Human Resources

JPS
Building Tomorrow Today

Telephone (601) 960-8742
Facsimile (601) 960-8751

To: ALL CURRENT JPS EMPLOYEES

When making changes to your address and/or name the following forms will need to be completed:

- **State and School Employees' Health Insurance Plan**
- **PERS – Change of Information Form**

INSTRUCTIONS:

Please complete the following areas on the State and School Employees' Health Insurance Plan Application for Coverage Form:

- **Section A**
- **Section B**
- **Last part of Section E that states "Other Changes"**

Please complete the following areas on the PERS – Change of Information Form:

- **Section 1**
- **Section 2**
- **Section 4**

Upon completion, please sign, date and mail back to the Office of Human Resources via pony mail.

If you have any questions, please contact the Office of Human Resources at (601) 960-8745.

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

CHANGE OF ADDRESS

PLEASE PRINT

Section A: Enrollee Information (all fields are required)

Social Security Number	First Name	MI	Last Name	
Home Address	City		State	ZIP
Primary Telephone Number	Secondary Telephone Number		Email Address	
Marital Status ❑ Single ❑ Married	Sex ❑ Male ❑ Female	Date of Birth (MMDDYYYY)	Date of Employment/Retirement	

Were you ever a full-time employee of a covered entity under the State and School Employees' Health Insurance Plan (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 participant in the PLAN? ❑ Yes ❑ No

If Yes, please provide your spouse's name and Social Security Number: _____

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 plan, 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	OR	❑ "A" Effective Date _____
❑ Retiree	❑ Enrollee + Child	❑ Base (HIGH DEDUCTIBLE)	❑ "B" Effective Date _____
❑ COBRA	❑ Enrollee + Children		Reason for Entitlement:
❑ Surviving Spouse	❑ Enrollee + Spouse & Child(ren)		❑ Age ❑ ESRD ❑ Disability

Section D: Other Coverage Information

Do any of the persons listed on this application have other health insurance coverage? ❑ No ❑ Yes If Yes, please provide the following information:

	1.	2.	3.	4.
Name of Individual Covered:				
Policyholder's Name:				
Policyholder's Date of Birth:				
Policy Number:				
Policyholder's Employment Status (Circle):	Active, Retiree or COBRA	Active, Retiree or COBRA	Active, Retiree or COBRA	Active, Retiree or COBRA
Insurance Company Name address & phone #:				
Coverage Type (Circle):	Group or Non-Group	Group or Non-Group	Group or Non-Group	Group or 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	Address (if different from Enrollee)	Current Status
1.	❑ Husband ❑ Wife				Employed? ❑ Yes ❑ No
2.	❑ Son ❑ Daughter				❑ Child under 26 ❑ Disabled
3.	❑ Son ❑ Daughter				❑ Child under 26 ❑ Disabled
4.	❑ Son ❑ Daughter				❑ Child under 26 ❑ Disabled
5.	❑ Son ❑ Daughter				❑ Child under 26 ❑ Disabled

Are any of the dependents listed above covered by Medicare Part A or Part B? ❑ **No** ❑ **Yes** **If Yes, please provide the following information:**

NAME	Medicare Number	Part A Effective Date	Part B Effective Date	Medicare Reason

Section F: Change Information

❑ **Add Enrollee**: ❑ Open Enrollment ❑ Marriage ❑ Loss of Coverage due to Divorce ❑ Birth ❑ Adoption

❑ Other _____ **Requested Effective Add Date** _____

❑ **Add Dependent(s)**: ❑ Open Enrollment ❑ Marriage ❑ Birth ❑ Adoption ❑ Other _____

Requested Effective Add Date _____ **IMPORTANT: List all dependents to be covered in Section E.**

❑ **Change Coverage Option to:** ❑ **Base Coverage (HIGH DEDUCTIBLE)** ❑ **Select Coverage**

❑ **Drop Dependent(s)**: ❑ Divorce ❑ Deceased ❑ Other _____

List all dependents to be dropped and provide the requested information in the spaces below:

NAME	SOCIAL SECURITY NUMBER	REQUESTED TERMINATION DATE

❑ **Other Changes** (Explain): chg of Address

FOR EMPLOYER / ADMINISTRATOR USE ONLY: GROUP NUMBER: 1273

❑ New Legacy Employee, Requested Effective Date _____ ENTERED BY: _____

❑ New Horizon Employee, Requested Effective Date _____ DATE: _____

❑ Retiree, Requested Effective Date _____

❑ COBRA, Requested Effective Date _____ VERIFIED BY: _____

❑ Surviving Spouse, Requested Effective Date _____ DATE: _____

❑ Change(s), Requested Effective Date _____

PERS of MISSISSIPPI

Change of Information

Form 1C – Revised 7/27/2010

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

1 Member/Benefit Recipient Information – *Fill in your name as currently filed with PERS and use sections 2 and 3 to submit new information before certifying information in Section 4.*

First Name: _____ MI: _____ Last Name: _____ ☐ Member ☐ Benefit Recipient

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

2 Change of Member/Benefit Recipient Information – *Check items to be updated then fill in only applicable information.*

To Change	New Information	Effective Date *mm/dd/ccyy*: _____
____ Name	First Name: _____ MI: _____ Last Name: _____	
____ Address	Mailing Address: _____ City: _____ State: _____ Zip: _____	
____ Phone	_____	☐ Cellular ☐ Home ☐ Work
____ Phone	_____	☐ Cellular ☐ Home ☐ Work
____ Phone	_____	☐ Cellular ☐ Home ☐ Work
____ E-Mail	_____	
____ Marital Status	*Select one and attach a copy of the marriage, divorce, or death certificate.*	☐ Married ☐ Divorced ☐ Widowed

3 Change of Family Information – *Use additional Form 1C,* Change of Information, *if listing more than five dependent children. Information is for determining statutory benefits only. Use Form 1B,* Beneficiary Designation, *to officially designate any and all beneficiaries.*

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

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

4 Member/Benefit Recipient Certification – ***Active members*** *should sign and submit form to employer for completion of Section 5. Employers will be responsible for submitting completed form to PERS, if necessary.* ***Inactive members and benefit recipients*** *should sign and submit form directly to PERS, as Section 5 is not applicable to these individuals.*

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

5 Employer Certification – *This section must be completed by an authorized employer representative, not the member. Employer certification of name change is required for active members to ensure consistency in the name used for reporting PERS, Social Security, and W-2 wage information.* ***All employee name and address changes must be entered into WEB-ERS.*** *Completion of Section 5 and submission to PERS by employers is only necessary when changes are being made to employee phone number(s), e-mail, marital status, or family information.*

Employer Name: _____ Employer Identification No.: _____

Employer Representative's Name: _____ Employer Representative's Title: _____

Employer Representative's Phone: _____ Fax: _____ E-Mail: _____

As employer representative, I certify that the name change information provided above is consistent with the active member's name used on the employer's records for reporting PERS, Social Security, and W-2 wage information.

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

Public Employees' Retirement System of Mississippi
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