

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 DA	TA (For assistan	ice see	the attached instruc	tions)					
Social Security Number/Nation	<u> </u>	,	Employee ID			First Active	e Duty Date		
	12 (0013)								
Employee Name: First, MI, Last		Eligibility County		Mailir	ng Address	☐ Check if new			
City			State		ZIP Code		Phone Numbe	r	
						☐ Home ☐			
Er	mail Address				Gene	der	Date of	Birth	
					□ M	□F			
Agency Name		Dept ID/Agency Number			Employee Class		Insurance Pay Rate		
Employee SSN/National ID (Correction		Employee Name	e Cha	nge or Corre	tion	Date of Birth	Correction	
Please provide this information, as									
Were you covered as a dependent und		-			BP) at the time o	f your hire? \square `	res □ No		
If yes, please provide the Social Secur					<u>-</u>				
Are you a University of Texas (UT) or				epende	nt transferring to	this GBP-part	icipating agency or	institution	
without a break in health coverage?					م م المامانة	luman Camilaaa	Enternation annuals		
the proof to accessHR.	ak in coverage to	your b	enetits coordinator. II	you ar	e a Health and F	iuman services	Enterprise employ	ee, provide	
•									
SECTION B: ACTION (Mark a									
DTA FTE to PTE/PTE to FTE OR R			•		-		☐ Leave of Absence	e	
PHC □ Post Hire Change RED □ R						e			
SECTION C: REASON CODE			· · · · · · · · · · · · · · · · · · ·						
Complete for changes during the plan				ent Dat	e:	(mm-d	d-yyyy)		
SECTION D: INSURANCE C	OVERAGE (A	1ark a	opropriate choices.)		_				
Madiaal Cassassas	Optional Coverage								
Medical 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						al coverage.)		
			nective date, il dillerent iro	m nire/re	mire date		mm-dd-yyyy)	Long-	
Medical	Dental		Optional Life*	Vol	untary AD/D	Dependent		Term	
	2 0		- Puonii =			Life*	Disability*	Disability *	
□ Waive	☐ Waive		□ Waive	□ Wa	aive	□ Waive	□ Waive	□ Waive	
☐ HealthSelect SM of Texas	☐ State of Texas		☐ Election I	□ You	u Only	□ Elect	□ Elect	□ Elect	
☐ HMO Name/City	Dental Choice	е	☐ Election 2	1	ı + Family	☐ Add/Drop			
A 11/D	Plan sM		☐ Election 3	\$,	Dependent			
Add/Drop Dependent	☐ HumanaDenta DHMO	al	☐ Election 4		mount	(See Section	E)		
(See Section E) ☐ Waive + Opt-Out	☐ Add/Drop De	nen.							
(By checking Waive + Opt-Out, you	dent (See Sect								
also certify that you have comparable	,								
coverage. See page 4 for important		lf v	ou want to elect a Te	xFlex h	ealth or day care	account as a n	ew enrollee		
information.)	If you want to elect a TexFlex health or day care account as a new enrollee nation.) or due to a qualifying life event, you must complete the TexFlex Enrollment Change Form.								
*May require evidence of insurability (EOI). EOI form is availa	able at	www.ers.state.tx.us	or from	your benefits coo	rdinator/accessH	IR.		
Employee Tobacco User Certification	n: If you are enrolli	ng in th	e GBP health plan, have	you us	ed any type of tol	acco product m	ore than 5 times in	the last 3	
months? This includes but is not limited to									
If you certified yourself as a tobacco us	ser, and a physiciar	says y	ou can't quit, ERS mu	st recei	ve a completed l	Physician Affida	vit available at ww y	w.ers.state.	
tx.us or by calling ERS.									
If you previously certified yourself as a		-	ive stopped using tob	acco fo	r three consecut	ive months, you	ı must complete a	Member Af-	
fidavit available at www.ers.state.tx.u	is or by calling ER	S.							

SSN		Employee	Name: First	, MI, Last				
Dependent Toba	DEPENDENT PERSONAL DA acco User Certification: If your dependen e last 3 months. This includes but is not limite	ts are enrolle	ed in the GBP hea	lth plan, certify below if your depend		ny type of t	obacco produ	ct more
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
□ S _P □ 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
□ S _P □ D		□ M			☐ Yes ☐ No	☐ Yes ☐ No	□ Yes □ No	☐ Yes ☐ No
□ Sp □ D □ S □ O		□ M			☐ Yes ☐ No	☐ Yes ☐ No	□ Yes	□ Yes
□ Sp □ D □ S □ O		□ M □ F			□ Yes □ No	□ Yes □ No	□ Yes □ No	□ Yes □ No
*Relationship Cod	e: Sp – Spouse D or S - Natural or adopte	ed daughter	or son O – Othe	er than natural or adopted child. Incl	udes stepch	nild, foster o	hild, or ward	child.
If you previously c www.ers.state.t If you previously c	child, you must complete a Dependent Chi ertified any of your dependents as a tobacco x.us or by calling ERS. ertified any of your dependents as a tobacco at www.ers.state.tx.us or by calling ERS.	user, and a p	ohysician says you	r dependent can't quit, ERS must rec	eive a comp	oleted Physi	cian Affidavit	
	dent have GBP coverage under ERS thro rovide the Social Security number unde	•		•				
	t a new addition to your household bed e only:		s event?					
	roll deductions for the elections inc			. , , ,	hat my in	surance c	overage m	av he
cancelled if I d	o not pay the required amounts due	e, either by	payroll deduc	tion or personal payment. Ι ι	ınderstan	d that all	insurance	, premiums
	on a pre-tax basis, except Depender needed to verify eligibility or to pro							
	benefits information are available f			•				
	s not allowed for health and den							
	that state law does not permit pendent. I understand that accepts							
	equirements for coverage. I underst							
	 and that a QLE does not always a nder the GBP rules, AND be consist 							
benefits for par	ticipants in the Texas Employees Gro	up Benefits	Program (GBI	P) is subject to change based o	n available	e State fur	nding.The Te	exas
year. I understa	ermines the level of funding for such be nd I may be asked to show document secution. I certify that all informations	tation to s	support my sel	ection. False information coul	d lead to	expulsion	from the 0	GBP and/
Employee's S	iignature			Date Signed (n	nm-dd-y	ууу)		

If you are a Health and Human Services Enterprise employee, return this form to $\mathit{accessHR}$

Keep a copy of this form for your files and return the original to your benefits coordinator.

Instructions to Complete the Benefits Election Form

- I. 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.

Event	Qualifying Life Event (QLE) Example	Reasor		
Employee Marital Status Change	Participant gets married			
	Participant gets a divorce or an annulment			
	Death of a spouse	DOD		
Dependent Status Change	Birth of a newborn child			
	Participant adopts, fosters, or gets court-appointed guardianship of child			
	Participant gains or loses dependent(s) through death			
	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.)			
	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			
	Child gets married			
Employment Status Change	Participant/Dependent employment status change			
	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			
	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			
	Significant change in cost/coverage of dependent's health or dental plan (excluding GBP)			
	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.)			
	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 be	nefits coordinator (HHS Enterprise employees contact accessHR) to drop dependent(s) added with an	MSO.		

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 *accessHR*.

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/accessHR for assistance. If you are a Health and Human Services Enterprise employee, contact accessHR 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