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
UNIVERSITY OF MISSISSIPPI

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		01/19/2021

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 ☐ Employee - Horizon ☐ Retiree ☐ COBRA ☐ Surviving Spouse	☐ Enrollee Only ☐ Enrollee + Spouse ☐ Enrollee + Child ☐ Enrollee + Children ☐ Enrollee + Spouse & Child(ren)	◯ Select ◯ Base (HIGH DEDUCTIBLE)	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 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 AND SCHOOL EMPLOYEES' LIFE INSURANCE PLAN
ENROLLMENT/CHANGE REQUEST FORM

Underwritten by Minnesota Life Insurance Company, an affiliate of Securian Financial Group, Inc.

Policy 33683-G

SECTION A: Employee/Employer Information

Employee/Retiree Last Name:	First Name:	MI:	Social Security Number:	Birthdate: (MM/DD/YYYY):
Employee/Retiree Home Address:			Email Address:	Home Phone: Alternate Phone:
Employer Name: UNIVERSITY OF MISSISSIPPI				Employer Phone: (662) 915-7431
Employer Address: PO Box 1848, University, MS 38677				

SECTION B: Coverage (NOTE: For more information on available coverage, contact Minnesota Life toll free at 877-348-9217)

ACTIVE FULL-TIME EMPLOYEE: Life benefits and Accidental Death and Dismemberment (AD&D) maximums are based on two times the employee's annual wage rounded to the next higher one thousand dollars, subject to a minimum of $30,000 and a maximum of $100,000. The employee and employer each pay 50 percent of the monthly premium.

☐ **New Employee** – Applications made within initial 31 days of employment; coverage becomes effective on the first day of employment.

Late Enrollee Applicant – Applications made after initial 31 days of employment will be subject to medical evidence of insurability; coverage will become effective on the first day of the month after or coincident with date of approval by Minnesota Life. (**Employee must also complete the Minnesota Life *GROUP LIFE INSURANCE EVIDENCE OF INSURABILITY form*.**)

Date of Employment: _____

RETIRED EMPLOYEE: Life benefit amounts are limited to $5,000, $10,000 or $20,000. Retired employees are not eligible for AD&D benefits. A retired employee should apply before, but no later than 31 days after the date active employee coverage terminates. A retiree pays 100 percent of the monthly premium.

Date of Retirement: _____ **COVERAGE AMOUNT REQUESTED:** **$5,000** **$10,000** **$20,000**

DISABLED EMPLOYEE: Life benefit amounts are equal to employee's current benefit level at the time coverage ceases as an active employee. Disabled employees must apply no later than 31 days from the date active employee coverage terminates. Minnesota Life is solely responsible for evaluating applications for coverage continuation. Premiums are waived after the first nine months.

(Employee must also complete the Minnesota Life *NOTICE OF DISABILITY* and *ATTENDING PHYSICIAN'S STATEMENT* forms.)

Date of Disability: _____

SECTION C: Beneficiary Information

NOTE: You cannot designate your life insurance beneficiary on this form. To designate your life insurance beneficiary, please follow the instructions below:

1. Log in to your *my*Blue site, **https://myblue.bcbsms.com**, and click on the My Benefits tab.
2. Scroll down to the Life Benefits section below Medical Benefits. This section will show you the effective date and amount of life insurance coverage you have.
3. Click the link in the Life Benefits section and you will be redirected to Minnesota Life's online beneficiary management tool. Follow the instructions on the site to submit your beneficiary designation.

Once you submit your beneficiary information, a confirmation statement will be mailed to you. You may view or update your beneficiary information any time by accessing Minnesota Life's website through the *my*Blue portal.

If you do not designate a life insurance beneficiary, any resulting life insurance benefits will be paid according to the defaults set forth in the policy.

If you do not have Internet access, contact Minnesota Life toll free at **877-348-9217** to request a paper beneficiary designation form.

Employee/Retiree Last Name	First Name	MI	Social Security Number	Daytime Phone

SECTION D: Authorization and Certification

I am applying for group term life insurance for myself through the State and School Employees' Life Insurance Plan (Plan). I understand that if my application is approved, coverage will become effective on the date fixed by the Plan or Minnesota Life. I certify that all information on this form is true and complete to the best of my knowledge and belief. I understand that this insurance is subject to all of the terms of the Plan of Insurance contained in the Minnesota Life Insurance Company, Group Policy #33683-G, and summarized in the Certificate of Coverage provided to me. I understand that any misrepresentation by me may result in the cancellation or rescission of coverage under the Plan.

I understand that if I am a late enrollee applicant, any insurance subject to evidence of good health or medical information will not become effective until Minnesota Life gives its written consent. I understand that my eligibility may be affected in the event I fail to sign this form within 31 days of the effective date of eligibility, or if for any reason my employer does not receive the *Enrollment/Change Request Form* within a reasonable time following the event.

I understand and authorize that the appropriate premiums for the coverage requested will be deducted from my wages or retirement benefits, as appropriate, and authorize release of employment and payroll information or other such eligibility information to the Plan and/or Minnesota Life as needed to verify my eligibility, benefit amounts, or other such information necessary in the proper administration of the Plan.

Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

_____ _____

Employee/Retiree Signature (Required) **Date**

SECTION E: Waiver/Request to Cancel Coverage (Only complete this section to waive or cancel coverage.)

☐ **Waiver of Coverage** – I hereby decline to apply for life insurance coverage in the State and School Employees' Life Insurance Plan. I understand that an active employee who waives coverage in the Plan may apply for coverage at a later date so long as he continues to qualify as an active employee. I further understand that late enrollee applicants are subject to medical evidence of insurability that may result in coverage being denied. I understand that a service retired employee or totally disabled employee who declines to apply for continuation of coverage in the Plan within 31 days of the date his coverage ceases as an active employee, forfeits his right to participate in the State and School Employees' Life Insurance Plan and will not be allowed to apply at a later date.

Cancellation of Coverage – I hereby request that my life insurance coverage in the State and School Employees' Life Insurance Plan be cancelled. I understand that an active employee who cancels his coverage in the Plan may apply for coverage at a later date so long as he continues to qualify as an active employee. I further understand that late enrollee applicants are subject to medical evidence of insurability that may result in coverage being denied. I understand that a service retired employee or totally disabled employee who cancels his coverage in the Plan forfeits his right to participate in the State and School Employees' Life Insurance Plan and will not be allowed to apply at a later date.

SIGN BELOW ONLY IF YOU DO NOT WANT LIFE INSURANCE COVERAGE.

_____ _____

Employee/Retiree Signature **Date**

FOR QUESTIONS REGARDING THE STATE AND SCHOOL EMPLOYEES' LIFE INSURANCE PLAN, VISIT THE PLAN'S WEBSITE AT http://KnowYourBenefits.dfa.ms.gov/ OR CONTACT THE DFA-OFFICE OF INSURANCE AT 866-586-2781.

FOR PERSONNEL/PAYROLL USE ONLY			
COVERAGE AMOUNT:	REQUESTED EFFECTIVE DATE:	GROUP NUMBER:	INFORMATION VERIFIED: (INITIAL AND DATE)

The University of Mississippi: Benefit Enrollment/Change Form

Employee Name:	**Date of Hire:**
Address:	**Status:** ☐ **9-Month** ☐ **12-Month**
City/State/Zip:	**Home Phone:**
SSN: **University ID Number:**	**Work Phone:**
Date of Birth: **Gender:** ☐ **Male** ☐ **Female** ☐ **Undeclared**	**Is your spouse employed by the University of Mississippi:** ☐ **Yes** ☐ **No**
Email Address: **Marital Status:**	**If yes, provide name:**

Check One: ☐ **New Hire** ☐ **Legal Marriage/Divorce** ☐ **Birth/Adoption/Foster Care** ☐ **Ineligible Dependent** ☐ **Open Enrollment**
☐ **Other Status Change** ________________________ ☐ **Date of Qualifying Event** _______________

University employees are paid twice a month. Premium deductions for 12-month employees occur over 24 pay periods and for a 9-month faculty member over 18 pay periods. **Pay Mode: Semi-Monthly**

Spouse/Dependent Information – List all dependents you wish to cover or drop from the insurance plans you have selected. Check all benefits that apply.

Name (Last, First, MI)	Social Security Number	M/F	Birth Date	Relationship	Disabled Dependent (yes/no)	Drop/Add	Dental	Vision	Flexible Spending Account	Accidental Death & Dismemberment	Long-term Disability	UNUM Life	Am. Heritage (Cancer & Intensive Care)	Life of Alabama (Cancer/Intensive Care)
							☐	☐	☐	☐	☐	☐	☐	☐
							☐	☐	☐	☐	☐	☐	☐	☐
							☐	☐	☐	☐	☐	☐	☐	☐
							☐	☐	☐	☐	☐	☐	☐	☐
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							☐	☐	☐	☐	☐	☐	☐	☐
							☐	☐	☐	☐	☐	☐	☐	☐

Dental - Delta Dental (Group #1126)

Premiums are withheld 12-Month / 9-Month

Section 125 Cafeteria Plan

	Employee Only 12-month / 9-month	Family 12-month / 9-month
Low Plan (division: 00002)	☐ $28.81 / $38.42	☐ $60.12 / $80.16
High Plan (division: 00001)	☐ $41.57 / $55.42	☐ $86.49/ $115.32

FOR HUMAN RESOURCES ONLY
Effective Date: _______________

Are you or your family member(s) currently covered under another dental plan: ☐ **Yes** ☐ **No**

If yes, provide the name of the participant(s) with other coverage. ____

☐ **Waive/Cancel Coverage**

Vision – Davis Vision (Group: UMM)

Premiums are withheld 12-Month / 9-Month

Section 125 Cafeteria Plan

Employee Only (12-month / 9-month)	Employee + 1 (12-month / 9-month)	Family (12-month / 9-month)
☐ $7.80 / $10.40	☐ $14.08 / $18.77	☐ $21.89 / $29.19

☐ **Waive/Cancel Coverage**

FOR HUMAN RESOURCES ONLY
Effective Date: _______________

The University of Mississippi: Benefit Enrollment/Change Form

Flexible Spending Accounts (FSA)

Contributions are withheld 12-Month / 9-Month *Section 125 Cafeteria Plan*

Annual Election

Dependent Care Spending Account ☐ $ _____
(annual election per family: $5,000)

Unreimbursed Medical Spending Account ☐ $ _____
(annual election per individual: $2,750)
Prescription FlexCard ☐ Yes ☐ No

FOR HUMAN RESOURCES ONLY

$_____ pay period election (D/C)
$_____ pay period election (M/R)

Effective Date: _____

☐ Waive Participation (To cancel participation in an existing plan, write '0' in the blank next to the respective plan type.)

Accidental Death and Dismemberment – National Union Fire Insurance Company of Pittsburgh #PAI9032465

Section 125 Cafeteria Plan

Amount of coverage available is a minimum of $10,000 and a maximum of $250,000 (in $10,000 increments), with amounts above $150,000 not to exceed 10x base salary. If you insure your spouse and/or dependent children under this plan, the amount of insurance applicable to the members of your family is based on the composition of your family at the time of loss and is expressed as a percentage of the employee's coverage.

☐ Employee Only ☐ Family Coverage Amount: **$**_____

☐ Waive/Cancel Coverage

FOR HUMAN RESOURCES ONLY

12-Month Cost / 9-Month Cost **$**_____

Effective Date: _____

Beneficiary Designation: Accidental Death & Dismemberment is a life insurance policy. Please make sure you designate a beneficiary(ies) by completing the ***AD&D Beneficiary Designation Form*** that can be accessed at http://hr.olemiss.edu/benefits/forms/. The designation form should be submitted to Human Resources via fax (662-915-5836) or campus mail/drop off at Human Resources, Jackson Avenue Center – Central. It is your responsibility to ensure forms are received by Human Resources. The employee is beneficiary for dependent coverage unless otherwise indicated.

Long-Term Disability (LTD) – Standard Insurance Company

You may elect disability coverage of 60% of your base salary up to $5,000 per month, until age 65. Benefits are payable after a 90 or 180 day elimination period subject to review by The Standard Insurance Company. *Pre-Existing Limitation may apply. **Guarantee Issue only applies to new hires and employees newly eligible for benefits. If you waive coverage when first eligible and wish to enroll later, Evidence of Insurability will be required and The Standard Insurance Company has the right at that time to refuse the request for coverage.

Premiums are withheld 12-Month / 9-Month

☐ Plan 1 (90-day option) ☐ Plan 2 (180-day option)

☐ Waive/Cancel Coverage

FOR HUMAN RESOURCES ONLY

Base Annual Earnings **$**_____

Position Title: _____

Hours Worked Per Week: _____

Effective Date: _____

Supplemental Term Life with AD&D – UNUM

Premiums are withheld 12-Month / 9-Month

** Guarantee Issue only applies to new hires and employees newly eligible for benefits. If you waive coverage when first eligible and wish to enroll later, Evidence of Insurability must be provided and UNUM has the right at that time to refuse the request for coverage.

Employee Coverage ** Amounts above $200,000 or 3 times salary, whichever is less, require Evidence of Insurability.

Employee Coverage

☐ 1X Salary ☐ 2X Salary ☐ 3X Salary

☐ 4X Salary ☐ 5X Salary ☐ 6X Salary

Maximum coverage available is 6X your annual base salary rounded to the Next higher multiple of $1,000 to a maximum of $600,000

☐ Waive Employee Coverage

FOR HUMAN RESOURCES ONLY

Annual Salary $ _____

Coverage Amount $_____ 12-Month / 9-Month Cost $_____

Effective Date: _____

Spouse Coverage ** Amounts above $25,000 require Evidence of Insurability. Spouse coverage cannot exceed 50% of the employee's approved coverage rounded own to the nearest $25,000.

.

☐ $25,000 ☐ $50,000 ☐ $75,000 ☐ $100,000

☐ Waive Spouse Coverage

FOR HUMAN RESOURCES ONLY

Coverage Amount $_____ 12-Month / 9-Month Cost $_____

Effective Date: _____

Dependent Child(ren) Coverage - All children are covered from birth to 6 months for $5,000 and at $10,000 from 6 months to age 19, or 25 if full-time student.

☐ Elect Coverage

☐ Waive Dependent Child(ren) Coverage

FOR HUMAN RESOURCES ONLY

12-Month / 9-Month Cost $_____

Effective Date: _____

Beneficiary Designations

UNUM is the administrator for beneficiary designation information. New plan participants will receive a letter and ***Beneficiary Designation Form*** from UNUM within one month of enrollment. By completing the form, you are designating the person(s) who will receive the payment if a UNUM life insurance claim is filed. Upon completion, the form must be returned directly to UNUM via email or fax. Instructions will be provided in the letter and on the form. Current participants may contact Client Service Associates at 1-866-220-8460 to verify beneficiary information on file with UNUM or make changes to their designation.

**If you do not designate a beneficiary, the payment of benefits will default to provisions of the contract.*

Delayed Effective Date ***Employee:*** Insurance will be delayed for Employees not actively at work until the first of the month following the date they return to work. Regularly scheduled vacation time is considered active employment. ***Dependent:*** Coverage for totally disabled dependents will be delayed until the first of the month following the date the individual is no longer totally disabled.

Policy Limitations and Exclusions **I understand all the policy exclusions and limitations listed in the certificate of coverage.** If electing to participate in any of the benefit plans mentioned above, I authorize the required payroll deductions. I understand that my payroll deduction amount will change if my coverage or costs change. I understand that if I cancel/decline participation, I may join the Plan at a specified later date; however, I will be required to provide evidence of insurability at my own expense, and the insurance company may refuse my request. In the event of any variations between this form and the Plan document, the terms of the Plan document will prevail.

Cancer/Dreaded Disease & Intensive Care - American Heritage (Underwritten by AllState)

Premiums are withheld 12-Month / 9-Month *Section 125 Cafeteria Plan*

This plan is subject to underwriting. Those electing coverage will be contacted by a representative of the William Morris Group or AllState to complete a medical health statement. Failure to complete the medical health statement in a timely manner or declination from underwriting will result in non-issuance of the policy. Premium is based upon age at time of election.

Select only one plan type. (CP12 plan)

	Employee Only 12-month / 9-month	Family 12-month / 9-month
Plan 1 and 2 (Low Option)		
Base – No Intensive Care		
Age 18 - 64	☐ $11.29 / $15.06	☐ $22.71 / $30.28
Age 65 - 69	☐ $25.92 / $34.56	☐ $54.07 / $72.10
Age 70 - 74	☐ $29.91 / $39.88	☐ $62.56 / $83.42
Age 75 - 80	☐ $32.82 / $43.76	☐ $68.71 / $91.62
Plan 1+ (Low Option)		
$400 per day Intensive Care		
Age 18 - 64	☐ $12.81 / $17.08	☐ $26.56 / $ 35.42
Age 65 - 69	☐ $28.13 / $37.52	☐ $59.28 / $ 79.04
Age 70 - 74	☐ $32.23 / $42.98	☐ $67.97 / $ 90.64
Age 75 - 80	☐ $35.54 / $47.40	☐ $75.04 / $100.06
Plan 2+ (Low Option)		
$600 per day Intensive Care		
Age 18 - 64	☐ $13.57 / $18.10	☐ $28.49 / $ 38.00
Age 65 - 69	☐ $29.24 / $39.00	☐ $61.89 / $ 82.52
Age 70 - 74	☐ $33.39 / $44.52	☐ $70.68 / $ 94.24
Age 75 - 80	☐ $36.90 / $49.20	☐ $78.21 / $104.28
Plan 3 and 4 (High Option)		
Base – No Intensive Care		
Age 18 - 64	☐ $21.21 / $28.28	☐ $ 42.71 / $ 56.96
Age 65 - 69	☐ $48.90 / $65.20	☐ $102.35 / $136.48
Age 70 - 74	☐ $56.39 / $75.20	☐ $118.38 / $157.84
Age 75 - 80	☐ $61.82 / $82.44	☐ $129.89 / $173.20
Plan 3+ (High Option)		
$400 per day Intensive Care		
Age 18 - 64	☐ $22.73 / $30.32	☐ $ 46.56 / $ 62.08
Age 65 - 69	☐ $51.11 / $68.16	☐ $107.56 / $143.42
Age 70 - 74	☐ $58.71 / $78.28	☐ $123.79 / $165.06
Age 75 - 80	☐ $64.54 / $86.06	☐ $136.22 / $181.62
Plan 4+ (High Option)		
$600 per day Intensive Care		
Age 18 - 64	☐ $23.49 / $31.32	☐ $ 48.49 / $ 64.66
Age 65 - 69	☐ $52.22 / $69.64	☐ $110.17 / $146.90
Age 70 - 74	☐ $59.87 / $79.84	☐ $126.50 / $168.68
Age 75 - 80	☐ $65.90 / $87.88	☐ $139.39 / $185.86

☐ **Waive/Cancel Coverage**

FOR HUMAN RESOURCES ONLY

Effective Date: _____

The University of Mississippi: Benefit Enrollment/Change Form

Cancer/Dreaded Disease & Intensive Care – Life of Alabama

Premiums are withheld 12-Month / 9-Month *Section 125 Cafeteria Plan*

This plan is subject to underwriting. Those electing coverage will be contacted by a representative of Life of Alabama to complete a medical health statement. Failure to complete the medical health statement in a timely manner or declination from underwriting will result in non-issuance of the policy. Premiums are withheld 12-Month / 9-Month *Section 125 Cafeteria Plan*

Cancer and Dreaded Disease Options: Select only one cancer plan type.

	Employee Only 12-month / 9-month	1 Parent Family 12-month / 9-month	Employee & Spouse 12-month / 9-month	2 parent Family 12-month / 9-month
Low Option	☐ $21.45 / $28.60	☐ $24.91 / $33.22	☐ $41.47 / $55.30	☐ $43.31 / $57.74
High Option	☐ $39.32 / $52.42	☐ $45.82 / $61.10	☐ $76.12 / $101.50	☐ $79.62 / $106.16

☐ **Waive/Cancel Cancer/Dreaded Disease Coverage**

Intensive Care Options: Select only one intensive care plan type.

	Employee Only 12-month / 9-month	1 Parent Family 12-month / 9-month	Employee & Spouse 12-month / 9-month	2 parent Family 12-month / 9-month
$300 per day ICU	☐ $3.68 / $ 4.91	☐ $3.96 / $ 5.28	☐ $ 5.66 / $ 7.55	☐ $ 6.74 / $ 8.99
$600 per day ICU	☐ $7.36 / $ 9.82	☐ $7.92 / $10.56	☐ $11.32 / $15.10	☐ $13.48 / $17.98
$750 per day ICU	☐ $9.20 / $12.27	☐ $9.90 / $13.20	☐ $14.15 / $18.87	☐ $16.85 / $22.47

☐ **Waive/Cancel Intensive Care Coverage**

FOR HUMAN RESOURCES ONLY

Effective Date: _____

I acknowledge that I voluntarily and without coercion made elections/waivers as documented on this form. I understand my salary will be reduced by the amount(s) shown on this enrollment form for the eligible benefit options I have elected and since premiums are collected one month in advance, the University will collect premiums in arrears as an additional payroll deduction. If my salary reduction for the elected insurance benefit(s) are increased or decreased while this agreement remains in effect, my salary will automatically be adjusted to reflect the change.

Cafeteria Plan elections will be irrevocable for the Plan Year except for modifications due to a qualifying event (divorce, marriage, death of spouse/dependent child, birth/adoption of a child, change of employment status of me or my spouse, cost of coverage/change, HIPAA special enrollment rights, or other event specified by the IRS provided I complete enrollment paperwork with the Department of Human Resources to request the election change within 60 days after the date of the qualifying event. Prior to each Plan Year, I will be given the opportunity to change my benefit election. If I fail to complete and submit to the Department of Human Resources a new election form within the allotted enrollment period, I understand my election will remain the same.

I understand my social security benefits may be reduced due to my participation in the Cafeteria Plan. My employer may reduce or cancel the amount of my salary reduction or otherwise modify this agreement in order to satisfy certain provisions of the Internal Revenue Code.

I understand my elected benefits will cease upon my termination of employment but will be afforded an opportunity to continue coverage via COBRA for qualifying plans.

If I participate in dependent care, reimbursements cannot exceed the amount incurred during the Plan Year. If I participate in an unreimbursed medical expense plan, I may be reimbursed for qualifying out-of-pocket medical expenses. Claims must be filed with Southern Administrators and Benefit Consultants (SABC) no later than 60 day into the subsequent Plan Year. Any account balance in excess of the $500 rollover processed after the 60-day grace period will be forfeited.

I understand that privacy statements are available via the University website at http://hr.olemiss.edu/benefits/. If I do not have access to the internet, I can request a paper copy from the Department of Human Resources. As an employee, I acknowledge that I am the subscriber of coverage, and that the Privacy Policy is also applicable to my spouse and/or my dependents. I also understand I will be reissued the Privacy Statement, as a material modification is made, and every three years, via the University's email system.

This election and salary reduction agreement is subject to the terms of my employer's cafeteria plan document.

EMPLOYEE SIGNATURE _____ **DATE SIGNED** _____

PERS of MISSISSIPPI

Membership Application

Form 1 – Revised 07/01/2016

Please print or type in black ink. Completed form should be mailed or faxed to PERS. See bottom of form for contact information.

❶ Member Information – *Attach a copy of the member's Social Security card.*

First Name: _____ MI: _____ Last Name: _____ Gender: ☐ M ☐ F

Provide previous name, if applicable. First Name: _____ MI: _____ Last Name: _____

Social Security No.: _____ Birth Date *mm/dd/ccyy*: _____ E-Mail: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ ☐ Cellular ☐ Home ☐ Work Phone: _____ ☐ Cellular ☐ Home ☐ Work

Have you previously served on active duty in the U.S. Armed Forces? *If yes, attach Form(s) DD214* ..... ☐ Yes ☐ No

Have you ever been a member of the Optional Retirement Plan (ORP) for Institutions of Higher Learning in the State of Mississippi? ..... ☐ Yes ☐ No

❷ Retirement Plan – Plans are governmental defined benefit plans qualified under Section 401(a) of the Internal Revenue Code. *Select applicable plan.*

■ Public Employees' Retirement System of Mississippi (PERS) ☐ Mississippi Highway Safety Patrol Retirement System (MHSPRS)

☐ Supplemental Legislative Retirement Plan (SLRP)

❸ Family Information – *Use additional* Membership Applications *if listing more than four dependent children. Information is for determining statutory benefits only. Use Form 1B,* Beneficiary Designation, *to officially designate any and all beneficiaries.*

Marital Status – *Select one. Add date for last three.* ☐ Single ☐ Married ☐ Divorced ☐ Widowed Effective Date *mm/dd/ccyy:* _____

Spouse's Full Name	**Social Security No.**	**Birth Date** *mm/dd/ccyy*	**Wedding Date** *mm/dd/ccyy*	**Gender**
				☐ M ☐ F

Dependent Child's Full Name – *Up to age 19, or 23 if unmarried and a full-time student*	**Social Security No.**	**Birth Date** *mm/dd/ccyy*	**Relationship**	**Gender**
				☐ M ☐ F
				☐ M ☐ F
				☐ M ☐ F
				☐ M ☐ F

❹ Member Certification – *If an authorized representative signs this form, attach a copy of the durable power of attorney, conservatorship or guardianship papers, or other legal documents as proof of authority to sign this form.*

Member's Signature: _____ Date *mm/dd/ccyy*: _____

❺ Employer Certification – *This section must be completed by an authorized employer representative, not the member.*

Member's Position Held/Job Title: _____ **Member's Hire Date** *mm/dd/ccyy:* _____

Member's Status: Elected Official: ☐ Yes ■ No Fee Paid Official: ☐ Yes ■ No Public Safety Employee: ☐ Yes ■ No

Employer Name: UNIVERSITY OF MISSISSIPPI Employer No.: 0001 - 034

Employer Representative's Name: Sherelyn Gooch Employer Representative's Title: HR Generalist

Employer Representative's Phone: (662) 915-1203 Fax: (662) 915-5836 E-Mail: stgooch@olemiss.edu

As employer representative, I certify that employment in this position meets the eligibility requirements of PERS Board of Trustees Regulation 25, *Eligibility of Part-time Employees for State Retirement Annuity Service Credit*, and PERS Board of Trustees Regulation 36, *Eligibility for Membership in the Public Employees' Retirement System of Mississippi (PERS)*.

Employer Representative's Signature: _____ Date *mm/dd/ccyy*: _____

Public Employees' Retirement System of Mississippi
429 Mississippi Street, Jackson, MS 39201-1005 800.444.7377 601.359.3589 601.359.5262, *fax* www.pers.ms.gov

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Beneficiary Designation

Form 1B – Revised 07/01/2016

Please print or type in black ink. Completed form should be mailed or faxed to PERS. See bottom of form for contact information.

❶ Member/Retiree Information

First Name: _____ MI: _____ Last Name: _____ ■ Member ☐ Retiree

Social Security No.: _____ Birth Date *mm/dd/ccyy*: _____ Gender: ☐ M ☐ F

❷ Retirement Plan – Plans are governmental defined benefit plans qualified under Section 401(a) of the Internal Revenue Code. *Select applicable plan.*

☐ Public Employees' Retirement System of Mississippi (PERS) ☐ Mississippi Highway Safety Patrol Retirement System (MHSPRS)

☐ Supplemental Legislative Retirement Plan (SLRP)

❸ Beneficiary Information – *Use additional Form 1B,* Beneficiary Designation, *to designate additional beneficiaries. If more than one primary beneficiary is named, the primary beneficiaries shall share equally unless otherwise indicated. Likewise, if more than one secondary beneficiary is named, the secondary beneficiaries shall share equally unless otherwise indicated. Total primary and secondary beneficiary percentages must equal 100 percent.*

Beneficiary Name	**Social Security No.**	**Birth Date** *mm/dd/ccyy*	**Relationship**	**Beneficiary Percentage** *P=Primary, S=Secondary Use whole numbers*	**Gender**
				☐ P ☐ S _____ %	☐ M ☐ F
				☐ P ☐ S _____ %	☐ M ☐ F
				☐ P ☐ S _____ %	☐ M ☐ F
				☐ P ☐ S _____ %	☐ M ☐ F
				☐ P ☐ S _____ %	☐ M ☐ F

❹ Member/Retiree Certification – *Check applicable acknowledgement then sign. If an authorized representative signs this form, attach a copy of the durable power of attorney, conservatorship or guardianship papers, or other legal documents as proof of authority to sign this form.*

■ **Member** – I acknowledge and understand that the PERS Board of Trustees is authorized to pay benefits in accordance with the statutory provisions that govern the retirement system in which I am a member. To the extent permitted by such statutory provisions at the time of my death prior to retirement, I hereby designate the above beneficiary(ies) to receive the payment of my accumulated contributions and any interest relating thereto. I further acknowledge and understand that certain benefits may be required by law to be paid that may limit, partially or totally, any payment to my designated beneficiary(ies).

☐ **Retiree –** I hereby designate the above beneficiary(ies) to receive any residual amount payable by reason of my death and the death of my joint annuitant(s), if applicable.

Member/Retiree's Signature: _____ Date *mm/dd/ccyy*: _____

❺ Employer Certification – *This section must be completed by an authorized employer representative, not the member. Only complete for active members.*

Employer Name: UNIVERSITY OF MISSISSIPPI Employer No.: 0001 - 034

Employer Representative's Name: Sherelyn Gooch Employer Representative's Title: HR Generalist

Employer Representative's Phone: (662) 915-1203 Fax: (662) 915-5836 E-Mail: _____

Employer Representative's Signature: _____ Date *mm/dd/ccyy*: _____

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