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

PLEASE PRINT

Section A: Enrollee Information (all fields are required)

Employer Name
Mississippi State University

Social Security Number	First Name	MI	Last Name

Home Address	City	State	ZIP

Primary Telephone Number	Secondary Telephone Number	Personal Email Address

Marital Status	Gender	Date of Birth (mm/dd/yyyy)	Date of Employment/Retirement
Single Married	Male Female		

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

Enrollee Type:
- ☐ Employee - Legacy
- ☐ Employee - Horizon
- ☐ Retiree
- ☐ COBRA
- ☐ Surviving Spouse

Coverage Type:
- ☐ Enrollee Only
- ☐ Enrollee + Spouse
- ☐ Enrollee + Child
- ☐ Enrollee + Children
- ☐ Enrollee + Spouse & Child(ren)

Coverage Option: (Choose Only One)
- ◯ Base
- ◯ Choice
- ◯ Select

Do you have Medicare? ☐ Yes ☐ No
Medicare Number: _____
☐ "A" Effective Date: _____
☐ "B" Effective Date: _____
Reason for Entitlement:
☐ Age ☐ ESRD ☐ Disability

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:

	1.	2.	3.	4.
Name of Individual Covered:				
Policyholder's Name:				
Policyholder's Date of Birth:				
Policyholder's Insurance Effective Date:				
Policy Number:				
Policyholder's Employment Status:	Active, Retiree or COBRA ☐ ☐ ☐	Active, Retiree or COBRA ☐ ☐ ☐	Active, Retiree or COBRA ☐ ☐ ☐	Active, Retiree or COBRA ☐ ☐ ☐
Insurance Company Name address & phone #:				
Coverage Type:	☐ Group ☐ Non-Group	☐ Group ☐ Non-Group	☐ Group ☐ Non-Group	☐ Group ☐ 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 ☐ Male ☐ Female				Employed? ☐ Yes ☐ No
2.	☐ Son ☐ Daughter				☐ Child under 26 ☐ Disabled
3.	☐ Son ☐ Daughter				☒ Child under 26 ☒ Disabled
4.	☐ Son ☐ Daughter				☐ Child under 26 ☐ 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 ☐ Choice 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: _____

State & School Employees' Health Insurance Plan Application for Coverage for New Hires Instructions

Mandatory Form

Section A:

- Enter your social security number
- Enter your first, middle initial, last name
- Enter your home address
- Enter your city, state, zip code
- Enter your primary and secondary telephone number
- Enter your date of birth
- Enter your date of employment/retirement

Were you ever a full-time employee of a covered entity under the Plan prior to 1/1/2006? Answer yes or no.

- No box = horizon plan
- Yes box = Legacy plan

If married, is your spouse a plan participant? This means does your spouse work for a state agency and does he/she participate in this health plan? Answer yes or no

Section B:

Check one of the circles:

- I hereby apply to ADD, CONTINUE AND/OR CHANGE COVERAGE
- I hereby WAIVE COVERAGE

Sign and date in section B if you are applying for coverage or waiving.

If you are waving coverage, go to page 2 and enter your name and social security number at the top of the page. This will finish your application to waive coverage. Please return in person, mail, fax, or email (via secure email) to: Human Resource Management office.

If you choose health insurance coverage, go to Section C:

Enrollee Type:

- Place a check mark in the appropriate box: Employee Legacy or Employee Horizon. You can find this information by looking back to Section A, to the question "Were you ever a full-time employee of a covered entity under the Plan prior to 1/1/2006? Look at the box you picked. You will see Horizon by the no box and Legacy by the yes box.

Coverage Type:

- Place a check mark in the type of coverage you choose.

Coverage Option:

- Place a check mark in the option that you choose.

Do you have Medicare:

- Check yes or no
- If yes, add dates for Parts A and/or B

Reason for Entitlement:

- If you checked yes for Medicare, please choose appropriate box for Medicare entitlement.

Are you a tobacco user?

- Check yes or no

- If you checked yes, please answer the question about free cessation program.

Section D:

Do any of the persons listed on this application have other health insurance coverage?

- Check yes or no
- Provide the appropriate information for everyone covered by other health insurance.

PAGE TWO

- Enter your last name, and first name.
- Enter your social security number.

Section E:

- Enter your dependents to be covered.
- Spouse first, then children next
- Enter last name, first name, middle initial
- Enter social security number
- Enter date of Birth
- Enter address if different
- Check if spouse is employed: yes or no
- Check appropriate boxes for child: under the age of 26, disabled

Are any of the dependents listed above covered by Medicare Part A or Parts B?

- Check yes or no
- If you checked yes, please provide the additional information requested for each covered individual.

You have now completed the health enrollment form.

Please send completed form to the Human Resource Department via:

- In person: 245 Barr Ave, 150 McArthur Hall
- U. S. Mail: PO Box 9603, Mississippi State, Ms 39762
- Fax: 662 325-0753
- Secure e-mail: contact your benefit specialist listed on the website: hrm.msstate.edu for information how to send secure email. To find your benefit specialist, view the home page, about us, our staff.
- Campus mailstop 9603