EMPLOYEES RETIREMENT SYSTEM OF TEXAS
P. O. Box 13207, Austin, Texas 78711-3207
(512) 867-7711 or (877) 275-4377 (toll free)

THIS SECTION ERS USE ONLY
☐ S ☐ E
☐ H ☐ J

APPLICATION TO REQUEST CONTINUATION OF COVERAGE FOR A DISABLED DEPENDENT CHILD, AT AGE 25 AND OVER

Information provided to the Employees Retirement System of Texas (ERS) is maintained for administration of 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 ERS.

PART I: EMPLOYEE/RETIREE STATEMENT

SECTION A: *PERSONAL DATA*

_____ _____ _____
EMPLOYEE/RETIREE NAME (Last, First, M.I.) SOCIAL SECURITY NUMBER AGENCY NUMBER

_____
ADDRESS (Street, City, State, Zip)

_____ _____ _____ _____
LEGAL NAME OF DEPENDENT (Last, First, M.I.) DEPENDENT SSN DEPENDENT DATE OF BIRTH DEPENDENT MARITAL STATUS

_____
DEPENDENT'S ADDRESS (Street, City, State, Zip)

SECTION B: *COVERAGE INFORMATION* (You must currently be enrolled to continue coverage)

Dependent Coverage(s) to be continued: Cancelled Date: _____

Health: ☐ HealthSelect ☐ HMO

☐ Dependent Life
☐ Employee and Family AD&D
☐ Dental

SECTION C: *EMPLOYEE/RETIREE STATEMENT*

1 Nature of disability:_____

2. Does this disability prevent the dependent from being able to work? ☐ Yes ☐ No

3. Date of first medical treatment: _____

4. If the dependent has been under observation, care or treatment in any hospital, or similar institution, please complete the following:
Name of hospital or institution _____

5. Has the dependent been employed since reaching age 25? ☐ Yes ☐ No
If "yes", give name(s) and address(es) of employee(s), date employed and earnings: _____
_____
_____

Attending physician's statement on the reverse side must also be completed

SECTION D: *CERTIFICATION*

I certify that the above named disabled dependent lives with me or his/her care is provided by me, and I am responsible for his/her care or support. I also certify that the statements made above are true and complete to the best of my knowledge. I hereby authorize any hospital or physician who has treated this dependent to furnish any medical information requested. I understand that continued coverage for this disabled dependent at the age of 25 and over is not guaranteed and is subject to approval by the carrier and/or the Employees Retirement System. I understand that any fraudulent statements may be cause for expulsion from this Program.

_____ _____ _____ _____
Signature of Employee/Retiree **Date Signed (mm-dd-yyyy)** **Home Telephone No.** **Work Telephone No.**

PART II: ATTENDING PHYSICIAN's STATEMENT

Any expense associated with the completion of this section will be the responsibility of the applicant.

1. Is the dependent incapable of self-sustaining employment due to a Mental or Physical Handicap? __Yes ___No

2. Did such incapacity exist prior to dependent's attainment of age 25? __Yes __No If "no", when did incapacity first exist?

   _____

3. Will dependent be capable of employment in the future? __Yes __No __Questionable.
   If "yes", give approximate date and the type of employment the dependent will be capable of performing.

   _____

4. Nature and cause of incapacity. Please provide complete diagnosis. You may attach a narrative summary relative to the diagnosis/prognosis:

   _____

   _____

   _____

5. Date of Onset: _____ Date dependent was last examined _____ Abnormal Findings at time of last examination: _____ Prognosis: _____

6. How does condition(s) restrict the dependent's ability to engage in normal activities?

   _____

   _____

   _____

7. Has this disability been diagnosed as permanent? __Yes __No. If "no, how long will condition last?

   _____

8. Physician Name (print): _____

9. Degree:_____ Specialty Board Certification: _____

10. Physician Signature:_____ Date: _____

11. Office Address:_____

12. Physician Phone No.( )_____Fax No. ( )_____

PART III: CARRIER USE ONLY

☐ Approved Re-Certification Date _____ ☐ Denied

☐ Additional Information Required _____

Underwriter/Counselor _____ Date _____