MISSISSIPPI'S STATE AND SCHOOL EMPLOYEES' HEALTH INSURANCE PLAN APPLICATION FOR COVERAGE ACA PLAN FOR W-2 CONTRACT EMPLOYEES

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**	

NOTE 1: *Contract Employees eligible to enroll in this plan must be considered full-time under Section 4980H of the Internal Revenue Code, according to the policy set in the Plan Document.*

NOTE 2: *Spouses are not eligible for this plan.*

NOTE 3: *Children, including step-children, under age 26 and/or disabled are eligible for this plan. If you wish to enroll your child(ren), you must provide proper documentation (Birth Certificate or Guardianship Paperwork) at the time of enrollment. Failure to provide copies of this documentation along with your enrollment form will result in enrollment in employee only coverage.*

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

☐ **I hereby apply to ADD OR CONTINUE 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.

Section C: Coverage

Enrollee Type:	**Coverage Type**:	**Coverage Option:**	**Do you have Medicare?** ☐ Yes ☐ No **Medicare Number:** _____
☐ Employee ☐ COBRA	☐ Enrollee Only ☐ Employee + Child ☐ Employee + Children	☐ Base Plan	☐ "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

Enrollee Signature: _____ Date:_____

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Section D: 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.	☐ Son ☐ Daughter				☐ Child under 26 ☐ Disabled
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**
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Enrollee Signature: _____ Date:_____