

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

PLEASE PRINT

Section A: Enrollee Information

Enrollee Last Name	First Name	MI	Social Security Number	Date of Birth (MMDDYYYY)	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
Home Address				Daytime Telephone Number	
Name of Employer (active employees only)				Date of Employment	

Section B: Authorization

Health Insurance Membership Agreement (Signature Required for New Enrollment, Reinstatement, Retirement, & Dependents)
 I apply for coverage (or continuation of coverage) for myself and dependents named on this Application For Coverage form through the State and School Employees' Health Insurance Plan (Plan). I agree that if my application for coverage is approved, coverage will be effective the date fixed by the Plan or its Administrator. I further agree that any changes affecting my membership agreement will not become effective until approved by the Plan or its Administrator. 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 the coverage applied for is subject to all exclusions, provisions, and limitations set forth by the Plan Document. I understand that any misrepresentation by me or my dependents may result in the cancellation of all benefits under the Plan. I understand that the appropriate premiums for the coverage requested will be deducted from my wages or retirement benefits, as appropriate. I agree to be bound by all terms and conditions of the Plan.

Waiver of Health Insurance (Also Complete Section A above)
 I have been offered coverage (or am eligible for continuation of coverage) through the State and School Employees' Health Insurance 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.

Are you waiving coverage because you are currently covered under another health insurance plan? Yes No

Enrollee Signature _____ Date _____

Section C: Type of Coverage

Enrollee Type: <input type="checkbox"/> Employee <input type="checkbox"/> Retiree <input type="checkbox"/> COBRA <input type="checkbox"/> Surviving Spouse	Type of Coverage Desired: <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)	Check here to apply for: <input type="checkbox"/> High Option Coverage for Children <input type="checkbox"/> High Deductible Health Plan (HDHP)	Do you have Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No <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		
Dependents to be Covered (Last Name, First Name, MI)	Relation to Enrollee	Social Security Number	Date of Birth	Address (if different from Enrollee)	Coverage Status
1.	<input type="checkbox"/> Husband <input type="checkbox"/> Wife				Employed? <input type="checkbox"/> Yes <input type="checkbox"/> No
2.	<input type="checkbox"/> Son <input type="checkbox"/> Daughter				<input type="checkbox"/> Child under 19 <input type="checkbox"/> Student 19-25 <input type="checkbox"/> Handicapped
3.	<input type="checkbox"/> Son <input type="checkbox"/> Daughter				<input type="checkbox"/> Child under 19 <input type="checkbox"/> Student 19-25 <input type="checkbox"/> Handicapped
4.	<input type="checkbox"/> Son <input type="checkbox"/> Daughter				<input type="checkbox"/> Child under 19 <input type="checkbox"/> Student 19-25 <input type="checkbox"/> Handicapped

Enrollee Last Name:	First Name:	Enrollee SSN:
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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 information:

NAME	POLICY HOLDER	POLICY ID NUMBER	NAME, ADDRESS, PHONE # OF INSURANCE COMPANY
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

If married, is your spouse a participant in the State and School Employees' Health Insurance Plan? Yes No
 If "yes", please provide your spouse's name and participant ID Number: _____

Are you or any of the dependents listed in Section C currently covered in the State and School Employees' Health Insurance Plan?
 Yes No If "Yes", indicate the participant ID Number under which you and any of your dependents are currently covered: _____

Were you covered under this Plan as an active employee last month? Yes No
 If yes, with whom were you employed? _____

Section E: Change Information and Authorization

Add Dependents due to: Marriage Newborn Adoption Other _____
 Requested Effective Add Date _____ List all dependents to be covered in Section C on the reverse of this form.

Add High Option Coverage for Child(ren) Drop High Option Coverage for Child(ren)
 Requested Effective Add Date _____ Requested Effective Drop Date _____

Change Plan Type to: (Check One) Standard Plan High Deductible Health Plan (HDHP)

Drop Dependents due to: Death Divorce Ineligible Child Other _____
 List all dependents to be dropped and provide the requested information in the space below:

NAME	SOCIAL SECURITY NUMBER	REQUESTED TERMINATION DATE	REASON FOR DROPPING COVERAGE
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Other Changes (Explain): _____

Enrollee Signature _____ Date _____

FOR EMPLOYER/ADMINISTRATOR USE ONLY	
Group Number _____ <input type="checkbox"/> New Employee, Requested Effective Date _____ <input type="checkbox"/> Change, Requested Effective Date _____ <input type="checkbox"/> Retiree, Requested Effective Date _____ <input type="checkbox"/> Surviving Spouse, Requested Effective Date _____ <input type="checkbox"/> COBRA, Requested Effective Date _____	ENTERED BY _____ DATE: _____ VERIFIED BY: _____ DATE: _____