NEW HIRE PACKAGE

Form **W-4**

Department of the Treasury
Internal Revenue Service

Employee's Withholding Certificate

► **Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay.**
► **Give Form W-4 to your employer.**
► **Your withholding is subject to review by the IRS.**

OMB No. 1545-0074

2020

Step 1: Enter Personal Information

(a) First name and middle initial	Last name	**(b) Social security number**
Address		► **Does your name match the name on your social security card?** If not, to ensure you get credit for your earnings, contact SSA at 800-772-1213 or go to *www.ssa.gov*.
City or town, state, and ZIP code		

(c) ☐ **Single or Married filing separately**
☐ **Married filing jointly** (or Qualifying widow(er))
☐ **Head of household** (Check only if you're unmarried and pay more than half the costs of keeping up a home for yourself and a qualifying individual.)

Complete Steps 2–4 ONLY if they apply to you; otherwise, skip to Step 5. See page 2 for more information on each step, who can claim exemption from withholding, when to use the online estimator, and privacy.

Step 2: Multiple Jobs or Spouse Works

Complete this step if you (1) hold more than one job at a time, or (2) are married filing jointly and your spouse also works. The correct amount of withholding depends on income earned from all of these jobs.

Do **only one** of the following.

(a) Use the estimator at *www.irs.gov/W4App* for most accurate withholding for this step (and Steps 3–4); **or**

(b) Use the Multiple Jobs Worksheet on page 3 and enter the result in Step 4(c) below for roughly accurate withholding; **or**

(c) If there are only two jobs total, you may check this box. Do the same on Form W-4 for the other job. This option is accurate for jobs with similar pay; otherwise, more tax than necessary may be withheld . . . . . ► ☐

TIP: To be accurate, submit a 2020 Form W-4 for all other jobs. If you (or your spouse) have self-employment income, including as an independent contractor, use the estimator.

Complete Steps 3–4(b) on Form W-4 for only ONE of these jobs. Leave those steps blank for the other jobs. (Your withholding will be most accurate if you complete Steps 3–4(b) on the Form W-4 for the highest paying job.)

Step 3: Claim Dependents

If your income will be $200,000 or less ($400,000 or less if married filing jointly):

Multiply the number of qualifying children under age 17 by $2,000 ► $ _____

Multiply the number of other dependents by $500 . . . . ► $ _____

Add the amounts above and enter the total here . . . . . **3** $

Step 4 (optional): Other Adjustments

(a) Other income (not from jobs). If you want tax withheld for other income you expect this year that won't have withholding, enter the amount of other income here. This may include interest, dividends, and retirement income . . . . . **4(a)** $

(b) Deductions. If you expect to claim deductions other than the standard deduction and want to reduce your withholding, use the Deductions Worksheet on page 3 and enter the result here . . . . . **4(b)** $

(c) Extra withholding. Enter any additional tax you want withheld each **pay period** . **4(c)** $

Step 5: Sign Here

Under penalties of perjury, I declare that this certificate, to the best of my knowledge and belief, is true, correct, and complete.

► _____ ► _____

Employee's signature (This form is not valid unless you sign it.) **Date**

Employers Only

Employer's name and address	First date of employment	Employer identification number (EIN)

Form 89-350-15-8-1-000 (Rev. 05/15)

MISSISSIPPI EMPLOYEE'S WITHHOLDING EXEMPTION CERTIFICATE

Mississippi Department of Revenue
P.O. Box 960
Jackson, MS 39205

Employee's Name _____ **SSN** _____

Employee's Residence Address _____ (Number and Street) _____ (City or Town) _____ (State) _____ (Zip Code)

	CLAIM YOUR WITHHOLDING PERSONAL EXEMPTION		
	Marital Status	**Personal Exemption Allowed**	**Amount Claimed**
EMPLOYEE:	**1. Single**	☐ Enter $6,000 as exemption . . . . ▶	$
File this form with your employer. Otherwise, you must withhold Mississippi income tax from the full amount of your wages.	**2. Marital Status** (Check One)	(a) ☐ Spouse **NOT** employed: Enter $12,000 ▶	$
		(b) ☐ Spouse **IS** employed: Enter that part of $12,000 claimed by you in multiples of $500. See instructions 2(b) below . ▶	$
	3. Head of Family	☐ Enter $9,500 as exemption. To qualify as head of family, you must be single and have a dependent living in the home with you. See instructions 2(c) and 2(d)below . . . . . ▶	$
EMPLOYER: **Keep this certificate with your records.** If the employee is believed to have claimed excess exemption, the Department of Revenue should be advised.	**4. Dependents** Number Claimed	You may claim $1,500 for each dependent*, other than for taxpayer and spouse, who receives chief support from you and who qualifies as a dependent for Federal income tax purposes. * A head of family may claim $1,500 for each dependents excluding the one which qualifies you as head of family. Multiply number of dependents claimed by you by $1,500. Enter amount claimed... ▶	$
	5. Age and Blindness	• Age 65 or older ☐ Husband ☐ Wife ☐ Single • Blind ☐ Husband ☐ Wife ☐ Single Multiply the number of blocks checked by $1,500. Enter the amount claimed . . . . . ▶ *** Note:** No exemption allowed for age or blindness for dependents.	$
	6. TOTAL AMOUNT OF EXEMPTION CLAIMED - Lines 1 through 5...▶		$
	7. Additional dollar amount of withholding per pay period if agreed to by your employer . . . . . ▶		$
Military Spouses Residency Relief Act Exemption from Mississippi Withholding	**8.** If you meet the conditions set forth under the Service Member Civil Relief, as amended by the Military Spouses Residency Relief Act, and have no Mississippi tax liability, write **"Exempt"** on Line 8. You must attach a copy of the Federal Form DD-2058 and a copy of your Military Spouse ID Card to this form so your employer can validate the exemption claim.. ▶		_____

I declare under the penalties imposed for filing false reports that the amount of exemption claimed on this certificate does not exceed the amount to which I am entitled or I am entitled to claim exempt status.

Employee's Signature: _____ **Date:** _____

INSTRUCTIONS

1. The personal exemptions allowed:

(a) Single Individuals	$6,000	(d) Dependents	$1,500
(b) Married Individuals (Jointly)	$12,000	(e) Age 65 and Over	$1,500
(c) Head of family	$9,500	(f) Blindness	$1,500

2. Claiming personal exemptions:

(a) Single Individuals enter $6,000 on Line 1.

(b) Married individuals are allowed a joint exemption of $12,000.

If the spouse is not employed, enter $12,000 on Line 2(a). If the spouse is employed, the exemption of $12,000 may be divided between taxpayer and spouse in any manner they choose - in multiples of $500. For example, the taxpayer may claim $6,500 and the spouse claims $5,500; or the taxpayer may claim $8,000 and the spouse claims $4,000. The total claimed by the taxpayer and spouse may not exceed $12,000. Enter amount claimed by you on Line 2(b).

(c) Head of Family

A head of family is a single individual who maintains a home which is the principal place of abode for himself and at least one other dependent. Single individuals qualifying as a head of family enter $9,500 on Line 3. If the taxpayer has more than one dependent, additional exemptions are applicable. See item (d).

(d) An additional exemption of $1,500 may generally be claimed for each dependent of the taxpayer. A dependent is any relative who receives chief support from the taxpayer and who qualifies as a dependent for Federal income tax purposes. Head of family individuals may claim an additional exemption for each dependent excluding the one which is required for head of family status. For example, a head of family taxpayer has 2 dependent children and his dependent mother living with him. The taxpayer may claim 2 additional exemptions. Married or single individuals may claim an additional exemption for each dependent, but **should not** include themselves or their spouse. Married taxpayers may divide the number of their dependents between them in any manner they choose; for example, a married couple has 3 children who qualify as dependents. The taxpayer may claim 2 dependents and the spouse 1; or the taxpayer may claim 3 dependents and the spouse none. Enter the amount of dependent exemption on Line 4.

(e) An additional exemption of $1,500 may be claimed by either taxpayer or spouse or both if either or both have reached the **age of 65** before the close of the taxable year. No additional exemption is authorized for dependents by reason of age. Check applicable blocks on Line 5.

(f) An additional exemption of $1,500 may be claimed by either taxpayer or spouse or both if either or both are **blind**. No additional exemption is authorized for dependents by reason of blindness. Check applicable blocks on Line 5. Multiply number of blocks checked on Line 5 by $1,500 and enter amount of exemption claimed.

3. Total Exemption Claimed:
Add the amount of exemptions claimed in each category and enter the total on Line 6. This amount will be used as a basis for withholding income tax under the appropriate withholding tables.

4. A NEW EXEMPTION CERTIFICATE MUST BE FILED WITH YOUR EMPLOYER WITHIN 30 DAYS AFTER ANY CHANGE IN YOUR EXEMPTION STATUS.

5. PENALTIES ARE IMPOSED FOR WILLFULLY SUPPLYING FALSE INFORMATION

6. IF THE EMPLOYEE FAILS TO FILE AN EXEMPTION CERTIFICATE WITH HIS EMPLOYER, INCOME TAX MUST BE WITHHELD BY THE EMPLOYER ON TOTAL WAGES WITHOUT THE BENEFIT OF EXEMPTION..

7. To comply with the Military Spouse Residency Relief Act (PL111-97) signed on November 11, 2009.

Employment Eligibility Verification

Department of Homeland Security
U.S. Citizenship and Immigration Services

USCIS
Form I-9
OMB No. 1615-0047
Expires 08/31/2019

▶START HERE: Read instructions carefully before completing this form. The instructions must be available, either in paper or electronically, during completion of this form. Employers are liable for errors in the completion of this form.

ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers **CANNOT** specify which document(s) an employee may present to establish employment authorization and identity. The refusal to hire or continue to employ an individual because the documentation presented has a future expiration date may also constitute illegal discrimination.

Section 1. Employee Information and Attestation *(Employees must complete and sign Section 1 of Form I-9 no later than the first day of employment, but not before accepting a job offer.)*

Last Name *(Family Name)*	First Name *(Given Name)*	Middle Initial	Other Last Names Used *(if any)*

Address *(Street Number and Name)*	Apt. Number	City or Town	State	ZIP Code

Date of Birth *(mm/dd/yyyy)*	U.S. Social Security Number	Employee's E-mail Address	Employee's Telephone Number
	☐☐☐ - ☐☐ - ☐☐☐☐		

I am aware that federal law provides for imprisonment and/or fines for false statements or use of false documents in connection with the completion of this form.

I attest, under penalty of perjury, that I am (check one of the following boxes):

☐ 1. A citizen of the United States

☐ 2. A noncitizen national of the United States *(See instructions)*

☐ 3. A lawful permanent resident (Alien Registration Number/USCIS Number): _____

☐ 4. An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy): _____
Some aliens may write "N/A" in the expiration date field. *(See instructions)*

Aliens authorized to work must provide only one of the following document numbers to complete Form I-9: An Alien Registration Number/USCIS Number OR Form I-94 Admission Number OR Foreign Passport Number.

1. Alien Registration Number/USCIS Number: _____
OR
2. Form I-94 Admission Number: _____
OR
3. Foreign Passport Number: _____
Country of Issuance: _____

QR Code - Section 1
Do Not Write In This Space

Signature of Employee	Today's Date *(mm/dd/yyyy)*

Preparer and/or Translator Certification (check one)

☐ I did not use a preparer or translator. ☐ A preparer(s) and/or translator(s) assisted the employee in completing Section 1.

(Fields below must be completed and signed when preparers and/or translators assist an employee in completing Section 1.)

I attest, under penalty of perjury, that I have assisted in the completion of Section 1 of this form and that to the best of my knowledge the information is true and correct.

Signature of Preparer or Translator	Today's Date *(mm/dd/yyyy)*

Last Name *(Family Name)*	First Name *(Given Name)*

Address *(Street Number and Name)*	City or Town	State	ZIP Code

STOP — *Employer Completes Next Page* — STOP

Employment Eligibility Verification

Department of Homeland Security
U.S. Citizenship and Immigration Services

USCIS
Form I-9
OMB No. 1615-0047
Expires 08/31/2019

Section 2. Employer or Authorized Representative Review and Verification

Employers or their authorized representative must complete and sign Section 2 within 3 business days of the employee's first day of employment. You must physically examine one document from List A OR a combination of one document from List B and one document from List C as listed on the "Lists of Acceptable Documents."

Employee Info from Section 1	Last Name *(Family Name)*	First Name *(Given Name)*	M.I.	Citizenship/Immigration Status

List A Identity and Employment Authorization	OR	List B Identity	AND	List C Employment Authorization
Document Title		Document Title		Document Title
Issuing Authority		Issuing Authority		Issuing Authority
Document Number		Document Number		Document Number
Expiration Date *(if any)(mm/dd/yyyy)*		Expiration Date *(if any)(mm/dd/yyyy)*		Expiration Date *(if any)(mm/dd/yyyy)*
Document Title				
Issuing Authority				
Document Number				
Expiration Date *(if any)(mm/dd/yyyy)*				
Document Title				
Issuing Authority				
Document Number				
Expiration Date *(if any)(mm/dd/yyyy)*				

Additional Information

QR Code - Sections 2 & 3
Do Not Write In This Space

Certification: I attest, under penalty of perjury, that (1) I have examined the document(s) presented by the above-named employee, (2) the above-listed document(s) appear to be genuine and to relate to the employee named, and (3) to the best of my knowledge the employee is authorized to work in the United States.

The employee's first day of employment *(mm/dd/yyyy)*: _____ ***(See instructions for exemptions)***

Signature of Employer or Authorized Representative	Today's Date *(mm/dd/yyyy)*	Title of Employer or Authorized Representative

Last Name of Employer or Authorized Representative	First Name of Employer or Authorized Representative	Employer's Business or Organization Name

Employer's Business or Organization Address (Street Number and Name)	City or Town	State	ZIP Code

Section 3. Reverification and Rehires *(To be completed and signed by employer or authorized representative.)*

A. New Name *(if applicable)*			B. Date of Rehire *(if applicable)*
Last Name *(Family Name)*	First Name *(Given Name)*	Middle Initial	Date *(mm/dd/yyyy)*

C. If the employee's previous grant of employment authorization has expired, provide the information for the document or receipt that establishes continuing employment authorization in the space provided below.

Document Title	Document Number	Expiration Date *(if any) (mm/dd/yyyy)*

I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented document(s), the document(s) I have examined appear to be genuine and to relate to the individual.

Signature of Employer or Authorized Representative	Today's Date *(mm/dd/yyyy)*	Name of Employer or Authorized Representative

LISTS OF ACCEPTABLE DOCUMENTS
All documents must be UNEXPIRED

Employees may present one selection from List A
or a combination of one selection from List B and one selection from List C.

LIST A Documents that Establish Both Identity and Employment Authorization	OR	LIST B Documents that Establish Identity	AND	LIST C Documents that Establish Employment Authorization
1. U.S. Passport or U.S. Passport Card		1. Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		1. A Social Security Account Number card, unless the card includes one of the following restrictions: (1) NOT VALID FOR EMPLOYMENT (2) VALID FOR WORK ONLY WITH INS AUTHORIZATION (3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION
2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)		2. ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		2. Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240)
3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa		3. School ID card with a photograph		3. Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal
4. Employment Authorization Document that contains a photograph (Form I-766)		4. Voter's registration card		4. Native American tribal document
5. For a nonimmigrant alien authorized to work for a specific employer because of his or her status: a. Foreign passport; and b. Form I-94 or Form I-94A that has the following: (1) The same name as the passport; and (2) An endorsement of the alien's nonimmigrant status as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form.		5. U.S. Military card or draft record		5. U.S. Citizen ID Card (Form I-197)
		6. Military dependent's ID card		6. Identification Card for Use of Resident Citizen in the United States (Form I-179)
		7. U.S. Coast Guard Merchant Mariner Card		7. Employment authorization document issued by the Department of Homeland Security
		8. Native American tribal document		
		9. Driver's license issued by a Canadian government authority		
		For persons under age 18 who are unable to present a document listed above:		
		10. School record or report card		
		11. Clinic, doctor, or hospital record		
		12. Day-care or nursery school record		
6. Passport from the Federated States of Micronesia (FSM) or the Republic of the Marshall Islands (RMI) with Form I-94 or Form I-94A indicating nonimmigrant admission under the Compact of Free Association Between the United States and the FSM or RMI				

Examples of many of these documents appear in Part 13 of the Handbook for Employers (M-274).

Refer to the instructions for more information about acceptable receipts.

MISSISSIPPI STATE AND SCHOOL EMPLOYEES' HEALTH INSURANCE PLAN
Tobacco Use Attestation Form

All sections of the form below must be completed in order for the form to be processed. Please print in blue or black ink.

LAST NAME:	FIRST NAME:	MI:	LAST FOUR OF SSN:	
HOME ADDRESS:	CITY:		STATE:	ZIP:
PERSONAL TELEPHONE NUMBER:	PERSONAL EMAIL ADDRESS:			

- **Please initial the appropriate box below to indicate whether or not you use tobacco on a regular basis.**
- **If you are a regular user of tobacco, please indicate whether or not you are interested in receiving information about the Mississippi State and School Employees' Health Insurance Plan's (Plan) free tobacco cessation programs.**

NON-TOBACCO USER

☐ I attest that I do not regularly use a tobacco product in any form (cigarettes, cigars, pipe, oral tobacco products, etc.).

I certify that all information provided by me on this form is complete and accurate.

Signature _____ Date _____

TOBACCO USER

☐ I acknowledge that I regularly use a tobacco product in some form (cigarettes, cigars, pipe, oral tobacco products, etc.).

☐ **I am interested** in receiving information about tobacco cessation programs offered by the Plan.

I certify that all information provided by me on this form is complete and accurate.

Signature _____ Date _____

Form Submission:

- **If you are an active employee, please return your form to your employer's Human Resources Department.**
- If you are a **non-Medicare retiree or COBRA participant**, please mail or fax your form to:

Blue Cross & Blue Shield of Mississippi
P.O. Box 23734
Jackson, MS 39225-3734
Fax: (601) 664-5342

For more information visit KnowYourBenefits.dfa.ms.gov

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 ☐ 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 OF MISSISSIPPI
GOVERNOR PHIL BRYANT

DEPARTMENT OF FINANCE AND ADMINISTRATION

KEVIN J. UPCHURCH
EXECUTIVE DIRECTOR

State and School Employees' Life Insurance Plan
Underwritten by Minnesota Life Insurance Company

Active Employee Life Insurance Beneficiary Designation

Designating a life insurance beneficiary is an important step that will allow you to determine who will receive your policy benefits. As you experience changes in your life, you should review your beneficiary designations to ensure that they still reflect how you want your benefits to be paid. With the implementation of the new online beneficiary management tool, you will now be able to make and/or change designations confidentially and conveniently, 24/7, simply by following the instructions below:

1. Log into the *my*Blue site, https://myblue.bcbsms.com (if you have not registered previously, please have your medical ID card handy)
2. Click on the **My Benefits** tab
3. Click on the link in the **Life Benefits** section and you will be directed to Minnesota Life's online beneficiary management tool
4. Enter the name and address, and the respective benefit percentages for each beneficiary you wish to name

After this information has been entered, you will receive an email acknowledgement, as well as a paper confirmation statement in the mail for your records, reflecting your beneficiary designation, and any applicable benefit percentages. Make sure that the information on your email acknowledgment/confirmation is exactly how you want your benefits to be paid. If any of the information is incorrect, log back into *my*Blue and repeat the steps above.

We are very excited about this new online option and encourage you to visit the *my*Blue site today to start the process for designating your life insurance beneficiary. Please note that if you do not execute the new beneficiary designation, any resulting life insurance proceeds will be paid according to the defaults described in the policy, which may not necessarily be according to your wishes.

Should you have any questions about your beneficiary designation, please call Minnesota Life at 1-877-348-9217.

STATE OF MISSISSIPPI
STATE AND SCHOOL EMPLOYEES' LIFE INSURANCE PLAN
ENROLLMENT/CHANGE REQUEST FORM
Underwritten by Minnesota Life Insurance Company – Policy 33683-G

Employee/Retiree Last Name:	First Name:	MI:	Social Security No.:	Birthdate (MMDDYYYY):	Sex ☐ Male ☐ Female
Employee/Retiree Home Address:			Home Telephone No.:	E-Mail Address:	
Employer Name:				Date of Employment:	
Employer Address:				Employer Telephone No.:	

SECTION B: 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 HERE ONLY IF YOU DO NOT WANT LIFE INSURANCE COVERAGE!**

_____ _____
Employee/Retiree Signature **Date**

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

ACTIVE EMPLOYEE: Life benefits and AD&D maximums based on two times the employee's annual wage rounded to the next higher one thousand dollars, subject to $30,000 minimum, $100,000 maximum. Employee and employer each pay 50% of the monthly premium.

☐ **New Employee** – applying within 31 days of employment; coverage will become effective on the first day of employment.

☐ **Late Enrollee Applicant** – applying 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 Insurance Company. **(Employee Must Also Complete the Minnesota Life *GROUP LIFE INSURANCE EVIDENCE OF INSURABILITY form.*)**

Date of Employment: _____

☐ **RETIRED EMPLOYEE:** Life benefit amounts limited to $5,000, $10,000, or $20,000. Retired Employees are not eligible for AD&D benefits. A Retired Employee should apply prior to, but no later than 31 days after, the date Active Employee coverage terminates. Retiree pays 100% of the monthly premium.

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

☐ **DISABLED EMPLOYEE:** Life benefit amount is equal to employee's current benefit level at the time coverage ceases as an Active Employee. Disabled Employee must apply no later than 31 days from the date Active Employee coverage terminates. Minnesota Life Insurance Company is solely responsible for evaluating applications for coverage continuation. Premium is waived after 1st 9 months.

(Employee Must Also Complete the Minnesota Life *NOTICE OF DISABILITY* and *ATTENDING PHYSICIAN'S STATEMENT* forms.)

Date of Disability: _____

Employee/Retiree Last Name	First Name	MI	Social Security Number	Daytime Telephone #
				( )

SECTION D: 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 into your *my*Blue site, **https://myblue.bcbsms.com**, and click on the My Benefits tab.
2. Click the Life Benefits section, which is right 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 Minnesota Life's 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 your *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, please contact Minnesota Life toll free at **877-348-9217** to request a paper form.

SECTION E: Authorization and Certification

I apply 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 Insurance Company. 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 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 Insurance Company 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**

FOR QUESTIONS REGARDING THE STATE AND SCHOOL EMPLOYEES' LIFE INSURANCE PLAN, VISIT THE PLAN'S WEBSITE AT HTTP://KNOWYOURBENEFITS.DFA.STATE.MS.US, 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)

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: Hollandale School District Employer No.: 0886 - 000

Employer Representative's Name: Elizabeth Jordan Employer Representative's Title: Payroll/Personnel

Employer Representative's Phone: (662) 827-2276 Fax: (662) 827-5261 E-Mail: ejordan@hollandalesd.org

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*: _____

PERS of MISSISSIPPI

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: Hollandale School District Employer No.: 0886 - 000

Employer Representative's Name: Elizabeth Jordan Employer Representative's Title: Payroll/Personnel

Employer Representative's Phone: (662) 827-2276 Fax: (662) 827-5261 E-Mail: ejordan@hollandalesd.org

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

AUTHORIZATION FOR PAYROLL DIRECT DEPOSIT

HOLLANDALE SCHOOL DISTRICT

I authorize the Hollandale School District and the financial institution below to initiate entries to my checking/saving accounts. This authority will remain in effect until I notify you in writing to cancel it in such time as to afford the financial institution a reasonable opportunity to act on it.

Employee Name_____ Social Security

_____

Address_____ Home

Phone_____

CHECKING Amount Acct# Bank & Address Bank Routing #

SAVING Amount Acct# Bank & Address Bank Routing#

Participating

Employee Signature_____

Date_____

AUTHORIZATION FOR CANCELLATION

_____

DATE_____

CHECK ONE: CHANGE_____ NEW ENROLLEE ___

AlwaysCare

Welcome Elizabeth Jordan

Current Group: (HLND1016) Hollandale School District

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Plan Coverage:

Insurance Type: Dental
Sub Groups: All SubGroups
Plan: STAR Gold
Plan Documents:

Dental Benefit Summary
Dental Coverage Certificate

Coverage Tier	Rate	Effective Date	Subscribers	Dependents	Total
Employee Only Dental	$20.26	10/01/2016	13	0	13
Employee/Spouse Dental	$40.52	10/01/2016	4	4	8
Employee/Children Dental	$44.58	10/01/2016	0	0	0
Employee/Family Dental	$65.86	10/01/2016	0	0	0
Totals			17	4	21

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The summary information on this website does not include all of the benefits, provisions, restrictions, and limitations that apply to the coverages and may not reflect current benefits. Please refer to the policy or certificate of insurance for complete benefit information.

Not all transactions, balances, or available benefits needed to administer your account are available through this website. The information supplied on this website is updated on a daily basis and is current as of 07/25/2017, the previous day. Please check back to confirm that changes have not taken place that would have changed this information over the last 24 to 48 hours.

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Hollandale School District- Gold Plan (MS)

AlwaysCare Dental[SM] Insurance

Group Number: HLND1016

Group Effective Date: October 1, 2016

Group Renewal Date: October 1, 2018

Outline of Benefits

Plan: Custom, Passive PPO

Deductible: $50 benefit year. Maximum 3 per family. Applies to Basic (Class B) Services.

Coinsurance: The plan pays the following percentages of maximum allowable charges for each class:

Class A	Preventive	100%
Class B	Basic	80%

Benefit Maximums: $1,000 per benefit year (Includes Class A, B Services).

Carryover Benefit: The Carryover Benefit for this policy/certificate is **$250.**

Covered Procedures and Waiting Periods:

Preventive Services (Class A): No waiting period.

- Routine exams (2 per 12 months)
- Prophylaxis (2 per 12 months)
  - (1 additional cleaning or periodontal maintenance per 12 months if member is in 2nd or 3rd trimester of pregnancy)
- Bitewing x-rays (maximum of 4 films) (1 per 12 months)
- Fluoride treatment for children up to age 16 (1 per 12 months)
- Sealants for children up to age 16 (permanent molars 1 per 36 months)
- Space maintainers for children up to age 16
- Adjunctive Pre-Diagnostic Oral Cancer Screening (1 per 12 months for age 40+)

Basic Services (Class B): No waiting period.

- Full mouth / panoramic x-rays (1 per 24 months)
- Emergency treatment (palliative treatment)
- Simple restorative services (Fillings) (Benefit allowed for amalgam restorations on posterior teeth)
- Simple extractions
- Oral surgery (extractions and impacted teeth) & Anesthesia (subject to review, covered with complex oral surgery)
- Repair of Crown, Denture, or Bridge

AlwaysCare

Welcome Elizabeth Jordan

Current Group: (HLND1016) Hollandale School District

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Plan Coverage:

Insurance Type: Dental
Sub Groups: All SubGroups
Plan: STAR Platinum
Plan Documents:

Dental Benefit Summary
Dental Coverage Certificate

Coverage Tier	Rate	Effective Date	Subscribers	Dependents	Total
Employee Only Dental	$30.46	10/01/2016	17	0	17
Employee/Spouse Dental	$60.92	10/01/2016	2	2	4
Employee/Children Dental	$67.02	10/01/2016	8	12	20
Employee/Family Dental	$97.36	10/01/2016	2	7	9
Totals			29	21	50

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Not all transactions, balances, or available benefits needed to administer your account are available through this website. The information supplied on this website is updated on a daily basis and is current as of 07/25/2017, the previous day. Please check back to confirm that changes have not taken place that would have changed this information over the last 24 to 48 hours.

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Hollandale School District- Platinum Plan (MS)

AlwaysCare Dental℠ Insurance

Group Number: HLND1016

Group Effective Date: October 1, 2016

Group Renewal Date: October 1, 2018

Outline of Benefits

Plan: Custom, Passive PPO

Deductible: $50 Annual per benefit year. No Limit. Applies to Basic (Class B) and Major (Class C) Services

Coinsurance: The plan pays the following percentages of maximum allowable charges for each class:

Class A	Preventive	100%
Class B	Basic	80%
Class C	Major	50%
Class D	Ortho	50%

Benefit Maximum: $2000 per benefit year. (Includes Class A, B and C Services)

Carryover Benefit: The Carryover Benefit for this policy/certificate is **$400.**

Covered Procedures and Waiting Periods:

Preventive Services (Class A): No waiting period.

- Adjunctive Pre-Diagnostic Oral Cancer Screening (1 per 12 months for age 40+)
- Bitewing x-rays (max 4 films; 1 per 12 months)
- Fluoride treatment for children up to age 16 (1 per 12 months)
- Prophylaxis (2 per 12 months)(1 additional cleaning or periodontal maintenance per 12 months if member is in 2nd or 3rd trimester of pregnancy)
- Routine Exams (2 per 12 months)
- Sealants for children up to age 16 (permanent molars, 1 per 36 months)
- Space maintainers for children up to age 16 (1 per 24 months)

Basic Services (Class B): No waiting period.

- Anesthesia (subject to review, covered with complex oral surgery)
- Emergency treatment (palliative treatment)
- Full mouth / panoramic x-rays (1 per 24 months)
- Oral Surgery (surgical extractions and impactions)
- Repair of Crown, Denture, or Bridge
- Simple extractions
- Simple restorative services (Fillings)(Benefit allowed for amalgam restorations on posterior teeth)

Major Services (Class C): 12 month waiting period. (Subject to Takeover Benefits for Existing Enrollees.)

- Crowns, Bridges, Dentures and Endosteal Implants (In lieu of an approved 3-unit Bridge)
- Endodontics (Root Canals)
- Inlays and Onlays
- Non-Surgical Periodontics
- Surgical Periodontics (gum treatments)

Ortho Services (Class D): 12 month waiting period. (Subject to Takeover Benefits for Existing Enrollees.)

- Annual maximum: $500
- Dep. Children to age 19 only
- Separate lifetime maximum: $1,000
- Up to 25% of lifetime allowance may be payable on initial banding.

This brochure is a brief overview of your plan. It does not list all benefits, nor does it list all exclusions and limitations. For more complete information, please refer to the Certificate, or the employer's Master Policy.

AlwaysCare

July 11, 2017

Participation by providers listed in this directory is not guaranteed and may be subject to change as the listing is updated. Please confirm with your dentist that they are currently participating in one of our networks before you schedule or receive care: AlwaysCare (AC), Dentemax (DMX), plusnetwork (PN).

The plusnetwork℠ is an enhanced network managed by Dentemax and UCCI.

If you are unable to find your dentist and would like to refer him or her to participate in-network, click here.

Provider Name	Specialty	Practice Name	Address	Phone	Network
Arkansas - Dermott - 71638					
Eubanks, Terri State license: 2854 NPI: 1306960737 Gender: F Accepting new patients: Yes	GD	Mainline Health Systems Inc	300 S School St	(870) 538-9720	DMXP
McDaniels, Michael D State license: 1748 NPI: 1952314262 Gender: M Accepting new patients: Yes	GD	Mainline Health Systems Inc	300 S School St	(870) 538-9720	DMXP
Pennington, Phillip NPI: 1811095656 Accepting new patients: Yes	GD	Mainline Health Systems Inc	300 S School St	(870) 538-9720	DMXP
Arkansas - Wilmot - 71676					
Eubanks, Terri State license: 2854 NPI: 1306960737 Gender: F Accepting new patients: Yes	GD	Mainline Health Systems Inc	203 McCombs St	(870) 473-2274	DMXP
McDaniels, Michael D State license: 1748 NPI: 1952314262 Gender: M Accepting new patients: Yes	GD	Mainline Health Systems Inc	203 McCombs St	(870) 473-2274	DMXP
Pennington, Phillip NPI: 1811095656 Accepting new patients: Yes	GD	Mainline Health Systems Inc	203 McCombs St	(870) 473-2274	DMXP
Louisiana - Oak Grove - 71263					
Costello, Robert V State license: 5630 NPI: 1376565580 Gender: M Accepting new patients: Yes	GD	Oak Grove Dental	414 Ross St	(318) 428-4255	AC
McGee, Patrick L State license: 6361 NPI: 1740626431 Gender: M Accepting new patients: Yes	GD	Oak Grove Dental	414 Ross St	(318) 428-4255	AC
Raymond, William D State license: 5955 NPI: 1245465392 Gender: M Accepting new patients: Yes	GD	Oak Grove Dental	414 Ross St	(318) 428-4255	AC
Slade, Caitlin State license: 6654 NPI: 1245687912 Gender: F Accepting new patients: Yes	GD	Oak Grove Dental	414 Ross St	(318) 428-4255	AC

Specialty Key:
EN = Endodontist GD = General Dentist OR = Orthodontist OS = Oral Surgeon PD = Pediatric Dentist PE = Periodontist PR = Prosthodontist
* No discount on non-covered services.

Provider Name	Specialty	Practice Name	Address	Phone	Network
Mississippi - Cleveland - 38732					
Hill, Richard D NPI: 1356443410 Accepting new patients: Yes	GD	Cleveland Dental Clinics Inc	4266 Highway 8 East	(662) 843-6356	DMX
Jennings, Jason M State license: 345708 NPI: 1598926081 Gender: M Accepting new patients: Yes	GD	Jirl Inc	716 1St St	(662) 843-2955	DMX
Leslie, Altus State license: 218585 NPI: 1861523748 Accepting new patients: Yes	GD	Cleveland Dental Clinics Inc	4266 Highway 8 East	(662) 843-6356	DMX
Phillips, Roenikya State license: 360711 NPI: 1407134109 Gender: F Accepting new patients: Yes	GD	Cleveland Dental Clinics Inc	4266 Highway 8 East	(662) 843-6356	DMX
Ragan, Robert State license: 115864 NPI: 1669501706 Gender: F Accepting new patients: Yes	GD	Robert Ragan DDS	216 N Pearman Ave	(662) 843-2431	DMX
Smth, Hugh C State license: 169975 NPI: 1104968395 Gender: M Accepting new patients: Yes	GD	Hugh C Smith Jr DDS	303 Hospital Dr	(662) 843-5011	DMX
Taylor, James R State license: 1556 NPI: 1093730517 Accepting new patients: Yes	GD	James R Taylor DMD PC	802 E Sunflower Rd	(662) 843-9556	DMX
Mississippi - Greenville - 38701					
Parkerson, James R State license: 129967 NPI: 1265529838 Gender: M Accepting new patients: Yes	GD	James R Parkerson Jr DDS Pa	851 S Main St	(662) 332-8512	AC
Parkerson, James R State license: 3026 NPI: 1295903300 Accepting new patients: Yes	GD	James R Parkerson Jr DDS Pa	851 S Main St	(662) 332-8512	AC
Mississippi - Greenville - 38703					
Eubanks, Carolyn State license: 188680 NPI: 1033207568 Accepting new patients: Yes	GD	Delta Health Center Inc	1414 Hospital St	(662) 741-8800	DMX
Hence, Marquinet C NPI: 1144476250 Gender: F Accepting new patients: Yes	GD	Delta Health Center Inc	1414 Hospital St	(662) 741-8800	DMX
Skelton, Theresa L State license: 288695 NPI: 1356494264 Accepting new patients: Yes	GD	Theresa Skelton, DMD, MS	1542 N Medical Park Dr	(662) 332-4902	AC
Wirtz, Roger State license: 2040 NPI: 1639318116 Gender: M Accepting new patients: Yes	GD	Theresa Skelton, DMD, MS	1542 N Medical Park Dr	(662) 332-4902	AC
Mississippi - Greenwood - 38930					
Baines, Gene M State license: 190580 NPI: 1396748067 Accepting new patients: Yes	GD	Gene Baines DMD	509 Hwy 82 W Ste B	(662) 455-3192	AC

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* No discount on non-covered services.

Provider Name	Specialty	Practice Name	Address	Phone	Network
Mississippi - Greenwood - 38930					
Grubbs, Stephen State license: 3499 NPI: 1780810465 Gender: M Accepting new patients: Yes	GD	S Lee Grubbs DMD Inc	100A E Claiborne Ave	(601) 924-3000	DMX
Mississippi - Hollandale - 38748					
Alexander, Kelly D State license: 104962 NPI: 1598776924 Gender: M Accepting new patients: Yes	GD	Kelly D. Alexander, DDS	104 E Washington St	(662) 827-2922	AC
Mississippi - Lexington - 39095					
Howard, Charles D State license: 4598 NPI: 1023145430 Gender: M Accepting new patients: Yes	GD	Bobby J Bell DMD	102 Wall St	(662) 834-1585	DMX
Polles, Jim H State license: 340206 NPI: 1669482014 Gender: M Accepting new patients: Yes	GD	Bobby J Bell DMD	102 Wall St	(662) 834-1585	DMX
Tutor, Heather K State license: 314500 NPI: 1043220312 Accepting new patients: Yes	GD	Heather Killebrew Tutor DMD	302 Court Sq	(662) 834-9899	DMX
Mississippi - Mound Bayou - 38762					
Eubanks, Carolyn State license: 188680 NPI: 1033207568 Accepting new patients: Yes	GD	Delta Health Clinic Inc	702 Martin Luther King St	(662) 741-2151	DMX
Hence, Marquinet C NPI: 1144476250 Gender: F Accepting new patients: Yes	GD	Delta Health Clinic Inc	702 Martin Luther King St	(662) 741-2151	DMX
Mississippi - Rolling Fork - 39159					
Asbill, Laura State license: 3604 NPI: 1649567983 Accepting new patients: Yes	GD	South Delta Dental Clinic LLC	21 S Fourth St Ste A	(662) 873-5170	AC
Woodson, James R State license: 3200 NPI: 1366644056 Gender: M Accepting new patients: Yes	GD	South Delta Dental Clinic LLC	21 S Fourth St Ste A	(662) 873-5170	AC
Mississippi - Ruleville - 38771					
Nichols, Brantley P State license: 3560 NPI: 1265696769 Gender: M Accepting new patients: Yes	GD	North Sunflower Medical Center	840 N Oak Ave	(662) 756-4620	DMX
Phillips, Lynsey G State license: 374014 NPI: 1538573316 Gender: F Accepting new patients: Yes	GD	North Sunflower Medical Center	102 N Ruby Ave	(662) 756-0000	AC
Tankersley, Jerry D State license: 2300 NPI: 1710111034 Gender: M Accepting new patients: Yes	GD	North Sunflower Medical Center	102 N Ruby Ave	(662) 756-0000	AC

Specialty Key:
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* No discount on non-covered services.

Provider Name	Specialty	Practice Name	Address	Phone	Network
Mississippi - Ruleville - 38771					
Williams, Richard A NPI: 1841319308 Gender: M Accepting new patients: Yes	GD	North Sunflower Medical Center	102 N Ruby Ave	(662) 756-0000	DMX
Williams, Richard A NPI: 1841319308 Gender: M Accepting new patients: Yes	GD	North Sunflower Medical Center	840 N Oak Ave	(662) 756-4620	DMX
Mississippi - Tchula - 39169					
Johnson, Lori D State license: 371013 NPI: 1821352667 Gender: F Accepting new patients: Yes	GD	Mallory Community Health Ctr	9715 Hwy 12	(662) 834-1857	AC
Julius, Quintin T State license: 8704 NPI: 1235338971 Gender: M Accepting new patients: Yes	GD	Mallory Community Health Ctr	9715 Highway 12	(662) 834-1857	DMX
Mississippi - Yazoo City - 39194					
April, Candice B State license: 3732 NPI: 1003103342 Gender: F Accepting new patients: Yes	GD	G A Carmichael Family Health Center	1547 Jerry Clower Blvd	(601) 859-5213	DMX
Brown, Jason R State license: 350709 NPI: 1083843551 Gender: M Accepting new patients: Yes	GD	Yazoo City Dental Clinic	1615 Easy St	(225) 926-2888	AC
Nelson, William N * State license: MS178677 NPI: 1659427698 Gender: M Accepting new patients: Yes	GD	William N Nelson Jr DDS Pa	332 E Jefferson St	(662) 746-8140	AC
Paul, Tracy State license: 3698 NPI: 1659719334 Gender: F Accepting new patients: Yes	GD	Paul Family Dentistry Inc	410 N Jerry Clower Blvd	(662) 746-3491	AC
Winford, Stasia S State license: 284694 NPI: 1740308055 Gender: F Accepting new patients: Yes	GD	Paul Family Dentistry Inc	410 N Jerry Clower Blvd	(662) 746-3491	DMX

Printed on 07/11/2017

Specialty Key:
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Welcome Elizabeth Jordan

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Plan Coverage:

Insurance Type: Vision
Sub Groups: All SubGroups
Plan: STAR Vision V276
Plan Documents:

Vision Benefit Summary
Vision Coverage Certificate

Coverage Tier	Rate	Effective Date	Subscribers	Dependents	Total
Employee Only Vision	$7.88	10/01/2016	26	0	26
Employee/Spouse Vision	$16.10	10/01/2016	3	3	6
Employee/Children Vision	$14.20	10/01/2016	13	21	34
Employee/Family Vision	$22.08	10/01/2016	3	10	13
Totals			45	34	79

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The summary information on this website does not include all of the benefits, provisions, restrictions, and limitations that apply to the coverages and may not reflect current benefits. Please refer to the policy or certificate of insurance for complete benefit information.

Not all transactions, balances, or available benefits needed to administer your account are available through this website. The information supplied on this website is updated on a daily basis and is current as of 07/25/2017, the previous day. Please check back to confirm that changes have not taken place that would have changed this information over the last 24 to 48 hours.

Hollandale School District (MS)

Group Effective Date: October 1, 2016
Group Renewal Date: October 1, 2018
Group Number: HLND1016
AlwaysVision℠: V276

Vision Benefit Summary (Custom Plan)-Elite Education Plan

Vision Care Services	Participating Providers	Out-of-Network Allowance
Exam	$10 Co-pay	Up to $35
Materials	$10 Co-pay	See below
Standard Plastic Lenses:		
Single Vision	Covered by Co-pay	Up to $25
Bifocal	Covered by Co-pay	Up to $40
Trifocal	Covered by Co-pay	Up to $50
Lenticular	$80 allowance	Up to $50
Progressive	$70 allowance	Up to $40
Lens Options:		
Standard Scratch Resistant Coating	Covered in Full	N/A
Polycarbonate Lenses for children to age 19 only	Covered at Wal-Mart & Sam's Club only	N/A
Frames: Members choose from any frame available at provider locations.	$120 retail frame ($94 at Wal-Mart, Sam's Club, & Costco***)	Up to $50
Contact Lenses*: (Includes fit, follow-up and materials)**		
Elective	Up to $130 retail	Up to $100 retail
Medically Necessary	Up to $210 retail	Up to $210 retail
Laser Vision Correction:	AlwaysCare offers nationwide access to discounts on LASIK surgery through a partnership with TLC Vision and other independent providers. Discounts are available with participating providers. This is not an insured benefit. Visit our web site to find the specialist closest to you.	
Frequency	Exam	Once every 12 months
	Eyeglass Lenses	Once every 12 months
	Frames	Once every 24 months
	Contact Lenses	Once every 12 months

*** In lieu of Eyeglass lenses and Frames. Allowances include the contact lens fitting fee.**
****Some providers, such as Walmart, may charge for a contact lens fit and evaluation separately from your contact lens allowance, leaving the entire allowance for materials.**
***** Special payment and reimbursement terms apply for material purchases at Costco.**

 - View Listings  - Email Provider List  - Map Providers  - Search Again

AlwaysVision Nearest Provider Listings

Mary Wilson
Todd Hall OD PA - 16 Miles
206 Baker Blvd
Leland, MS 38756-3402
Phone: (662) 686-2020
Provides: Exam and Materials (Glasses and Contacts)

Todd Hall
Todd Hall OD PA - 16 Miles
206 Baker Blvd
Leland, MS 38756-3402
Phone: (662) 686-2020
Provides: Exam and Materials (Glasses and Contacts)

Jasmine Shipp
Shipp Family Eyecare - 17 Miles
1831 Highway 1 S
Greenville, MS 38701-7355
Phone: (662) 332-9026
Provides: Exam and Contacts Only

Robert Shipp
Shipp Family Eyecare - 17 Miles
1831 Highway 1 S
Greenville, MS 38701-7355
Phone: (662) 332-9026
Provides: Exam and Contacts Only

WalMart Vision Center #182 - 17 Miles
1831 Highway 1 S
Greenville, MS 38701-7355
Phone: (662) 332-9026
Provides: Materials Only (Glasses and Contacts)

Joseph Portera
20/20 Eye World Inc - 17 Miles
1607 Highway 1 S
Greenville, MS 38701-7832
Phone: (662) 378-2085
Provides: Exam and Materials (Glasses and Contacts)

Leesa Smith
20/20 Eye World Inc - 17 Miles
1607 Highway 1 S
Greenville, MS 38701-7832
Phone: (662) 378-2085
Provides: Exam and Materials (Glasses and Contacts)

Mary Griffin
Rolling Fork Eye Clink PA - 18 Miles
64 S Fourth St
Rolling Fork, MS 39159-5147
Phone: (662) 873-4045
Provides: Exam and Materials (Glasses and Contacts)

Wilburn Lord
Rolling Fork Eye Clink PA - 18 Miles
64 S Fourth St
Rolling Fork, MS 39159-5147
Phone: (662) 873-4045
Provides: Exam and Materials (Glasses and Contacts)

Wilburn Lord
Greenville Eye Clinic PA - 19 Miles
239 S Washington Ave
Greenville, MS 38701-4234
Phone: (662) 332-0163
Provides: Exam and Materials (Glasses and Contacts)

Mary Griffin
Greenville Eye Clinic PA - 19 Miles
239 S Washington Ave
Greenville, MS 38701-4234
Phone: (662) 332-0163
Provides: Exam and Materials (Glasses and Contacts)

Wilburn Lord
Indianola Eye Clinic PA - 21 Miles
104 Church St
Belzoni, MS 39038-3936
Phone: (662) 247-1774
Provides: Exam and Materials (Glasses and Contacts)

Matthew Bellipanni
Bellipanni Eye Clinic PLLC - 21 Miles
206 Church St
Belzoni, MS 39038-3630
Phone: (662) 247-0511
Provides: Exam and Materials (Glasses and Contacts)

Mary Griffin
Indianola Eye Clinic PA - 21 Miles
104 Church St
Belzoni, MS 39038-3936
Phone: (662) 247-1774
Provides: Exam and Materials (Glasses and Contacts)

Wilburn Lord
Indianola Eye Clinic PA - 23 Miles
224 Virginia St
Indianola, MS 38751-2221
Phone: (662) 887-3671
Provides: Exam and Materials (Glasses and Contacts)

Matthew Bellipanni
Bellipanni Eye Clinic PLLC - 23 Miles
104 S Martin Luther King Jr Dr
Indianola, MS 38751-2366
Phone: (662) 887-3120
Provides: Exam and Materials (Glasses and Contacts)

Mary Griffin
Indianola Eye Clinic PA - 23 Miles
224 Virginia St
Indianola, MS 38751-2221
Phone: (662) 887-3671
Provides: Exam and Materials (Glasses and Contacts)

Walter Rose
Rose Eye Clinic - 23 Miles
401 Catchings Ave
Indianola, MS 38751-2468
Phone: (662) 887-5668
Provides: Exam and Materials (Glasses and Contacts)

AlwaysCare offers access to several quality national eye care networks. This Provider Listing shows only a sample of our entire network. The specific providers selected for each plan may vary from those listed here. Members should log in to AlwaysAssist to see the providers that accept their plan. We encourage you to contact us or your selected provider prior to visiting their location.