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

PLEASE PRINT

Section A: Enrollee Information (all fields are required)

Employer Name				
Social Security Number	**First Name**	**MI**	**Last Name**	
Home Address		**City**	**State**	**ZIP**
Primary Telephone Number	**Secondary Telephone Number**	**Personal Email Address**		
Marital Status ☐ Single ☐ Married	**Gender** ☐ Male ☐ Female	**Date of Birth (mm/dd/yyyy)**	**Date of Employment/Retirement**	

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	◯ Select	**Medicare Number:** _____
☐ Employee - Horizon	☐ Enrollee + Spouse	◯ Base (HIGH DEDUCTIBLE)	☐ "A" Effective Date: _____
☐ Retiree	☐ Enrollee + Child		☐ "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: _____

Print

Base Coverage

	In-Network	Out-of-Network
Calendar Year Deductible - Individual Coverage	$1,800	
Calendar Year Deductible - Family Coverage	$3,000	
Coinsurance/Co-payment Maximum - Individual Coverage	$2,500	$4,000
Coinsurance/Co-payment Maximum - Family Coverage	$5,000	$8,000

Under Base Coverage, there is no separate deductible for prescription drugs. If you have employee only coverage, you must meet the individual deductible ($1,800) before the Plan begins paying benefits for medical and/or prescription drugs. For employees with dependent/family coverage, there is no individual deductible or coinsurance/co-payment maximum; rather, the family deductible ($3,000) must be met before any benefits (medical and/or prescription drugs) will be paid.

After the appropriate deductible ($1,800 or $3,000) under Base Coverage has been met, the Plan will pay 80% of allowable charges for covered medical services when you use participating providers. Prescription drug co-payments will apply after the deductible is met.

Once an individual with employee only coverage has paid the coinsurance/co-payment maximum ($2,500 or $4,000), benefits will be paid at 100% of the allowable charge. For participants with family coverage, benefits will be paid at 100% of the allowable charge after the family coinsurance/co-payment maximum ($5,000 or $8,000) has been met.

The State pays 100% of the active employee premium for employees enrolled in Base Coverage.

Select Coverage

	In-Network	Out-of-Network
Calendar Year Deductible - Individual Coverage	$1,000	$2,000
Calendar Year Deductible - Family Coverage	$2,000	$4,000
Individual Medical Coinsurance Maximum	$2,500	$3,500
Individual Prescription Drug Deductible	$75	

Under Select Coverage, there are separate deductibles for medical and prescription drug benefits. The prescription drug benefit deductible ($75) is applied on an individual basis, regardless as to whether the employee has employee only or family coverage. Once a covered individual has met his/her prescription drug deductible, co-payments ($12, $45, or $70) will apply.

If you have employee only coverage, you must meet the individual deductible ($1,000) before the Plan begins paying benefits for covered medical services. For employees with dependent/family coverage, all covered participants in the family will have satisfied their medical deductibles once a family has paid the family deductible ($2,000 or $4,000).

After the appropriate deductible has been met, the Plan will pay 80% of allowable charges for covered medical services when you use participating providers. Once the individual medical coinsurance maximum is met, benefits will pay at 100% of the allowable charge for all covered medical services for that individual. There is no family coinsurance maximum under Select Coverage. The prescription drug deductible and co-payment amounts will not apply toward the medical calendar year deductible or coinsurance maximum.

Doctor Office Visit Co-pay of $25.00 (Select coverage only)