Participation Agreement for Benefit Enrollment
Mississippi Department of Corrections

Plan Year Effective: January 1, 2022 **through** December 31, 2022
Employer Name: MS Department of Corrections (MDOC)
Name: ____________________
Address: ____________________
City, State, Zip: ____________________

Email Address: ____________________
Phone Number: ____________________
Location: ____________________
Date of Birth: __________ **Date of Hire:** __________
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	Coverage Type Employee Only, Employee + Child, Employee + Spouse, Family	Rate/Amount	Election for Pre-Tax Cafeteria (this column can be left blank if you did not enroll in the Cafeteria Plan above)
Dental Insurance thru Always Care Benefits, Inc.			
Vision Care thru Always Care Benefits, Inc.			

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

Payroll Elections	Coverage Type Employee Only, Employee + Child, Employee + Spouse, Family	Rate/Amount
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):

Name	Relation	Date of Birth	Social Security Number

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

EMPLOYEE SIGNATURE: ______________________________ DATE: ____________________