the Bureau of Human Resources during the last three months of the preceding period that the total disability continues.

The Bureau of Human Resources has the right to require proof from time-to-time of the continuance of total disability during the first two years after receipt of the initial proof of such disability. Thereafter, proof will be required not more than once a year. As part of any proof, you may be required to be examined at the Bureau of Human Resources's expense by a medical examiner of our choice.

The amount of coverage on which contributions are waived is the amount in force on the date the total disability began. The amount of coverage on which contributions are waived will be reduced at the times and to the extent it would have been reduced had you remained covered, but not disabled. Dependent Life Coverage is not provided under this waiver provision.

If you die while coverage is being continued under this provision, the amount of coverage in force under the Plan at the time of death will be paid to your beneficiary(ies).

If you do not return to active work in a class eligible for life coverage under the Plan within 31 days after benefits under this provision end, you may exercise your continuation privilege, as described in "Continuation of Life Benefit." The Employee may do this as though termination of employment had occurred on the date his life benefits ended.

Coverage under this paragraph, when approved, both Basic and Supplemental, will continue for as long as you are totally disabled, or until the last day of the month in which you reach age 65, whichever comes first.

You can continue Basic and Supplemental Life Coverage from age 65 to age 70 by paying the appropriate contributions for coverage.