



**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	
<input type="checkbox"/> S	<input type="checkbox"/> E
<input type="checkbox"/> H	<input type="checkbox"/> 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       Dependent Life  
                  HMO       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 perform-  
ing.  
\_\_\_\_\_
  
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 \_\_\_\_\_