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

**PLEASE PRINT**

**Section A: Enrollee Information (all fields are required)**

**Employer Name:** Pearl River Community College

| 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: | Coverage Type: | Coverage Option: (Choose Only One) | Do you have Medicare? ☐ Yes ☐ No |
|---|---|---|---|
| ☐ Employee - Legacy | ☐ Enrollee Only | ☐ Base | Medicare Number: _____ |
| ☐ Employee - Horizon | ☐ Enrollee + Spouse | | ☐ "A" Effective Date: _____ |
| ☐ Retiree | ☐ Enrollee + Child | ☐ Select | ☐ "B" Effective Date: _____ |
| ☐ COBRA | ☐ Enrollee + Children | | Reason for Entitlement: |
| ☐ Surviving Spouse | ☐ Enrollee + Spouse & Child(ren) | | ☐ 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 ☐ 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:** _____