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: ❑ Male ❑ Female

Home Address	City	State	ZIP	Daytime Telephone Number

Name of Employer (current employees only – otherwise indicate "Retired" or "COBRA")	Date of Employment/Retirement

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 on the reverse of this form.**

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		❑ "A" Effective Date ____________
❑ Employee - Horizon	❑ Enrollee + Spouse	❑ Select	
❑ Retiree	❑ Enrollee + Child	OR	❑ "B" Effective Date ____________
❑ COBRA	❑ Enrollee + Children		**Reason for Entitlement:**
❑ Surviving Spouse	❑ Enrollee + Spouse & Child(ren)	❑ Base **(HIGH DEDUCTIBLE)**	❑ Age ❑ ESRD ❑ Disability

Dependents to be Covered (Last Name, First Name, MI)	Relation to Enrollee	Social Security No.	Date of Birth	Address (if different from Enrollee)	Current Status
1.	❑ Husband ❑ Wife				Employed? ❑ Yes ❑ No
2.	❑ Son ❑ Daughter				❑ Child under 19 ❑ Student 19-25 ❑ Handicapped
3.	❑ Son ❑ Daughter				❑ Child under 19 ❑ Student 19-25 ❑ Handicapped
4.	❑ Son ❑ Daughter				❑ Child under 19 ❑ Student 19-25 ❑ Handicapped
5.	❑ Son ❑ Daughter				❑ Child under 19 ❑ Student 19-25 ❑ Handicapped

Enrollee Last Name:	First Name:	Enrollee SSN:

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 NUMBER	INSURANCE COMPANY (Name, Address, Telephone #)

If married, is your spouse a participant in the State and School Employees' Health Insurance Plan (PLAN)? ❑ Yes ❑ No
If Yes, please provide your spouse's name and Social Security Number:______________________

Are you or any of the dependents listed in Section C currently covered in the PLAN? ❑ Yes ❑ No
If Yes, indicate the Social Security Number of the enrollee 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? ______________________

Were you ever a full-time employee of a covered entity under the PLAN prior to 1/1/2006? ❑ Yes (Legacy) ❑ No (Horizon)
If Yes, please list your most recent (pre-1/1/06) employer and dates of employment:______________________
____

Section E: Change Information

❑ **Add Enrollee** due to: ❑ Open Enrollment ❑ Marriage ❑ Divorce ❑ Birth ❑ Adoption ❑ Other ______________

Requested Effective Add Date ______________

❑ **Add Dependent(s)** due to: ❑ Open Enrollment ❑ Marriage ❑ Birth ❑ Adoption ❑ Other ______________

Requested Effective Add Date______________ **IMPORTANT: List all dependents to be covered in Section C**

❑ **Drop Dependent(s)** due to: ❑ Ineligible Child ❑ Divorce ❑ Death ❑ Other______________
List all dependents to be dropped and provide the requested information in the spaces below:

NAME	SOCIAL SECURITY NUMBER	REQUESTED TERMINATION DATE

❑ **Change Coverage Option to:** ❑ **Base Coverage (HIGH DEDUCTIBLE)** ❑ **Select Coverage**

❑ **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 ______________

Sheltered Under Pre-tax Benefit Plan (PRE-TAX)

I understand that all eligible benefit coverages offered by Mississippi State University are available to me through payroll deduction under the University's Pre-tax Benefit Plan as provided under Section 125 of the Internal Revenue Code. I elect to purchase benefits under the plans that I have elected to enroll in and authorize premiums to be paid on my behalf equal to my contributions for such insurance. I understand that selection of new insurance coverage does not automatically provide coverage and I must complete an application for insurance.

I understand that any election made under the Pre-tax Benefit Plan herein is irrevocable and may be changed only during the annual benefit enrollment period (effective date of February 1) **or** in the event of a change in family status (i.e., marriage, divorce, death of a spouse or a dependent, birth or adoption of a child, termination of employment of a spouse, switching from part-time to full-time employment status or from full-time to part-time status of a spouse, or employee or spouse taking an unpaid leave of absence). Family status changes must be made within 31 days of the qualifying event.

Finally, if I later choose not to participate in the Pre-tax Plan, or wish to change the plans under which I am covered, I may change such election made herein only as of January 1 following the date this selection is made. I also understand that if changes are not made by January 1, then I will be treated as having continued the same elections in effect for subsequent plan years (January 1 - December 31). I am aware that any expenses paid through the Pre-tax Benefit Plan are no longer eligible as deductions for federal or state income tax purposes and participation may reduce my future social security entitlements.

I understand that if I elect to have my insurance premiums deducted from my payroll check on a pre-tax basis, I should read the Mississippi State University Cafeteria Plan Summary Plan Description. I am aware that this information may be found at the Human Resources Management (HRM) website, www.hrm.msstate.edu.

	I ACCEPT the option of having the premiums for my **State and School Employees' Health Insurance Plan** sheltered under the **Pre-tax** Benefit Plan. I understand that my insurance premiums for this coverage will be deducted from my payroll check on a pre-tax basis.

Name____ Social Security Number_____________________________

Click on the box at right to return to the form. ⚬

Not Sheltered Under Pre-tax Benefit Plan (AFTER-TAX)

I understand that all eligible benefit coverages offered by Mississippi State University are available to me through the University's Pre-tax Benefit Plan. I have been offered the opportunity to participate in this Plan and do hereby decline this opportunity.

	I DECLINE the option of having the premiums for my **State and School Employees' Health Insurance Plan** sheltered under the **Pre-tax** Benefit Plan. I understand that my insurance premiums for this coverage will be deducted from my payroll check after taxes are deducted.

Name____ Social Security Number_____________________________

Click on the box at right to return to the form. ⚬

Coverage Definitions

The names of the two coverage options under the Plan (State and School Employees' Life and Health Plan) changed January 1, 2006.

The High Deductible Health Plan is called **Base Coverage**. The Standard Plan is called **Select Coverage**. The name change is automatic. **Current employees will only complete an Application for Coverage form if they wish to change coverage types or add dependents during Open Enrollment.**

Current employees and employees hired before January 1, 2006, who have ever been employed by a community/junior college, public libraries public school districts, State agency or university will be called a **Legacy Employee**.

Any employee initially hired on or after January 1, 2006, will be called a **Horizon Employee**. The State will pay 100% of the cost of Base Coverage. Employees can "buy up" to Select Coverage.