

**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
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Social Security Number	First Name	MI	Last Name
Home Address		City	State
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?  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**

<b>Enrollee Type:</b> <input type="checkbox"/> Employee - Legacy <input type="checkbox"/> Employee - Horizon <input type="checkbox"/> Retiree <input type="checkbox"/> COBRA <input type="checkbox"/> Surviving Spouse	<b>Coverage Type:</b> <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)	<b>Coverage Option:</b> (Choose Only One) <input type="checkbox"/> Select OR <input type="checkbox"/> Base (HIGH DEDUCTIBLE)	<b>Do you have Medicare?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Medicare Number:</b> _____ <input type="checkbox"/> "A" Effective Date: _____ <input type="checkbox"/> "B" Effective Date: _____ <b>Reason for Entitlement:</b> <input type="checkbox"/> Age <input type="checkbox"/> ESRD <input type="checkbox"/> Disability
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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:
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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 <input type="checkbox"/> Male <input type="checkbox"/> Female				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): \_\_\_\_\_

<b>FOR EMPLOYER / ADMINISTRATOR USE ONLY:</b> <b>GROUP NUMBER:</b> _____ <input type="checkbox"/> New Legacy Employee, Requested Effective Date: _____ <input type="checkbox"/> New Horizon Employee, Requested Effective Date: _____ <input type="checkbox"/> Retiree, Requested Effective Date: _____ <input type="checkbox"/> COBRA, Requested Effective Date: _____ <input type="checkbox"/> Surviving Spouse, Requested Effective Date: _____ <input type="checkbox"/> Change(s), Requested Effective Date: _____	<b>ENTERED BY:</b> _____ <b>DATE:</b> _____  <b>VERIFIED BY:</b> _____ <b>DATE:</b> _____
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