MISSISSIPPI'S STATE AND SCHOOL **EMPLOYEES'** HEALTH INSURANCE PLAN APPLICATION FOR COVERAGE

PLEASE PRINT Section A: Enrollee Information (all fields are required)		Employer Name		
Social Security Number	First Name	MI	Last Name	
Home Address		City	State	ZIP
Primary Telephone Number	Secondary Telephone Number	Personal Email Address		
Marital Status ☐ Single ☐ Married	Gender ☐ Male ☐ Female	Date of Birth (mm/dd/yyyy)	Date of Employment/Retirement	

Were you ever a full-time employee of a covered entity under the Plan prior to 1/1/2006? ☐ No (Horizon) ☐ Yes (Legacy)

If yes, please list your most recent (pre-1/1/06) employer and dates of employment: ______

If married, is your spouse a Plan participant? ☐ Yes ☐ No If yes, Spouse Name and SSN: ______

Section B: Health Insurance Membership Agreement Authorization (CHECK ONLY ONE BOX, SIGN AND DATE)

○ I hereby apply to ADD, CONTINUE AND/OR CHANGE COVERAGE for myself and/or my dependents named on this Application For Coverage form through the State and School Employees' Health Insurance Plan (PLAN). I certify that all information provided by me on this application is complete and accurate, and is the basis for providing coverage herein. I understand that any misrepresentation by me or my dependents may result in the cancellation of my/our coverage under the PLAN. I understand that the coverage applied for is subject to all exclusions, provisions, and limitations set forth by the *Plan Document*. I agree to be bound by all terms and conditions of the PLAN. I understand and agree that if my application for coverage is approved, any requested coverage changes will be effective the date fixed by the PLAN or its Administrator. I understand that if the requested coverage is approved, I am responsible for payment of the appropriate premiums and hereby authorize for such payments to be payroll deducted, or as appropriate, withheld from my State of Mississippi retirement benefits.

○ I hereby WAIVE COVERAGE **in the State and School Employees'** Health Insurance Plan. I have been offered coverage (or am eligible for continuation of coverage) through the PLAN, but I elect not to be covered. I understand that by waiving coverage at this time, I may only request coverage for myself or myself and eligible dependents at an Open Enrollment Period or during a Special Enrollment Period. I understand that if I am a retiree and I waive coverage, I will not be allowed to re-enroll or have my coverage reinstated at a later date. If you are waiving coverage because you are currently covered under another health insurance policy, please complete Section D.

Enrollee Signature: ______ Date: ______

Section C: Coverage

Enrollee Type:	Coverage Type:	Coverage Option: (Choose Only One)	Do you have Medicare? ☐ Yes ☐ No
☐ Employee - Legacy ☐ Employee - Horizon ☐ Retiree ☐ COBRA ☐ Surviving Spouse	☐ Enrollee Only ☐ Enrollee + Spouse ☐ Enrollee + Child ☐ Enrollee + Children ☐ Enrollee + Spouse & Child(ren)	○ Base ○ Select	Medicare Number: ______ ☐ "A" Effective Date: ______ ☐ "B" Effective Date: ______ Reason for Entitlement: ☐ Age ☐ ESRD ☐ Disability

Are you a tobacco user? ☐ Yes ☐ No If yes, are you interested in participating in the Plan's free cessation program? ☐ Yes ☐ No

Section D: Other Coverage Information

Do any of the persons listed on this application have other health insurance coverage? ☐ Yes ☐ No If yes, please provide the following:

	1.	2.	3.	4.
Name of Individual Covered:				
Policyholder's Name:				
Policyholder's Date of Birth:				
Policyholder's Insurance Effective Date:				
Policy Number:				
Policyholder's Employment Status:	Active, Retiree or COBRA ☐ ☐ ☐	Active, Retiree or COBRA ☐ ☐ ☐	Active, Retiree or COBRA ☐ ☐ ☐	Active, Retiree or COBRA ☐ ☐ ☐
Insurance Company Name address & phone #:				
Coverage Type:	☐ Group ☐ Non-Group	☐ Group ☐ Non-Group	☐ Group ☐ Non-Group	☐ Group ☐ Non-Group

Enrollee Last Name:	First Name:	Enrollee SSN:

Section E: Dependents

Dependents to be Covered (Last Name, First Name, MI)	Relation to Enrollee	Social Security Number	Date of Birth (mm/dd/yyyy)	Address (if different from Enrollee)	Current Status
1.	Spouse ☐ Male ☐ Female				Employed? ☐ Yes ☐ No
2.	☐ Son ☐ Daughter				☐ Child under 26 ☐ Disabled
3.	☐ Son ☐ Daughter				☐ Child under 26 ☐ Disabled
4.	☐ Son ☐ Daughter				☐ Child under 26 ☐ Disabled

Are any of the dependents listed above covered by Medicare Part A or Part B? ☐ Yes ☐ No
If yes, please provide the following:

Name	Medicare Number	Part A Effective Date	Part B Effective Date	Medicare Reason
____	____	____	____	____
____	____	____	____	____
____	____	____	____	____

Section F: Change Information

☐ Add Enrollee: ☐ Open Enrollment ☐ Marriage ☐ Birth ☐ Adoption ☐ Loss of Coverage due to Divorce
☐ Other: ______________________ Requested Effective Date: ______________________

☐ Add Dependent(s): ☐ Open Enrollment ☐ Marriage ☐ Birth ☐ Adoption ☐ Other: ______________________
(List all dependents in Section E.) Qualifying Event/ Effective Date: ______________________

☐ Change Coverage: ☐ Base Coverage Select Coverage

Drop Dependent(s): ☐ Divorce ☐ Deceased ☐ Other: ______________________

Provide information below for dependents to be dropped:

Name	Social Security Number	Requested Termination Date
____	____	____

Other Changes (Explain):

FOR EMPLOYER / ADMINISTRATOR USE ONLY: GROUP NUMBER: ______________________

New Legacy Employee, Requested Effective Date: ______________________

New Horizon Employee, Requested Effective Date: ______________________

Retiree, Requested Effective Date: ______________________

COBRA, Requested Effective Date: ______________________

Surviving Spouse, Requested Effective Date: ______________________

Change(s), Requested Effective Date: ______________________

ENTERED BY: ______________

DATE: ______________

VERIFIED BY: ______________

DATE: ______________