

Information provided to Employees Retirement System of Texas (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 (For assistance, see the attached instructions.)

Social Security Number/National ID (SSN)		Employee ID		First Active Duty Date	
Employee Name: First, MI, Last		Eligibility County		Mailing Address <input type="checkbox"/> Check if new	
City		State		ZIP Code	
				<input type="checkbox"/> Home <input type="checkbox"/> Cell ()	
Email Address			Gender		Date of Birth
			<input type="checkbox"/> M <input type="checkbox"/> 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

Were you covered as a dependent under the 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

If yes, please provide proof of no break in coverage to your benefits coordinator. If you are a Health and Human Services Enterprise employee, provide the proof to accessHR.

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

SECTION B: ACTION CODE Effective Date: _____ (mm-dd-yyyy)

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: QUALIFYING LIFE EVENT (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*
<input type="checkbox"/> Waive <input type="checkbox"/> HealthSelect SM of Texas* <i>(evidence of insurability may be required)</i> <input type="checkbox"/> HMO Name/City _____ <input type="checkbox"/> Add/Drop Dependent (See Section E) <input type="checkbox"/> Waive + Opt-Out <i>(By checking Waive + Opt-Out, you also certify that you have comparable coverage. See page 3 for important information.)</i>	<input type="checkbox"/> Waive <input type="checkbox"/> State of Texas Dental Choice Plan SM <input type="checkbox"/> HumanaDental DHMO <input type="checkbox"/> Add/Drop Dependent (See Section E)	<input type="checkbox"/> Waive <input type="checkbox"/> OL1 Election I <input type="checkbox"/> OL2 Election II <input type="checkbox"/> OL3 Election III <input type="checkbox"/> OL4 Election IV	<input type="checkbox"/> Waive <input type="checkbox"/> Member Only <input type="checkbox"/> Member + Family \$ _____ Amount	<input type="checkbox"/> Waive <input type="checkbox"/> Elect <input type="checkbox"/> Add/Drop Dependent (See Section E)	<input type="checkbox"/> Waive <input type="checkbox"/> Elect	<input type="checkbox"/> Waive <input type="checkbox"/> Elect
If you want to elect a Flexible Spending Account – Health or Day Care through TexFlex as a new enrollee or due to a qualifying life event, you must complete the TexFlex Enrollment Change Form.						

*May require evidence of insurability (EOI). EOI form is available at www.ers.state.tx.us or from your benefits coordinator/accessHR.

If you have a QLE, you may provide proof that you had other health coverage within 31 day to enroll in HealthSelect, instead of applying through the EOI process.

Continue to next page to complete form.

SSN _____ Employee Name: First, MI, Last _____

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

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
<input type="checkbox"/> Sp <input type="checkbox"/> D <input type="checkbox"/> S <input type="checkbox"/> O		<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Sp <input type="checkbox"/> D <input type="checkbox"/> S <input type="checkbox"/> O		<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Sp <input type="checkbox"/> D <input type="checkbox"/> S <input type="checkbox"/> O		<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Sp <input type="checkbox"/> D <input type="checkbox"/> S <input type="checkbox"/> O		<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Sp <input type="checkbox"/> D <input type="checkbox"/> S <input type="checkbox"/> O		<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> 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 chose "D, S, or O-Other", you must complete a **Dependent Child Certification** form (ERS GI 1.081) available at www.ers.state.tx.us or by calling ERS.

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
 - Birth
 - Marriage
 - Acquisition of other than natural child
 - Not newly acquired

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

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 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/accessHR 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 understand that acceptance of a premium does not constitute valid enrollment of the ineligible person nor waive the eligibility requirements for coverage. I understand that my GBP coverage will remain in effect for the plan year unless I have a qualifying life event (QLE) and that a QLE does not always allow me to make changes to my insurance coverage because the insurance change must be allowable under the GBP rules, AND be consistent with the QLE. I understand that if I or my dependent(s) do not enroll in HealthSelect during our initial period of eligibility, evidence of insurability may be required to enroll in such health plan, unless I can provide proof I have had health coverage elsewhere within the last 30 days. I understand I may be asked to show documentation to support my selection. False information could lead to expulsion from the Group Benefits Program and/or criminal prosecution. If you are a Health and Human Services Enterprise employee, return the original to accessHR. I authorize payroll deductions for the elections indicated on this Benefits Election Form. I understand that all insurance premiums are deducted on a pre-tax basis, except Dependent Life and Disability. **I certify that all information provided on this form is valid and true to the best of my knowledge.**

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

Instructions to Complete the Benefits Enrollment Form

This form may be used to:

- Enroll in Texas Employees Group Benefits Program (GBP) coverage.
- Make allowable changes to GBP coverage or employee data.
- Make changes to your National ID, name, date of birth, contact numbers, or mailing address.

You may contact your benefits coordinator/accessHR for assistance. If you are a Health and Human Services Enterprise employee, contact accessHR for assistance.

Remember, insurance rules will determine if you can enroll in or make the insurance changes you want. You may notify your benefits coordinator when you move or have a change in family status (qualifying life event), or you may enter the event into ERS OnLine at www.ers.state.tx.us and make your election changes. If you do not make changes within 31 days, you may not be eligible to make the changes you want.

New Employees:

- May elect health coverage at time of hire; however, this coverage will be effective the first day of the month following the 90th day of employment.
- May elect optional coverage on at time of hire without being enrolled in medical coverage.
- Complete this form in its entirety. Read the authorization in Section F, then sign and date.
- You must complete a Dependent Child Certification Form if you enroll dependent children in coverage.

Rehires:

- Complete this form in its entirety. Read the authorization in Section F, then sign and date.
- May elect optional coverage without being enrolled in medical coverage.
- You must complete a Dependent Child Certification Form if you enroll dependent children in coverage.

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 (new hire, marriage, etc.).
- Using the chart below, identify a reason code (required in Section C) when changing insurance coverage.
- Read the authorization in Section F, then sign and date.
- You must complete a Dependent Child Certification Form if you enroll dependent children in coverage.

NOTE: The examples below are not all-inclusive; other similar circumstances may also represent a qualifying life event.

Event	Qualifying Life Events Example	Reason Code
Employee Marital Status Change	Marriage Divorce or Annulment Death of spouse	MAR DIV DOD
Dependent Status Change	Birth of new dependent Adoption/Foster placement of new dependent Employee gains or loses dependent(s) through death Dependent becomes eligible or loses eligibility for insurance coverage Dependent gets married	BIR ADP DOD DEP DGM
Employment Status Change	Employee/Dependent employment status change Dependent becomes eligible for insurance through employment	ESC DWP
Address Change that changes Dependent Eligibility	Dependent moves out of health plan service area Dependent moves out of dental plan service area	DMV DMV
Medicare or Medicaid Status Change	Employee/Dependent gains Medicare/Medicaid eligibility Employee/Dependent loses Medicare/Medicaid eligibility	MDG MDL
Significant Change in Cost/Coverage Imposed by Third Party	Significant increase or decrease in cost of day care provider, if you are enrolled in Flexible Spending Account - Day Care Significant change in cost/coverage of dependent's health and/or dental plan, excluding GBP	SCC SCC
Court Ordered Coverage Change	Employee gains requirement to provide coverage for child/spouse Employee loses requirement to provide coverage for child/spouse	MSO MSD*

*Employees must contact their benefits coordinator/accessHR to drop dependent(s) added with MSO.
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Important Information about the Health Insurance Opt-Out Credit (Section D)

Notice to TRICARE and Medicare members: Due to federal legislation, TRICARE and Medicare members cannot receive in the Opt-Out Credit.

If you check "Waive + Opt-Out" on the Benefits Election Form, you agree to the following:

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 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. The credit is in lieu of the state contribution for basic health coverage. I am able to view the Health Insurance Opt-Out Credit applied toward my eligible optional coverage premium in ERS OnLine.

I understand that if I later choose to enroll in the basic health plan offered to eligible participants, currently HealthSelect, I will be required to pass Evidence of Insurability requirements (proof of good health), unless I can provide proof I have had health coverage elsewhere within the last 31 days.

The Health Insurance Opt-Out Credit is designed for employees and retirees who don't need the State's health insurance now or in the future because they are enrolled in other health insurance that is as good as or better than what the State provides.

If you check "Waive + Opt-Out" next to "Medical Coverage" on this enrollment form, a monthly credit of \$60 (if you are a full-time employee) or \$30 (if you are a part-time employee) can be applied toward dental and/or Voluntary Accidental Death and Dismemberment (AD&D) premiums under the Group Benefits Program (GBP). In order to enroll in coverage check the box next to the coverage where your credit will be applied. If you check "waive" for Dental and/or Voluntary AD&D, then the coverage will drop.

More information available at:
Employees Retirement System of Texas
(512) 867-7711 in Austin (877) 275-4377 toll-free
www.ers.state.tx.us

You may either enter your changes in ERS OnLine 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 accessHR.