

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

PLEASE PRINT		Employer Name		
Section A: Enrollee Information (all fields are required)				
Social Security Number	First Name	MI	Last Name	
Home Address		City	State	ZIP
Primary Telephone Number	Secondary Telephone Number	Personal Email Address		
Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married	Gender <input type="checkbox"/> Male <input type="checkbox"/> 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? <input type="checkbox"/> No (Horizon) <input type="checkbox"/> Yes (Legacy)				
If <u>yes</u> , please list your most recent (pre-1/1/06) employer and dates of employment: _____				
If married, is your spouse a Plan participant? <input type="checkbox"/> Yes <input type="checkbox"/> 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: <input type="checkbox"/> Employee - Legacy <input type="checkbox"/> Employee - Horizon <input type="checkbox"/> Retiree <input type="checkbox"/> COBRA <input type="checkbox"/> Surviving Spouse	Coverage Type: <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)	Coverage Option: (Choose Only One) <input type="radio"/> Select <input type="radio"/> Base (HIGH DEDUCTIBLE)	Do you have Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No Medicare Number: _____ <input type="checkbox"/> "A" Effective Date: _____ <input type="checkbox"/> "B" Effective Date: _____ Reason for Entitlement: <input type="checkbox"/> Age <input type="checkbox"/> ESRD <input type="checkbox"/> Disability
Are you a tobacco user? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, are you interested in participating in the Plan's free cessation program? <input type="checkbox"/> Yes <input type="checkbox"/> 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:

Name of Individual Covered:	1. _____	2. _____	3. _____	4. _____
Policyholder's Name:	_____	_____	_____	_____
Policyholder's Date of Birth:	_____	_____	_____	_____
Policyholder's Insurance Effective Date:	_____	_____	_____	_____
Policy Number:	_____	_____	_____	_____
Policyholder's Employment Status:	Active, Retiree or COBRA <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Active, Retiree or COBRA <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Active, Retiree or COBRA <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Active, Retiree or COBRA <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Insurance Company Name address & phone #:	_____	_____	_____	_____
Coverage Type:	<input type="checkbox"/> Group <input type="checkbox"/> Non-Group	<input type="checkbox"/> Group <input type="checkbox"/> Non-Group	<input type="checkbox"/> Group <input type="checkbox"/> Non-Group	<input type="checkbox"/> Group <input type="checkbox"/> Non-Group

Enrollee Last Name:	First Name:	Enrollee SSN:
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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 <input type="checkbox"/> Male <input type="checkbox"/> Female				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

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: _____
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