ERS
Employees Retirement System of Texas

BENEFITS ELECTION FORM

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 ERS.

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.

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 3 before completing.)*

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

SECTION D: INSURANCE COVERAGE *(Mark appropriate choices.)*

Medical Coverage	Optional Coverage (Newly hired employees may elect coverage on first active duty date or within 31 days of hire/rehire without enrolling in medical coverage.) Effective date, if different from hire/rehire date _____ (mm-dd-yyyy)					
Medical	**Dental**	**Optional Life****	**Voluntary AD&D**	**Dependent Life****	**Short-term Disability****	**Long-term Disability ****
☐ Waive ☐ HealthSelect℠ of Texas ☐ HMO Name/City _____ ☐ Add/Drop Dependent (See Section E) ☐ Opt-Out* *(By checking Opt-Out, you also certify that you have comparable coverage. Excludes Medicare.)*	☐ Waive ☐ State of Texas Dental Choice Plan℠ ☐ HumanaDental DHMO ☐ State of Texas Dental Discount Plan℠ ☐ Add/Drop Dependent *(See Section E)*	☐ Waive ☐ Election I ☐ Election 2 ☐ Election 3 ☐ Election 4	☐ Waive ☐ You Only ☐ You + Family $_____ Amount	☐ Waive ☐ Elect ☐ Add/Drop Dependent *(See Section E)*	☐ Waive ☐ Elect	☐ Waive ☐ Elect
	If you want to elect a TexFlex health or day care account as a new enrollee or due to a qualifying life event, you must complete the TexFlex Enrollment Change 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)
** May require evidence of insurability (EOI). See 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 5 or more times in the last 3 months? This includes but is not limited to cigarettes, pipes, cigars, cigarillos, snuff, or chewing tobacco products. ☐ Yes ☐ No

Continue to next page to complete form.

SSN ________________________________ Employee Name: First, MI, Last ____

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

Dependent Tobacco User Certification: If your dependents are enrolled in the GBP health plan, certify below if your dependent used any type of tobacco product 5 or more times in the last 3 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	Dep. Life	Tobacco User
☐ Sp ☐ D ☐ S ☐ O		☐ M ☐ F			☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
☐ Sp ☐ D ☐ S ☐ O		☐ M ☐ F			☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
☐ Sp ☐ D ☐ S ☐ O		☐ M ☐ F			☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
☐ Sp ☐ D ☐ S ☐ O		☐ M ☐ F			☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
☐ Sp ☐ D ☐ S ☐ O		☐ M ☐ F			☐ 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. You will also be required to submit documentation proving 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

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 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 (5) or more times within the pasts three (3) 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. All premium charges will be prospective. I will not be refunded any part of the Tobacco User premiums. 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 of 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 as a tobacco user, you may be able to participate in 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 alternative, see the Physician's Affidavit Form or call ERS. 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 a Non-Tobacco User Affidavit Form (ERS 2.937) available at
www.ers.state.tx.us, or recertify using your online account at **www.ers.state.tx.us**.

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 insurance coverage 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 by Third Party	Significant change in cost by day care provider	SCC
	Significant change in cost/coverage of dependent's health 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*

* 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.