

**MISSISSIPPI'S 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 <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"/> Base <input type="radio"/> Select	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: _____	_____	_____	_____
Policyholder's Insurance Policy Number: _____	_____	_____	_____
Policyholder's Employment Status: Active, Retiree or COBRA	Active, Retiree or COBRA	Active, Retiree or COBRA	Active, Retiree or COBRA
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<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:
---------------------	-------------	---------------

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				<input type="checkbox"/> 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: _____