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

**PLEASE PRINT**

**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 | Email Address |
|---|---|---|
| | | |

| Marital Status | Sex | Date of Birth (MMDDYYYY) | Date of Employment/Retirement |
|---|---|---|---|
| ❑ Single ❑ Married | ❑ Male ❑ Female | | |

**Were you ever a full-time employee of a covered entity under the State and School Employees' Health Insurance Plan (PLAN) prior to 1/1/2006? ❑ No (Horizon) ❑ Yes (Legacy) If Yes, please list your most recent (pre-1/1/06) employer and dates of employment:** _____

_____

**If married, is your spouse a participant in the PLAN? ❑ Yes ❑ No**

**If Yes, please provide your spouse's name and Social Security Number:** _____

**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.**

Enrollee Signature _____ Date _____

**Section C: Coverage**

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

**Section D: Other Coverage Information**

**Do any of the persons listed on this application have other health insurance coverage? ❑ No ❑ Yes If Yes, please provide the following information:**

| | 1. | 2. | 3. | 4. |
|---|---|---|---|---|
| Name of Individual Covered: | | | | |
| Policyholder's Name: | | | | |
| Policyholder's Date of Birth: | | | | |
| Policy Number: | | | | |
| Policyholder's Employment Status (Circle): | Active, Retiree or COBRA | Active, Retiree or COBRA | Active, Retiree or COBRA | Active, Retiree or COBRA |
| Insurance Company Name address & phone #: | | | | |
| Coverage Type (Circle): | Group or Non-Group | Group or Non-Group | Group or Non-Group | Group or Non-Group |

| Enrollee Last Name: | First Name: | Enrollee SSN: |
|---|---|---|
| | | |

**Section E: Dependents**

| Dependents to be Covered (Last Name, First Name, MI) | Relation to Enrollee | Social Security Number | Date of Birth | Address (if different from Enrollee) | Current Status |
|---|---|---|---|---|---|
| 1. | ❑ Husband<br>❑ Wife | | | | Employed?<br>❑ Yes<br>❑ No |
| 2. | ❑ Son<br>❑ Daughter | | | | ❑ Child under 26<br>❑ Disabled |
| 3. | ❑ Son<br>❑ Daughter | | | | ❑ Child under 26<br>❑ Disabled |
| 4. | ❑ Son<br>❑ Daughter | | | | ❑ Child under 26<br>❑ Disabled |
| 5. | ❑ Son<br>❑ Daughter | | | | ❑ Child under 26<br>❑ Disabled |

**Are any of the dependents listed above covered by Medicare Part A or Part B?** ❑ **No** ❑ **Yes** **If Yes, please provide the following information:**

| NAME | Medicare Number | Part A Effective Date | Part B Effective Date | Medicare Reason |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |

**Section F: Change Information**

❑ **Add Enrollee**: ❑ Open Enrollment ❑ Marriage ❑ Loss of Coverage due to Divorce ❑ Birth ❑ Adoption

❑ Other _____ **Requested Effective Add Date** _____

❑ **Add Dependent(s)**: ❑ Open Enrollment ❑ Marriage ❑ Birth ❑ Adoption ❑ Other _____

**Requested Effective Add Date** _____ **IMPORTANT: List all dependents to be covered in Section E.**

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

❑ **Drop Dependent(s)**: ❑ Divorce ❑ Deceased ❑ Other _____

**List all dependents to be dropped and provide the requested information in the spaces below:**

| NAME | SOCIAL SECURITY NUMBER | REQUESTED TERMINATION DATE |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

❑ **Other Changes** (Explain):

FOR EMPLOYER / ADMINISTRATOR USE ONLY: GROUP NUMBER: _____

❑ New Legacy Employee, Requested Effective Date _____ ENTERED BY: _____

❑ New Horizon Employee, Requested Effective Date _____ DATE: _____

❑ Retiree, Requested Effective Date _____

❑ COBRA, Requested Effective Date _____ VERIFIED BY: _____

❑ Surviving Spouse, Requested Effective Date _____ DATE: _____

❑ Change(s), Requested Effective Date _____