Department of Administration
Office of Group Insurance
PO Box 83720
Boise ID 83720-0035
(208) 332-1860
ogi@adm.idaho.gov

Self Pay Reporting Form

Basic Life

Agency _____ **Month of Coverage** _____

LWOP *Eligible to pay for 6 months only.*

Name & SSN	Date of Disability	Certified Monthly Salary	Benefit Election	Premium Paid (Mthly Salary Paid x .277%)
			Total Premium	

Misc.

Name & SSN	Self Pay Reason	Certified Monthly Salary	Benefit Election	Premium Paid (Mthly Salary Paid x .277%)
			Total Premium	