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

PLEASE PRINT

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