



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

Self Pay Reporting Form

Basic 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 (Monthly Salary x .257%)
Total				

Misc.

Name & Social Security No.	Self Pay Reason	Premium Paid
Total		