

# STATE OF MISSISSIPPI STATE AND SCHOOL EMPLOYEES' HEALTH INSURANCE PLAN APPLICATION FOR COVERAGE

**PLEASE PRINT**

**Section A: Enrollee Information (all fields are required)**

Enrollee Last Name	First Name	MI	Social Security Number	Date of Birth (MMDDYYYY)	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Home Address			City	State	ZIP	Email Address
Telephone - Work #			Home #		Cell #	
Name of Employer (current employees only - otherwise indicate "Retired" or "COBRA")					Date of Employment/Retirement	

**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 plan, please complete Section D on the reverse of this form.**

Enrollee Signature \_\_\_\_\_ Date \_\_\_\_\_

**Section C: Coverage**

<b>Enrollee Type:</b> <input type="checkbox"/> Employee - Legacy <input type="checkbox"/> Employee - Horizon <input type="checkbox"/> Retiree <input type="checkbox"/> COBRA <input type="checkbox"/> Surviving Spouse	<b>Coverage Type:</b> <input type="checkbox"/> Enrollee Only <input type="checkbox"/> Enrollee + Spouse <input type="checkbox"/> Enrollee + Child <input type="checkbox"/> Enrollee + Children <input type="checkbox"/> Enrollee + Spouse & Child(ren)	<b>Coverage Option (Choose Only One)</b> <input type="checkbox"/> Select <b>OR</b> <input type="checkbox"/> Base (HIGH DEDUCTIBLE)	<b>Do you have Medicare?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> "A" Effective Date _____ <input type="checkbox"/> "B" Effective Date _____ <b>Reason for Entitlement:</b> <input type="checkbox"/> Age <input type="checkbox"/> ESRD <input type="checkbox"/> Disability		
<b>Dependents to be Covered</b> (Last Name, First Name, MI)	<b>Relation to Enrollee</b>	<b>Social Security No.</b>	<b>Date of Birth</b>	<b>Address</b> (if different from Enrollee)	<b>Current Status</b>
1.	<input type="checkbox"/> Husband <input type="checkbox"/> Wife				Employed? <input type="checkbox"/> Yes <input type="checkbox"/> No
2.	<input type="checkbox"/> Son <input type="checkbox"/> Daughter				<input type="checkbox"/> Child under -26 <input type="checkbox"/> Disabled
3.	<input type="checkbox"/> Son <input type="checkbox"/> Daughter				<input type="checkbox"/> Child under -26 <input type="checkbox"/> Disabled
4.	<input type="checkbox"/> Son <input type="checkbox"/> Daughter				<input type="checkbox"/> Child under -26 <input type="checkbox"/> Disabled
5.	<input type="checkbox"/> Son <input type="checkbox"/> Daughter				<input type="checkbox"/> Child under -26 <input type="checkbox"/> Disabled

Enrollee Last Name:	First Name:	Enrollee SSN:
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**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 information:

NAME	POLICY HOLDER	POLICY NUMBER	INSURANCE COMPANY (Name, Address, Telephone #)
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

If married, is your spouse a participant in the State and School Employees' Health Insurance Plan (PLAN)?  Yes  No  
 If Yes, please provide your spouse's name and Social Security Number: \_\_\_\_\_

Are you or any of the dependents listed in Section C currently covered in the PLAN?  Yes  No  
 If Yes, indicate the Social Security Number of the enrollee under which you and any of your dependents are currently covered: \_\_\_\_\_

Were you covered under this PLAN as an active employee last month?  Yes  No  
 If Yes, with whom were you employed? \_\_\_\_\_

Were you ever a full-time employee of a covered entity under the PLAN prior to 1/1/2006?  Yes (Legacy)  No (Horizon)  
 If Yes, please list your most recent (pre-1/1/06) employer and dates of employment: \_\_\_\_\_

**Section E: Change Information**

**Add Enrollee** due to:  Open Enrollment  Marriage  Divorce  Birth  Adoption  Other \_\_\_\_\_  
 Requested Effective **Add** Date \_\_\_\_\_

**Add Dependent(s)** due to:  Open Enrollment  Marriage  Birth  Adoption  Other \_\_\_\_\_  
 Requested Effective **Add** Date \_\_\_\_\_ **IMPORTANT: List all dependents to be covered in Section C**

**Drop Dependent(s)** due to:  Ineligible Child  Divorce  Death  Other \_\_\_\_\_  
 List **all dependents to be dropped** and provide the requested information in the spaces below:

NAME	SOCIAL SECURITY NUMBER	REQUESTED TERMINATION DATE
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**Change Coverage Option** to:  Base Coverage (HIGH DEDUCTIBLE)  Select Coverage

**Other Changes** (Explain): \_\_\_\_\_

<b>FOR EMPLOYER / ADMINISTRATOR USE ONLY:</b> GROUP NUMBER: _____	
<input type="checkbox"/> New Legacy Employee, Requested Effective Date _____	ENTERED BY: _____
<input type="checkbox"/> New Horizon Employee, Requested Effective Date _____	DATE: _____
<input type="checkbox"/> Retiree, Requested Effective Date _____	VERIFIED BY: _____
<input type="checkbox"/> COBRA, Requested Effective Date _____	DATE: _____
<input type="checkbox"/> Surviving Spouse, Requested Effective Date _____	
<input type="checkbox"/> Change(s), Requested Effective Date _____	