

Participation Agreement for Benefit Enrollment Mississippi Department of Corrections

Plan Year Effective: January 1, 2023 through December 31, 2023

Email Address: _____

Employer Name: MS Department of Corrections (MDOC)

Phone Number: _____

Name: _____

Location: _____

Address: _____

Date of Birth: _____ Date of Hire: _____

City, State, Zip: _____

Social Security Number: _____

I wish to enroll in the Cafeteria Plan YES NO

Annual Salary _____

Job Title _____

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 voluntary selected benefits. This agreement is designed to conform with the requirements of the MDOC Cafeteria Plan in accordance with Sections 125, 79, 105, 106 and 126 of the Internal Revenue Code.

State of Mississippi Employee Benefit Plans - Voluntary Employee Benefits

Benefit Description and Administrator	<u>Coverage Type</u> Employee Only, Employee + Child, Employee + Spouse, Family	<u>Rate/Amount</u>	<u>Election for Pre-Tax Cafeteria</u> (this column can be left blank if you did not enroll in the Cafeteria Plan above)
Dental Insurance thru Ameritas			
Vision Care thru Ameritas			

The Benefit Plans listed below must be elected with your HR Specialist prior to meeting with a Benefit Counselor.

Payroll Elections	<u>Coverage Type</u> Employee Only, Employee + Child, Employee + Spouse, Family	<u>Rate/Amount</u>
State Health		
State Life		
TransAmerica Burial Policy		
Legal Shield		
MAPC		
CPO		
MASE		
ERF		
SSCA		

Dependent Information

If electing employee + spouse, employee + children, or family coverage on any elections please provide the following information on your dependents (please continue listing dependents on the back of this paper if necessary):

<u>Name</u>	<u>Relation</u>	<u>Date of Birth</u>	<u>Social Security Number</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

I am requesting MDOC payroll deduct premiums for the listed dependents and coverages indicated on this form.

EMPLOYEE SIGNATURE: _____ DATE: _____