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

PLEASE PRINT

Section A: Enrollee Information (all fields are required)

Employer Name

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 yes, 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:	**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

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 (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 (mm/dd/yyyy)	Address (if different from Enrollee)	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: _____

❑ **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: _____