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 ❑ Wife				Employed? ❑ Yes ❑ No
2.	❑ Son ❑ Daughter				❑ Child under 26 ❑ Disabled
3.	❑ Son ❑ Daughter				❑ Child under 26 ❑ Disabled
4.	❑ Son ❑ Daughter				❑ Child under 26 ❑ Disabled
5.	❑ Son ❑ Daughter				❑ Child under 26 ❑ 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 _____