

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

<b>PLEASE PRINT</b>		Employer Name			
<b>Section A: Enrollee Information (all fields are required)</b>					
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 <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?      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**

<b>Enrollee Type:</b> Employee - Legacy Employee - Horizon Retiree COBRA Surviving Spouse	<b>Coverage Type:</b> Enrollee Only Enrollee + Spouse Enrollee + Child Enrollee + Children Enrollee + Spouse & Child(ren)	<b>Coverage Option:</b> (Choose Only One)  Select  Base (HIGH DEDUCTIBLE)	<b>Do you have Medicare?</b> Yes      No <b>Medicare Number:</b> _____ "A" Effective Date: _____ "B" Effective Date: _____ <b>Reason for Entitlement:</b> 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:

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

Enrollee Last Name:	First Name:	Enrollee SSN:
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**Section E: Dependents**

Dependents to be Covered <small>(Last Name, First Name, MI)</small>	Relation to Enrollee	Social Security Number	Date of Birth <small>(mm/dd/yyyy)</small>	Address <small>(if different from Enrollee)</small>	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**

<b>Add Enrollee:</b> Open Enrollment      Marriage      Birth      Adoption      Loss of Coverage due to Divorce Other: _____ Requested Effective Date: _____
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<b>Add Dependent(s):</b> Open Enrollment      Marriage      Birth      Adoption      Other: _____ <small>(List all dependents in Section E.)</small> Qualifying Event/ Effective Date: _____
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<b>Change Coverage:</b> Base Coverage      Select Coverage
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<b>Drop Dependent(s):</b> Divorce      Deceased      Other: _____ Provide information below for dependents to be dropped:
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Name	Social Security Number	Requested Termination Date
_____	_____	_____
_____	_____	_____
_____	_____	_____

<b>Other Changes</b> (Explain): _____
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<b>FOR EMPLOYER / ADMINISTRATOR USE ONLY:</b> 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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