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 *(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** ☐ **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 Enterprise employee, provide the proof to accessHR.

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) ☐ Waive + Opt-Out *(By checking Waive + Opt-Out, you also certify that you have comparable coverage. See page 4 for important information.)*	☐ Waive ☐ State of Texas Dental Choice Plan℠ ☐ HumanaDental DHMO ☐ Add/Drop Dependent *(See Section E)*	☐ Waive ☐ Election 1 ☐ 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.					

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

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
☐ Sp ☐ D ☐ S ☐ O		☐ M ☐ F			☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
☐ Sp ☐ D ☐ S ☐ O		☐ M ☐ F			☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
☐ Sp ☐ D ☐ S ☐ O		☐ M ☐ F			☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
☐ Sp ☐ D ☐ S ☐ O		☐ M ☐ F			☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
☐ Sp ☐ D ☐ S ☐ O		☐ M ☐ F			☐ 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.

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 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 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/*access*HR 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. **Notice about Insurance** - Funding for health and other insurance benefits for participants in the Texas Employees Group Benefits Program (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. I understand I may be asked to show documentation to support my selection. False information could lead to expulsion from the GBP and/or criminal prosecution. **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)** ____________

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 Enterprise employee, return this form to *access*HR

Instructions to Complete the Benefits Election Form

1. Complete this form in its entirety. Read the authorization in Section F, sign, and date.
2. Must complete a Dependent Child Certification form (ERS GI 1.081) available at www.ers.state.tx.us if you enroll children in coverage.
3. May elect optional coverage without enrolling in health coverage.

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.

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.

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) (new hire, 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. Contact your benefits coordinator/ accessHR for additional help with your changes.

Family Status Change Reference Chart

Event	Qualifying Life Event (QLE) Example	Reason
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 of 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
Court Ordered Coverage Change (Eligibility rules apply for these dependents)	Participant gains requirement to provide coverage for child/spouse (Example: employee receives a medical support order to provide health coverage for his child.)	MSO
	Participant requirement to provide coverage for child/spouse expires (Example: employee's medical support order 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 accessHR) to drop dependent(s) added with an MSO.

Benefit changes must be consistent with the QLE. Dependent eligibility and enrollment rules apply.

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 *access*HR.

You may be asked to show proof of the QLE or proof of dependent eligibility.

Important Information about the Health Insurance Opt-Out Credit (Section D)

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

Notice:
• Medicare is not comparable coverage.

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 (dental and Voluntary AD&D) in which I am enrolled. The credit is in lieu of the state contribution for basic health coverage.

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

Remember, 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 using your online account 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.

More information available at:
ERS
(877) 275-4377 toll-free
www.ers.state.tx.us