

**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				City	State
				ZIP	Daytime Telephone Number
Name of Employer (for active employees)				Date of Employment	

Section B - Authorization

Health Insurance Membership Agreement (Signature Required for New Enrollment/Addition of Dependents)

I apply for coverage for myself and dependents named on this enrollment application 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)

I have been offered 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.

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	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

Section C: Type of Coverage (Continued)

5.	<input type="checkbox"/> Son <input type="checkbox"/> Daughter				<input type="checkbox"/> Child under 19 <input type="checkbox"/> Student 19-25 <input type="checkbox"/> Handicapped
6.	<input type="checkbox"/> Son <input type="checkbox"/> Daughter				<input type="checkbox"/> Child under 19 <input type="checkbox"/> Student 19-25 <input type="checkbox"/> Handicapped

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 Social Security Number: _____

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

Section E: Change Information and Authorization (Complete for ANY Change)

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 _____

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 PERSONNEL/PAYROLL USE ONLY	ADMINISTRATOR USE ONLY
Department Code _____ Division Code _____	Contract Type: _____
<input type="checkbox"/> New Employee, Requested Effective Date _____	Type of Contract
<input type="checkbox"/> Change, Requested Effective Date _____	<input type="checkbox"/> Enrollee Only
<input type="checkbox"/> Retiree, Requested Effective Date _____	<input type="checkbox"/> Enrollee + Spouse
<input type="checkbox"/> Surviving Spouse, Requested Effective Date _____	<input type="checkbox"/> Enrollee + Child
<input type="checkbox"/> COBRA, Requested Effective Date _____	<input type="checkbox"/> Enrollee + Children
<input type="checkbox"/> Transfer within the Plan, Current ID# _____	<input type="checkbox"/> Enrollee + Spouse + Child(ren)
	Effective Date: _____
	Department Code: _____
	Division Code: _____