



INSURANCE MULTIPURPOSE FORM

Employees Retirement System of Texas

Section A: Employee Data *(For assistance, see the attached instructions).*

National ID/SSN: _____ EmplID: _____ Effective Date: _____ (mm/dd/yyyy) First Active Duty Date: _____ (mm/dd/yyyy)

Employee Name: _____ (First, Middle, Last) Gender: M F Birth Date: _____ (mm/dd/yyyy)

Check if New Address

Mailing Address: _____ City: _____ State: _____ Eligibility County: _____ ZIP Code: _____

Telephone Number: _____ E-Mail Address: _____ Insurance Pay Rate: _____

Change Employee Name: _____ Change Birth Date: _____ (mm/dd/yyyy)

Employee Previously Covered Under Natl. ID/SSN: _____ Employee Natl. ID/SSN: Correction: _____

Agency Name: _____ DeptID/Agency Number: _____ Employee Class: _____

Section B: Action Code

- HIR New Hire REH Rehire TER Termination PHC Post Hire Change FSC Family Status Change EOI Evidence of Insurability
 LOA Leave of Absence (LWP) LOA Leave of Absence (FML) RED Reduction RFL Return from LWP/FML
 DTA FTE to PTE/PTE to FTE **OR** Retiree RTW/Retiree LTW

Section C: Qualifying Life Event *(See Family Status Change reference table on page 2 before completing.)*

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

Section D: Medical Coverage *(Mark appropriate choices.)*

- Medical Coverage** Waive HealthSelect (Evidence of Insurability may be required.) HMO Name _____
 Waive + Opt-Out (By checking Waive + Opt-Out, you also certify that you have comparable coverage. See page 3 of this form for important information.)
 Add/Drop Dependent (See Section E)

Optional Coverage (Newly hired employees may elect coverage on First Active Duty Date or within 30 days of hire without enrolling in Medical coverage.)

- Dental Waive Dental Maintenance Plan State of Texas Dental Choice Plan (GEHA) Add/Drop Dependent (See Section E)
 Optional Life Waive OL1 Election I OL2 Election II OL3 Election III * OL4 Election IV *
 AD/D Waive Mbr Only Mbr+Family Amount \$ _____
 Dependent Life Waive Elect Add/Drop Dependent (See Section E)
 Disability Short-Term Waive Elect Long-Term Waive Elect

* Always requires Evidence of Insurability (EOI). EOI form is available at www.ers.state.tx.us or from your Benefits Coordinator.

Section E: Dependent Coverage *(Read instructions before completing.)*

Name (Last, First, Middle)	Gender	Birth Date (mm-dd-yyyy)	Dep. National ID/SSN (Required for 12 months or older)	Relationship*	Medical	Dental	Dep. Life
	<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> Sp <input type="checkbox"/> D <input type="checkbox"/> S <input type="checkbox"/> O	<input type="checkbox"/> Enroll <input type="checkbox"/> Drop	<input type="checkbox"/> Enroll <input type="checkbox"/> Drop	<input type="checkbox"/> Enroll <input type="checkbox"/> Drop
	<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> Sp <input type="checkbox"/> D <input type="checkbox"/> S <input type="checkbox"/> O	<input type="checkbox"/> Enroll <input type="checkbox"/> Drop	<input type="checkbox"/> Enroll <input type="checkbox"/> Drop	<input type="checkbox"/> Enroll <input type="checkbox"/> Drop
	<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> Sp <input type="checkbox"/> D <input type="checkbox"/> S <input type="checkbox"/> O	<input type="checkbox"/> Enroll <input type="checkbox"/> Drop	<input type="checkbox"/> Enroll <input type="checkbox"/> Drop	<input type="checkbox"/> Enroll <input type="checkbox"/> Drop
	<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> Sp <input type="checkbox"/> D <input type="checkbox"/> S <input type="checkbox"/> O	<input type="checkbox"/> Enroll <input type="checkbox"/> Drop	<input type="checkbox"/> Enroll <input type="checkbox"/> Drop	<input type="checkbox"/> Enroll <input type="checkbox"/> Drop
	<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> Sp <input type="checkbox"/> D <input type="checkbox"/> S <input type="checkbox"/> O	<input type="checkbox"/> Enroll <input type="checkbox"/> Drop	<input type="checkbox"/> Enroll <input type="checkbox"/> Drop	<input type="checkbox"/> Enroll <input type="checkbox"/> Drop

Dependent(s) Previously Covered Under National ID/SSN: _____

*Relationship Code: Sp - Spouse D or S - Natural or adopted Daughter or Son O - Other-than-natural or adopted child (Attach form GI-1.081)

Section F: Authorization *(Carefully read the statement below and sign and date)*

I authorize payroll deductions for the elections indicated on this Insurance Multipurpose Form. I understand that all insurance premiums are deducted on a pre-tax basis, except Dependent Life and Disability. 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 or ERS. I understand that double coverage 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 any fraudulent statements made by me on this form may be cause for expulsion from the GBP. I understand that the inability to adequately substantiate the event and the event date could result in adverse federal income tax consequences to me. 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. I certify that all information provided on this form is valid and true to the best of my knowledge. If you are a Health and Human Services Enterprise employee, return the original to accessHR.

Employee's Signature _____ Date Signed (MM-DD-YYYY) _____

Instructions to Complete the Insurance Multipurpose Form

Information provided to ERS is maintained for the administration of your benefits. If you have questions about your information, or believe that information provided to ERS may be incorrect, please notify ERS.

This form may be used to:

- Apply for Texas Employees Group Benefits Program (GBP) coverages.
- Make allowable changes to GBP coverages or employee data.
- Make changes to your National ID, name, date of birth, sex code or mailing address.

You may contact your Benefits Coordinator 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 30 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 90-day waiting period.
- May elect optional coverage on First Active Duty Date without being enrolled in medical coverage.
- Complete this form in its entirety. Read the authorization in Section F, then sign and date.

Rehire:

- 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.

Employees making changes to their insurance coverage and during the plan year:

- Use this form to indicate only the changes you want to make.
- Complete this form on or within 30 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(s). A family status change (FSC) is not required when making eligible changes through EOI.
- Read the authorization in Section F, then sign and date.

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

Family Status Change (FSC) Reference Table

Event	Qualifying Life Events Example	Reason
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 Other (X) Child Moves Out Dependent Gets Married	BIR ADP DOD DEP XMO 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 NOTE: Employee address change opens an event only if eligibility county changes.	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 cost change by day care provider Significant change in cost/coverage of dependent's health plan (excludes GBP) Significant change in cost/coverage of dependent's dental plan (excludes GBP)	SCC SCC SCC
Court Ordered Coverage Change	Employee gains requirement to provide coverage for child/spouse Employee denied requirement to provide coverage for child/spouse	MSO MSD*

* Employees must contact their Benefits Coordinator to drop dependent(s) added with an MSO.

You may either enter your changes on 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.

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

If you check "Waive + Opt-Out" on the Insurance Multipurpose 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 may view the application of the Health Insurance Opt-Out Credit 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, my enrollment will be subject to evidence of insurability requirements (proof of good health) that I may not pass.

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, you can apply a monthly credit of \$60 (if you are a full-time employee) or \$30 (if you are a part-time employee) toward dental and/or voluntary Accidental Death and Dismemberment (AD&D) premiums under the Group Benefits Program (GBP). Check the coverage you choose to apply your credit to – "Dental" and/or "AD/D." (Do not check "Waive" next to "Dental" and/or "AD/D" unless you want to drop that coverage from your current benefits.)

Notice to TRICARE members: Due to federal legislation, TRICARE members cannot participate in the Opt-Out Credit as of January 1, 2008. If you select the Opt-Out Credit now, your choice will be valid through December 31, 2007; however, you must drop the Opt-Out Credit as of January 1, 2008. You will receive notification from ERS and have the opportunity to re-enroll in a health plan without evidence of insurability (proof of good health).

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