ERS
Employees Retirement System of Texas

BENEFITS ELECTION FORM

You may complete your benefits election either by:
- Using your online account at **www.ers.state.tx.us**, or
- Sending this completed form to your benefits coordinator or HHS Employee Service Center for employees at HHS Enterprise agencies

Information provided to ERS is maintained for managing your benefits.
If you have questions about your information, or believe that information provided to ERS may be incorrect, please notify your Benefits Coordinator or HHS Employee Service Center.

SECTION A: EMPLOYEE DATA (To be completed by employee.)

Social Security Number/National ID (SSN)	Employee ID	First Active Duty Date	
Employee Name: First, MI, Last	**Eligibility County**	**Mailing Address** ☐ **Check if new**	
City	**State**	**ZIP Code**	**Phone Number**
			☐ Home ☐ Cell ( )
Email Address		**Gender**	**Date of Birth**
		☐ M ☐ F	
Agency Name	**Dept ID/Agency Number**	**Employee Class**	**Insurance Pay Rate**
Employee SSN/National ID Correction	**Employee Name Change or Correction**		**Date of Birth Correction**

Please provide this information, as it could affect the waiting period for your medical insurance.

- Were you covered as a dependent under the Texas Employees Group Benefits Program (GBP) at the time of your hire? ☐ Yes ☐ No
  If yes, please provide the Social Security number of the person covering you: _____
- Are you a University of Texas (UT) or Texas A&M University (TAMU) employee or dependent transferring to this GBP-participating agency or institution without a break in health coverage? ☐ Yes ☐ No Date coverage ends _____
  If yes, please provide proof of no break in coverage to your benefits coordinator. If you are a Health and Human Services (HHS) Enterprise employee, provide the proof to HHS Employee Service Center.
- Are you recently rehired with the same state agency within 90 days of leaving active military duty? ☐ Yes ☐ No
  If yes, please provide your military release date: _____.

SECTION B: ACTION (Mark appropriate choice.)

DTA ☐ FTE to PTE/PTE to FTE **OR** Retiree RTW/Retiree LTW **FSC** ☐ Family Status Change **HIR** ☐ New Hire
LOA ☐ Leave of Absence **PHC** ☐ Post Hire Change **RED** ☐ Reduction while on LOA **REH** ☐ Rehire **RFL** ☐ Return from Leave

SECTION C: REASON CODE (See Family Status Change reference table on page 4 before completing.)

Complete for changes during the plan year. Reason Code: _____ Event Date: _____ (mm-dd-yyyy)

Continue to next page to complete form.

SECTION D: BENEFITS OPTIONS (Mark appropriate choices.)

Health Coverage	Optional Benefits (Newly hired employees may elect benefits on first active duty date or within 31 days of hire/rehire without enrolling in health coverage.) Effective date, if different from hire/rehire date ______________________ (mm-dd-yyyy)					
Health	**Dental**	**Vision**	**Optional Term Life Insurance***	**Voluntary AD&D**	**Dependent Term Life Insurance***	**Short-term Disability***
☐ Waive ☐ HealthSelect℠ of Texas ☐ Consumer Directed HealthSelect℠ ☐ HMO Name ______________________ ☐ Enroll/Add/Drop Dependent (See Section E) ☐ Waive + Opt-Out Credit *(By checking Waive + Opt Out Credit, you also certify that you have comparable coverage. See back of form for important information.)*	☐ Waive ☐ State of Texas Dental Choice Plan℠ ☐ State of Texas Dental Discount Plan℠ ☐ HumanaDental DHMO ☐ Enroll/Add/Drop Dependent *(See Section E)*	☐ Waive ☐ State of Texas Vision ☐ Enroll/ Add/Drop Dependent *(See Section E)*	☐ Waive ☐ Enroll Elect coverage level ☐ OL1 Election 1 ☐ OL2 Election 2 ☐ OL3 Election 3 ☐ OL4 Election 4 Decrease Level to ☐ OL1 Election 1 ☐ OL2 Election 2 ☐ OL3 Election 3	☐ Waive ☐ You Only ☐ You + Family $__________ Amount up to $200,000 in increments of $5,000	☐ Waive ☐ Enroll/Add/ Drop Dependent *(See Section E)*	☐ Waive ☐ Enroll **Long-term Disability*** ☐ Waive ☐ Enroll
	If you want to elect a TexFlex health, dependent care, or limited account as a new enrollee or due to a qualifying life event, you must complete the TexFlex Enrollment Change Form. If you want to enroll in the Commuter Spending Account for parking or transit as a new enrollee or make changes, you must complete the Commuter Spending Account Form.					

*A monthly credit of up to $60 (or $30 for part-time participants) can be applied to optional coverage (dental and AD&D, excludes State of Texas Dental Discount Plan and Vision).

To add this coverage will require evidence of insurability (EOI). Initiate the EOI process online by signing into your online account at **www.ers.state.tx.us, or contact your benefits coordinator/HHS Employee Service Center.

Employee Tobacco-User Certification: If you are enrolling in the GBP health plan, have you used any type of tobacco product five or more times in the last three months? This includes but is not limited to cigarettes, pipes, cigars, cigarillos, snuff or chewing tobacco products.
☐ Yes ☐ No

SSN ______________________________ **Employee Name: First, MI, Last** ____

SECTION E: DEPENDENT PERSONAL DATA (and coverage choices.)

Dependent Tobacco-user Certification: If your dependents are enrolled in a GBP health plan, you must certify below if your dependent used any type of tobacco product five or more times in the last three months. This includes but is not limited to cigarettes, pipes, cigars, cigarillos, snuff or chewing tobacco products.

Dependent Relationship*	Dependent's Name (First, MI, Last)	Gender	Date of Birth (mm-dd-yyyy)	Dependent SSN (Required for 12 months or older)	Health	Dental	Vision	Dep. Life	Tobacco User
☐ Sp ☐ D ☐ S ☐ O		☐ M ☐ F			☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
☐ Sp ☐ D ☐ S ☐ O		☐ M ☐ F			☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
☐ Sp ☐ D ☐ S ☐ O		☐ M ☐ F			☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
☐ Sp ☐ D ☐ S ☐ O		☐ M ☐ F			☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
☐ Sp ☐ D ☐ S ☐ O		☐ M ☐ F			☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

* Relationship Code: Sp – Spouse D or S - Natural or adopted daughter or son O – Other than natural or adopted child. Includes stepchild, foster child, or ward child.

If you are adding a child, you must complete a Dependent Child Certification form (ERS GI 1.081) available at **www.ers.state.tx.us** or by calling ERS. For dependents newly enrolled in health coverage, you will be required to provide documentation to verify your dependents' eligibility.

Did your dependent have GBP coverage under ERS through another member within the last 31 days? ☐ Yes ☐ No

If yes, please provide the Social Security number under which your dependent was covered: ________________________________

Is this dependent a new addition to your household because of this event? Please check one only:

☐ Adoption ☐ Acquisition of other than natural child ☐ Birth ☐ Not newly acquired ☐ Marriage

Continue to next page to complete form.

SECTION F: AUTHORIZATION (Carefully read the statements below before you sign and date.)

I authorize payroll deductions for the elections indicated on this Benefits Election Form. I understand that my insurance coverage may be cancelled if I do not pay the required amounts due, either by payroll deduction or personal payment. I understand that all insurance premiums are deducted on a pre-tax basis, except Dependent Life, State of Texas Dental Discount Plan, and Disability. I authorize any provider to release any information on persons covered when needed to verify eligibility or to process an insurance claim/complaint. I understand that insurance participation rules and enrollment and benefits information are available from my benefits coordinator/HHS Employee Service Center or ERS. **I understand that double coverage for dependents is not allowed for health, vision and dental coverage in the Texas Employees Group Benefits Program (GBP). I understand that state law does not permit me to receive more than one state insurance contribution as either an employee, retiree, or dependent**. I certify that I am familiar with the requirements for enrolling myself and/or dependent(s) in the GBP based on a new/post hire change or a qualifying life event (QLE). I further certify that my QLE is valid, correct, and allowable under the GBP. I understand that I may be asked to show documentation to support my QLE and will be required to submit documentation for any newly enrolled dependents, proving their eligibility. I also understand that if I knowingly provide any materially incorrect, incomplete, untrue, information, I may be permanently expelled from the GBP and/or subject to criminal prosecution.

Notice about Insurance: Funding for health and other insurance benefits for participants in the GBP is subject to change based on available state funding. The Texas Legislature determines the level of funding for such benefits and has no continuing obligation to provide funding for those benefits beyond each fiscal year.

Tobacco-Use Certification: I certify my understanding and agreement to the following: “Tobacco Products” are cigarettes, cigars, pipe tobacco, chewing tobacco, snuff, dip or any other products that contain tobacco, and a “Tobacco User” is a person who has used any Tobacco Products five or more times within the past three consecutive months. If I (or any of my covered dependents): 1) have used Tobacco Products as a Tobacco User; or 2) start using Tobacco Products without notifying ERS, I will be subject to monetary penalties and may be terminated from participation in the GBP. Also, failure to notify ERS will constitute fraud. Under the penalties of perjury, the above information is true and correct. Providing or entering false information may disqualify me from continued coverage in the GBP. If I intentionally misrepresent material facts or engage in fraud, my coverage may be rescinded retroactively to the date of the misrepresentation or fraudulent act. In that event, I will receive thirty days notice before my coverage is rescinded. Further, if I or any of my covered dependents start using Tobacco Products without notifying ERS, I will be subject to monetary penalties and such failure to notify ERS will constitute fraud.

If you certified yourself or any of your dependents as a tobacco user, you may be able to participate in Choose to Quit, an alternative to the tobacco-user premium, if it is right for your health status and complies with your doctor’s recommendations. For more information about this program, visit, **www.ers.state.tx.us/Employees/Health/Tobacco_Policy**.

If you previously certified yourself or any of your dependents as a tobacco user, and you or they have stopped using tobacco for three consecutive months, you must complete the Tobacco User Certification Form (ERS 2.933) available at **http://www.ers.state.tx.us/Insurance/Tobacco/Tobacco_User_Certification__Form/**, or change the certification using your online account at **www.ers.state.tx.us**.

If you selected “Waive + Opt-Out Credit”: I certify that I do not want the health plan coverage offered to me as an eligible participant. I am waiving my health plan coverage and certify that I have other health plan coverage with substantially equivalent coverage to the basic health plan. I understand waiving my state health insurance will cancel my prescription drug coverage and $5,000 Basic Term Life policy. I will receive a credit of up to $60 (or $30 for part-time participants) that will be applied only toward the cost of eligible optional coverage in which I am enrolled (dental and/or Voluntary Accidental Death and Dismemberment (AD&D). Excludes the State of Texas Dental Discount Plan and State of Texas Vision). The credit is in place of the state contribution for basic health coverage. Due to federal legislation Medicare members cannot receive the Opt-Out Credit. I am able to view the Health Insurance Opt-Out Credit applied toward my eligible optional coverage premium by signing into my online account at **www.ers.state.tx.us**.

I understand that if I am currently in a waived status, I must have a QLE or wait until Summer Enrollment to enroll in medical or optional coverage offered to eligible participants.

Employee’s Signature _____ **Date Signed (mm-dd-yyyy)** _____

Keep a copy of this form for your files and return the original to your benefits coordinator.

If you are a Health and Human Services (HHS) Enterprise employee, return this form to HHS Employee Service Center.

New Employees:

- May elect health coverage at time of hire; however, this coverage will be effective when you have satisfied your waiting period.

Employees making changes to their benefits options during the plan year:

- Use this form to indicate only the changes you want to make.
- Complete this form on or within 31 days after your qualifying life event (QLE) (birth, marriage, etc.).
- Using the chart below, identify a reason code (required in Section C) when changing insurance coverage.

Below are examples of qualifying life events; other similar circumstances may also represent a qualifying life event. Remember, rules will determine if you can enroll in or make the insurance changes you want. You may either enter your changes using your online account at **www.ers.state.tx.us** or send this form to your benefits coordinator.

If you are a Health and Human Services Enterprise employee, you may send this form to HHS Employee Service Center. If you do not make changes within 31 days, you may not be eligible to make the changes you want.

Family Status Change Reference Chart

Employee Marital Status Change	Participant gets married	**MAR**
	Participant gets a divorce or an annulment	**DIV**
	Death of a spouse	**DOD**
Dependent Status Change	Birth of a newborn child	**BIR**
	Participant adopts, fosters, or gets court-appointed guardianship, or becomes managing conservator of a child	**ADP**
	Participant gains or loses dependent(s) through death	**DOD**
	Dependent becomes eligible or loses eligibility for insurance coverage (Example: Participant's spouse is covering their child. The child lost eligibility for the spouse's insurance because the child does not attend school.)	**DEP**
	Dependent is related by blood or marriage, and was previously claimed on the participant's income tax return, but is no longer eligible to be claimed on participants income tax return	**XMO**
	Child gets married	**DGM**
Employment Status Change	Participant/Dependent employment status change	**ESC**
	Dependent becomes eligible for insurance after a waiting period	**DWP**
Address Change that Changes Dependent Eligibility	Dependent moves out of health or dental plan service area	**DMV**
Medicare/Medicaid/CHIP Eligibility Change	Participant/Dependent gains Medicare/Medicaid/CHIP eligibility	**MDG***
	Participant/Dependent loses Medicare/Medicaid/CHIP eligibility	**MDL***
Significant Change in Cost/Coverage Imposed byThird Party	Significant change in cost by day care provider	**SCC**
	Significant change in cost/coverage of dependent's health, vision or dental plan (excluding GBP)	**SCC**
	HIPP approval or loss of eligibility	**SCC**
Office of the Attorney General (OAG) Ordered Coverage Change (Eligibility rules apply for these dependents)	Participant gains requirement to provide coverage for child through a National Medical Support Notice (NMSN) issued by the Office of the Attorney General (OAG) (Example: employee receives an NMSN to provide health coverage for his child.)	**MSO**
	NMSN issued by the Office of the Attorney General (OAG), which requires participant to provide coverage for child expires (Example: employee's NMSN to provide health coverage for his child expires and the employee is no longer required to continue coverage for the child.)	**MSD****

* DEPENDENT ENROLLMENT INFORMATION:

CHIPRA requires a 60-day QLE window to notify ERS if the following:

1. If the dependent is not in the GBP and loses their eligibility for Medicaid or CHIP OR

2. If the dependent is not in the GBP and they become eligible for premium assistance through Medicaid or HIPP they have 60 days to enroll in the GBP.

DROP DEPENDENT COVERAGE INFORMATION:

In other QLE instances related to Medicaid or CHIP there is the usual 30-day window to drop dependents from the GBP.

** Employees must contact their benefits coordinator (HHS Enterprise employees contact HHS Employee Service Center) to drop dependent(s) added with a National Medical Support Notice (NMSN).

You may be asked to show proof of the QLE and will be required to submit documentation for newly enrolled dependents, proving their eligibility.

Employees Retirement System of Texas PO Box 13207 Austin, Texas 78711-3207 (877) 275-4377