

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

<b>PLEASE PRINT</b>		<b>Employer Name</b>	
<b>Section A: Enrollee Information (all fields are required)</b>		<b>Rankin County School District</b>	
<b>Social Security Number</b>	<b>First Name</b>	<b>MI</b>	<b>Last Name</b>
<b>Home Address</b>		<b>City</b>	<b>State</b> <b>ZIP</b>
<b>Primary Telephone Number</b>	<b>Secondary Telephone Number</b>	<b>Personal Email Address</b>	
<b>Marital Status</b> <input type="checkbox"/> Single <input type="checkbox"/> Married	<b>Gender</b> <input type="checkbox"/> Male <input type="checkbox"/> Female	<b>Date of Birth (mm/dd/yyyy)</b>	<b>Date of Employment/Retirement</b>
Were you ever a full-time employee of a covered entity under the Plan prior to 1/1/2006? <input type="checkbox"/> No (Horizon) <input type="checkbox"/> Yes (Legacy) If <u>yes</u> , please list your most recent (pre-1/1/06) employer and dates of employment: _____ If married, is your spouse a Plan participant? <input type="checkbox"/> Yes <input type="checkbox"/> 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**

<b>Enrollee Type:</b> <input type="checkbox"/> Employee - Legacy <input type="checkbox"/> Employee - Horizon <input type="checkbox"/> Retiree <input type="checkbox"/> COBRA <input type="checkbox"/> Surviving Spouse	<b>Coverage Type:</b> <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)	<b>Coverage Option:</b> (Choose Only One) <input type="radio"/> Select <input type="radio"/> Base (HIGH DEDUCTIBLE)	<b>Do you have Medicare?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Medicare Number:</b> _____ <input type="checkbox"/> "A" Effective Date: _____ <input type="checkbox"/> "B" Effective Date: _____ <b>Reason for Entitlement:</b> <input type="checkbox"/> Age <input type="checkbox"/> ESRD <input type="checkbox"/> Disability
Are you a tobacco user? <input type="checkbox"/> Yes <input type="checkbox"/> No    If yes, are you interested in participating in the Plan's free cessation program? <input type="checkbox"/> Yes <input type="checkbox"/> 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:

Name of Individual Covered:	1. _____	2. _____	3. _____	4. _____
<b>Policyholder's Name:</b>	_____	_____	_____	_____
<b>Policyholder's Date of Birth:</b>	_____	_____	_____	_____
<b>Policyholder's Insurance Effective Date:</b>	_____	_____	_____	_____
<b>Policy Number:</b>	_____	_____	_____	_____
<b>Policyholder's Employment Status:</b>	Active, Retiree or COBRA <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Active, Retiree or COBRA <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Active, Retiree or COBRA <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Active, Retiree or COBRA <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
<b>Insurance Company Name address &amp; phone #:</b>	_____	_____	_____	_____
<b>Coverage Type:</b>	<input type="checkbox"/> Group <input type="checkbox"/> Non-Group	<input type="checkbox"/> Group <input type="checkbox"/> Non-Group	<input type="checkbox"/> Group <input type="checkbox"/> Non-Group	<input type="checkbox"/> Group <input type="checkbox"/> Non-Group

Enrollee Last Name:	First Name:	Enrollee SSN:
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### 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 <input type="checkbox"/> Male <input type="checkbox"/> Female				<input type="checkbox"/> Employed? <input type="checkbox"/> Yes <input type="checkbox"/> No
2.	<input type="checkbox"/> Son <input type="checkbox"/> Daughter				<input type="checkbox"/> Child under 26 <input type="checkbox"/> Disabled
3.	<input type="checkbox"/> Son <input type="checkbox"/> Daughter				<input type="checkbox"/> Child under 26 <input type="checkbox"/> Disabled
4.	<input type="checkbox"/> Son <input type="checkbox"/> Daughter				<input type="checkbox"/> Child under 26 <input type="checkbox"/> 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

<input type="checkbox"/> <b>Add Enrollee:</b> <input type="checkbox"/> Open Enrollment <input type="checkbox"/> Marriage <input type="checkbox"/> Birth <input type="checkbox"/> Adoption <input type="checkbox"/> Loss of Coverage due to Divorce <input type="checkbox"/> Other: _____ Requested Effective Date: _____		
<input type="checkbox"/> <b>Add Dependent(s):</b> <input type="checkbox"/> Open Enrollment <input type="checkbox"/> Marriage <input type="checkbox"/> Birth <input type="checkbox"/> Adoption <input type="checkbox"/> Other: _____ (List all dependents in Section E.) Qualifying Event/ Effective Date: _____		
<input type="checkbox"/> <b>Change Coverage:</b> <input type="checkbox"/> Base Coverage <input type="checkbox"/> Select Coverage		
<input type="checkbox"/> <b>Drop Dependent(s):</b> <input type="checkbox"/> Divorce <input type="checkbox"/> Deceased <input type="checkbox"/> Other: _____ Provide information below for dependents to be dropped:		
<b>Name</b>	<b>Social Security Number</b>	<b>Requested Termination Date</b>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
<input type="checkbox"/> <b>Other Changes</b> (Explain): _____		
<b>FOR EMPLOYER / ADMINISTRATOR USE ONLY:</b> 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: _____

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