

**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 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 <u>prior to 1/1/2006</u> ? 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

Enrollee Type: Employee - Legacy Employee - Horizon Retiree COBRA Surviving Spouse	Coverage Type: Enrollee Only Enrollee + Spouse Enrollee + Child Enrollee + Children Enrollee + Spouse & Child(ren)	Coverage Option: (Choose Only One) Select Base (HIGH DEDUCTIBLE)	Do you have Medicare? Yes No	
			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:

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	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:
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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

Add Enrollee:	Open Enrollment	Marriage	Birth	Adoption	Loss of Coverage due to Divorce	Other: _____	Requested Effective Date: _____
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Add Dependent(s):	Open Enrollment	Marriage	Birth	Adoption	Other: _____	Qualifying Event/ Effective Date: _____
<small>(List all dependents in Section E.)</small>						

Change Coverage:	Base Coverage	Select Coverage
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Drop Dependent(s):	Divorce	Deceased	Other: _____
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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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