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: MISSISSIPPI VALLEY STATE UNIVERSITY Employer No.: 0001 - 035

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

Employer Representative's Phone: (662) 254-3531 Fax: (662) 254-3784 E-Mail: _____

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

Reset Form Print

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: MISSISSIPPI VALLEY STATE UNIVERSITY Employer No.: 0001 - 035

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

Employer Representative's Phone: (662) 254-3531 Fax: (662) 254-3784 E-Mail: _____

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

Reset Form Print

403(b) Salary Deferral and Investment Election Agreement

Mississippi Valley State University

Participant Name	Social Security No.
Address	
City	State / Zip
Date of Birth / Date of Employment / Email Address	
Evening Phone / Day Phone	
Position/Title	☐ Married ☐ Unmarried / ☐ Full Time ☐ Part Time

PARTICIPATION ELECTIONS

Salary Deferral Elections	☐	I hereby apply for Participation in the above-named 403(b) Plan and direct my employer to withhold through payroll reduction the following amounts from each pay. I understand this election will be applied to future contributions only and will remain in effect until I direct new elections through the Plan's Internet or Voice Response System. NOTE: I understand that if I am 50 years of age or will reach the age of 50 during this calendar year any contribution deferrals in excess of the traditional salary will be applied to the Age 50 Catch-up option.
Election to Defer Participation	☐	I do not want to participate in the Plan at this time. I understand that I may change this election by completing a new Enrollment Form prior to the next Plan Entry Date.
Election to Revoke Participation	☐	Please discontinue my Salary Deferral Contributions to the Plan. I understand that I will be able to resume participation by completing a new Enrollment Form prior to the next Plan Entry Date.

I direct my new money to be invested in the funds selected below. I understand these investment directions will remain in effect until I direct new elections through the Plan's web site or voice response system.

Investment Elections

Fund Name	Amount to Roth 403(b) (Per Pay Period)	Amount to Traditional 403(b) (Per Pay Period)
AXA Equitable		
TIAA-CREF		
Variable Annuity Life Insurance Company (VALIC)		
Total	0	0

By signing this Agreement, Employee agrees to modify his/her salary as indicated above and Employer agrees to contribute this amount on Employee's behalf into the 403(b) annuity(ies) or custodial account(s) selected by Employee and authorized by the Employer. It is intended that the requirements of all applicable state and federal tax rules and regulations (Applicable Law) will be met. Employee understands and agrees that this Agreement:

1. Is legally binding and irrevocable with respect to amounts paid or available while it is in effect; however, is effective only for amounts not yet earned or made available.
2. May be terminated at any time for amounts not yet paid or available, and that a termination request is permanent and remains in effect until a new salary reduction agreement is submitted;

Participant Name	Social Security No.

Employee further agrees that:

- In conjunction with his/her Employer, he/she is responsible for determining that his/her salary reduction amount does not exceed the limits of the Applicable Law;
- He/she is responsible for the accuracy of information provided by Employee, which is used in determining Employee's maximum annual contribution limit;
- Employer has no liability for any losses suffered by Employee that result from his/her participation in the 403(b) plan;
- He/she acknowledges that Employer has made no representation to Employee regarding the advisability, appropriateness or tax consequences of the purchase of the 403(b) plan. Nothing herein shall affect the terms of employment between Employer and Employee;
- This agreement supersedes all prior 403(b) salary reduction and/or deduction agreements and shall automatically terminate if employment with Employer is terminated.

Important Information

- Although Employer must authorize Service Providers, Employer does not choose the annuity contract(s) or custodial account(s) in which 403(b) contributions are invested.
- Employees are responsible for setting up and signing the legal documents to establish the annuity contract or custodial account, except for certain group annuity contracts under which Employer may be required to establish the contract.
- In order to receive the expected tax results, Employees are responsible for investing in annuity contracts or custodial accounts that meet the requirements of Section 403(b) of the Internal Revenue Code.
- Employees are responsible for naming a death beneficiary under the 403(b) plan. This is normally done at the time the annuity contract or custodial account is established. Beneficiary designations should be reviewed periodically.
- Employers are responsible for all distributions and any other transactions with the Service Provider. All rights under the annuity contracts or custodial accounts are enforceable solely by Employee, Employee's beneficiary or Employee's authorized representative. However Employer has certain responsibilities under the 403(b) Plan with respect to the integrity of the transactions for the Plan and may require an authorized representative from the Employer (or their Designee) to approve any
- requested transaction by Employees. Employee must cooperate directly with Service Provider, Employer, or their Designee, as directed by Employer to transfer contract(s) or custodial account(s) to another Service Provider, begin distributions, make loans, exchanges or otherwise access 403(b) plan assets.
- Employees are responsible for determining that salary reductions do not exceed the allowable contribution limits under Applicable Law.

Participant Name	Social Security No.

EMPLOYEE SIGNATURE

☐ Check here if you control another consulting or other business or company.

I understand that all rights under the annuity(s) or custodial accounts established by me under the 403(b) plan are enforceable solely by me, my beneficiary or my authorized representative. I also understand that no later than January 1, 2009, my Employer will have a 403(b) Plan in place that will require my Employer, or their designee to authorize certain distributions and loans, and that it will not be solely my responsibility to authorize such transactions. By signing this Agreement, I authorize any Service Provider, or their delegee to provide information on my Account to Employer or another Service Provider if such information is necessary for compliance purposes or to effectuate such transactions as I may request.

SIGNATURES

Under penalties of perjury, I certify that the above information (including my social security number) is correct and I am an employee of the Employer. I also: (1) acknowledge receipt of the current prospectus; (2) agree to promptly give Instructions to the Sponsor necessary to enable the Custodian to carry out its duties under the Group Custodial Agreement; (3) represent that whenever information as to any taxable year is required to be filed with the Internal Revenue Service, the individual will file such information with Internal Revenue Service unless filed by the Custodian; (4) accept responsibility for computing the annual Exclusion Allowance and the limitations on Elective Deferrals under the Internal Revenue Code; and (5) acknowledge that this Group Custodial Agreement operates in conjunction with the Employer's 403(b) Plan document. I hereby agree to participate in the 403(b)(7) Group Custodial Account offered by the Custodian. I acknowledge receipt of a copy of the custodial account document under which this 403(b)(7) Group Custodial Account is established, and a copy of this Participation Agreement. I direct that my contribution be invested as indicated on my enrollment form, and I direct that all benefits upon my death be paid as indicated above. In the event that this is a rollover contribution, the undersigned hereby irrevocably elects, pursuant to the requirements of Section 1.402(a)(5)-1T of the IRS regulations, to treat this contribution as a rollover contribution.

Sponsor: PenServ Plan Services, Inc.

Participant Signature: _____ Date: _____

Employer Name Mississippi Valley State University

DELTA DENTAL

Delta Dental Insurance Company

ENROLLMENT/CHANGE FORM

P.O. Box 1809
Alpharetta, GA 30023-1809
1-800-521-2651
Fax: 770-641-5393

12 Mo EEs: ()High Plan div 01001 / () Low Plan div 02001
10 Mo EEs: ()High Plan div 01002 / () Low Plan div 02002
9 Mo EEs: ()High Plan div 01003 / () Low Plan div 02003

For Employer Use Only	
Effective Date	Group No. 25-06166
Fi	Sublocation

Check One (**Enrollees can change plans only during open enrollment.)

- ☐ New Hire
- ☐ Open Enrollment
- ☐ Change Dental Plans**
- ☐ COBRA
- ☐ Add/Delete Dependent
- ☐ Terminate Employee Coverage
- ☐ Spouse Employment Change
- ☐ Marital Change
- ☐ Other _____

Indicate qualifying date:

COBRA Enrollment Only

Please indicate qualifying event:

- ☐ Termination
- ☐ Reduction in Hours
- ☐ Divorce
- ☐ Widowed/Surviving Dependent
- ☐ Dependent Child No Longer Eligible

Indicate qualifying date:

Primary Enrollee Information

VERY IMPORTANT - PLEASE PRINT LEGIBLY (Please leave one blank box between each word)

Name: _____ (Last, First)

Mailing Address: _____ (Street Address)

_____ (City) _____ (State) _____ (Zip) _____ (Pay period - if applicable)

Primary Enrollee ID/Soc. Sec. No. _____ Date of Birth: _____ (Month) _____ (Day) _____ (Year)

Name of Employer/Group MS Valley State University Location _____

Marital Status: Single ☐ Married ☐ Gender: Male ☐ Female ☐ Phone # ( ) _____ – _____

Do you have dependent children? Yes ☐ No ☐ Are you or your dependents covered under another dental plan? Yes ☐ No ☐

Dependent Information

(VERY IMPORTANT - PLEASE PRINT LEGIBLY. To add additional dependents, please attach a separate sheet.)

PLEASE LIST ELIGIBLE DEPENDENTS TO BE COVERED IN ADDITION TO YOURSELF
(If enrolling one dependent, ALL must be enrolled.)

	Add	Delete	Male	Female	Date of Birth: (Month) (Day) (Year)
Spouse:	☐	☐	☐	☐	
Dependent:	☐	☐	☐	☐	
Dependent:	☐	☐	☐	☐	
Dependent:	☐	☐	☐	☐	
Dependent:	☐	☐	☐	☐	
Dependent:	☐	☐	☐	☐	
Dependent:	☐	☐	☐	☐	
Dependent:	☐	☐	☐	☐	

☐ I authorize any payroll deduction that may be required towards the cost of this coverage. I certify that the information in this form is true and correct to the best of my ability. I understand that my election cannot be changed during the year unless I experience a change in family status and the election change is consistent with the family status change.

☐ I decline coverage at this time.

Notice: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Signature of Enrollee _____ Date _____

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** MISSISSIPPI VALLEY STATE UNIVERSITY			
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 ☐ 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: _____

Print

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: MISSISSIPPI VALLEY STATE UNIVERSITY				Employer Phone:
Employer Address:				

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)

Fiscal Year _____
Prorated: Yes ☐ No ☐
Bi-weekly: Yes ☐ No ☐

Mississippi Valley State University
BENEFIT DEDUCTION FORM

NAME: _____ Employee Number: _____ Department: _____

Date: _____ _____ _____ Hire Date: _____ 12 Mo. ☐ 10 Mo. ☐ 9 Mo. ☐

The deductions listed below will start and/or be cancelled from my payroll check as indicated by the check mark. I understand that a new form must be completed for any changes made.

GROUP INSURANCES	**Start Deduction (Date)**	**Amount to be Deducted**	**Amount to be Cancelled**	**Date Processed In Banner**	**CAFÉ. Plan**
***Health Insurance* - Blue Cross Blue Shield of MS** ___Legacy ___Horizon ___Select Coverage ___Base Coverage					
***Life* - Minnesota Life Insurance** LFE – LIF – I50					
***Dental Insurance* - Delta Dental Inc. or Ameritas**					
***Vision Insurance* - EyeMed Vision Care**					
Supplemental Insurances					
American Fidelity					
Accident "AFA" pretax					
Cancer "AFP" pretax					
Disability "AF" post tax					
GAP "AFG" pretax					
Life "AFL" post-tax					
Flex Spending ___Dependent Care "FSD" ___Healthcare "FSH"					
AFLAC					
Accident					
Cancer					
Hospital					
Life					
AFLAC GROUP					
Tax Sheltered Annuities (TSAs)					
AXA Equitable Life "ELT"					
TIAA CREF "TCT"					
VALIC "VAT"					
Mississippi Deferred Compensation "DCT"					
Transamerica Life Insurance					
Other					

_____ _____ _____ _____
Employee Signature Date Human Resources Date

I hereby apply for the options listed above. I authorize MVSU to adjust my pay as required by my election. I understand that this election is binding and cannot be revoked or modified until January 1 of each year, unless I experience a Life Status Change as defined in the Cafeteria Plan document (i.e. marriage, divorce, birth, etc.). I further understand that any amounts remaining in my account(s) not used for eligible expenses incurred during the plan year will be forfeited in accordance with the current plan provisions and tax laws.

EyeMed VISION CARE®

Enrollment/Change Form

Please print and complete all sections.
See instructions below.

EMPLOYER INFORMATION: To be Completed by Employer					
Group Number	**Employer Name**	**Location Code**	**Division Code**	**Client Co Code**	**Effective Date**
9732314	MISSISSIPPI VALLEY STATE UNIVERSITY				

EMPLOYEE INFORMATION A: Add (enroll) T: Terminate C: Change (change of name, address or phone)						
☐ADD ☐TERM ☐CHG	**Sex** ☐M ☐F	**Member ID**	**Last Name (Employee or subscriber)**	**First Name**	**M.I.**	**Date of Birth**
Social Security Number	**Home Street Address**		**City/State/Zip**			**Home Phone ( )**

FAMILY INFORMATION (Only those eligible may be enrolled.) A: Add (enroll) T: Terminate C: Change (change of name)						
☐A ☐T ☐C	**Sex** ☐M ☐F	**Last Name (spouse)**	**First Name**	**M.I.**	**Date of Birth**	**Social Security Number**
☐A ☐T ☐C	**Sex** ☐M ☐F	**Last Name (dependent)**	**First Name**	**M.I.**	**Date of Birth**	**Social Security Number**
☐A ☐T ☐C	**Sex** ☐M ☐F	**Last Name (dependent)**	**First Name**	**M.I.**	**Date of Birth**	**Social Security Number**
☐A ☐T ☐C	**Sex** ☐M ☐F	**Last Name (dependent)**	**First Name**	**M.I.**	**Date of Birth**	**Social Security Number**
☐A ☐T ☐C	**Sex** ☐M ☐F	**Last Name (dependent)**	**First Name**	**M.I.**	**Date of Birth**	**Social Security Number**

Employee Signature: _____ Date: _____

Instructions:

Employer name: Legal name of the employer.
Group Number: Provided by EyeMed or EyeMed representative.
Location code: Optional field for employers to track multiple locations.
Effective date: Date set by employer in accordance with EyeMed proposal. Employer also sets effective date for new adds during contract period.

Family Information: List only eligible family members who are enrolling.
Dependent eligibility is the same as employer's health plan.
(A) Add: Open (group) enrollment or new (individual) enrollment during the contract period.
(T) Terminate: To terminate enrollment.
(C) Change: A change of name, employee address or employee phone.

Once you elect EyeMed vision coverage, you cannot cancel for a 12-month period based upon your enrollment date.
Deductions are adjusted according to payroll frequency.

ELECTION AND SALARY REDUCTION AGREEMENT

(PLEASE PRINT)

EMPLOYER: _____

PLAN YEAR: _____ **thru** _____

ELIGIBILITY DATE:_____ **FIRST PAY DATE:** _____

PAY MODE (M-Monthly, S-Semi Monthly, Bi-Biweekly or W-Weekly): _____

LOCATION NAME & NO.: _____

NAME:_____ **SSN:** _____

ADDRESS:_____ **DOB:** _____

_____ **DOH:** _____

_____ **SALARY (Per Pay Period): $** _____

The purpose of this agreement is to authorize the election of eligible benefits and the reduction in salary necessary to facilitate the employer providing the employee with selected benefits. This agreement is designed to conform with a cafeteria plan in accordance with Sections 125, 79, 105, 106 and 126 of the Internal Revenue Code.

INSURANCE ELECTIONS:	**CAFETERIA** (Per Deduction)	**NON CAFETERIA** (Per Deduction)	**Deduction Mode**
PRE-TAXED			
_____	_____		_____
_____	_____		_____
_____	_____		
_____	_____		
_____	_____		
POST TAXED			
_____		_____	_____
_____		_____	
_____		_____	

M - Monthly = 12
S - Semi Monthly = 24
Bi - Bi Weekly = 26
W - Weekly = 52

FLEXIBLE SPENDING:	**AMOUNT** (Per Deduction)	**PLAN YEAR AMOUNT**
Dependent Care Expenses:	_____	
Unreimbursed Medical Expenses:	_____	
Premium Reimbursement:	_____	

Please sign only one line.

YES I **WISH TO PARTICIPATE -** I agree that my salary will be reduced by the amount(s)shown for the benefit option(s) I have elected under the Cafeteria Plan. I have read and understand the information on the reverse side of this document.

EMPLOYEE SIGNATURE: _____ DATE: _____

NO I **DO NOT WISH to Participate** - I have been explained the benefits of the Cafeteria Plan and given the opportunity to participate, but I DECLINE. I understand that I may only participate at the start of the next Plan Year or in the event of a Status Change.

EMPLOYEE SIGNATURE: _____ DATE: _____

Southern Administrators and Benefit Consultants, Inc.
P.O. Box 2449 ℂ Madison, Mississippi 39130-2449
WWW.SABCFLEX.COM

As a participant, I understand the following:

My salary will be reduced by the amount shown on the reverse side of this page for the benefit option(s) I have elected under the Cafeteria Plan.

- C My social security benefits may be reduced due to my participation in the Cafeteria Plan.

- C Elections made will be irrevocable for the plan year except for modifications due to a qualified Change in Status (divorce, marriage, death of spouse or dependent, birth or adoption of a child, or the change of employment status of a spouse).

- C 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.

- C Prior to each plan year, I will be given the opportunity to change my benefit election. If I fail to complete and return a new election form within the regular enrollment period, preceding each plan year, I understand my election will remain the same.

- C 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.

- C If I participate for dependent care expenses, I will be reimbursed up to the amount incurred during the plan year, not to exceed the amount of my dependent care balance.

- C If I participate for the Unreimbursed Medical (URM) expenses, I will be reimbursed for out-of-pocket medical expenses up to the amount incurred (date service was provided, not paid) during the plan year, not to exceed my plan year election.

- C If I participate for the Dependent Care and/or Unreimbursed medical expense spending account(s), any funds remaining after the end of the sixty (60) days grace period, following the end of the plan year, will be forfeited to my employer.

- C I have been explained the flexible spending reimbursement procedures and the requirements of the plan, I understand my reimbursements will be based on certain required third party documentation and eligibility of the expense. I understand that upon submission of each claim, I certify that the documentation submitted is valid and eligible under the guidelines of the plan. Submission of falsified and/or inaccurate information may result in disciplinary action and/or penalties.

TERMINATION OF EMPLOYMENT:

Please refer to your plans Summary Plan Description or contact your Plan Administrator and/or SABC for the following plan design information:

I understand that if I terminate my employment, my elected benefits under the Cafeteria Plan will cease. Depending on my Employer's Plan design, my Unreimbursed Medical election may:

- C Continue, in lieu of COBRA, my Employer will deduct from my salary (pre-taxed) any unpaid URM elections for the plan year.

- C Terminate, and I will only be able to claim for expenses that incurred prior to my termination. If I have a positive URM balance at the time of termination, I can extend my election due to a COBRA qualifying event and I will be given the opportunity to continue on a self pay basis.

PREMIUM REIMBURSEMENT PLANS:

- Premium Reimbursement Account participants must submit a declaration of coverage from their provider which indicates the policy is in effect. After each payment that corresponds with the payments due for months included in the plan year, participant must submit, along with a Request for Reimbursement form and proof of payment.

- C The maximum amount of reimbursement for Premium Reimbursement Accounts is based on the yearly cost of individually contracted health premiums.

MY ELECTION AND SALARY REDUCTION AGREEMENT IS SUBJECT TO THE TERMS OF MY EMPLOYER'S CAFETERIA PLAN DOCUMENT.