STATE OF IDAHO
DEPARTMENT OF ADMINISTRATION
OFFICE OF GROUP INSURANCE
P.O. BOX 83720 BOISE, ID 83720-0035
(208) 332-1860
ogi@adm.idaho.gov

Self Pay Reporting Form

Voluntary Term Life

Agency _____ **Month** _____

LWOP *Eligible to Pay for 6 months only.*

Name & Social Security No.	Reason for LWOP	LWOP Date	Certified Monthly Salary	Premium Paid
			Total	

Disability *Use only if employee has filed a disability claim*

Name & Social Security No.	Date Disabled	Certified Monthly Salary	Premium Paid
		Total	