



Retiree/Surviving Dependent Insurance Change/Cancellation Form

You may either enter your changes using your online account at www.ers.state.tx.us or send this completed form to:

ERS
P.O. Box 13207
Austin, Texas 78711-3207
(877) 275-4377 Toll-free

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: PERSONAL DATA (For assistance, see the attached instructions.)

My Participant Type is (choose one):		<input type="checkbox"/> ERS Retiree	<input type="checkbox"/> ERS Surviving Dependent	<input type="checkbox"/> Higher Ed Retiree	<input type="checkbox"/> Higher Ed Surviving Dependent
Retiree/Survivor Name: First, MI, Last		Last 4 digits of SSN		Phone Number	E-Mail Address
		xxx-xx-		<input type="checkbox"/> Home <input type="checkbox"/> Cell	
Mailing Address	<input type="checkbox"/> Check if new	City	State	ZIP Code	Eligibility County

SECTION B: REASON CODE (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 C: INSURANCE COVERAGE (Mark boxes to indicate the coverage changes applicable.)

Medical Coverage	<input type="checkbox"/> Waive* <input type="checkbox"/> HealthSelect SM of Texas	<input type="checkbox"/> HMO Name _____
	<input type="checkbox"/> Waive + Opt-Out (By checking Waive + Opt Out, you also certify that you have comparable coverage. See back of the form for important information.)	
	<input type="checkbox"/> Add/Drop Dependent (See Section D.)	

*Surviving dependents who waive coverage may not re-enroll in the Texas Employees Group Benefits Program (GBP). The Waive + Opt-Out credit is not available to surviving dependents.

Optional Coverage (May be elected without being enrolled in medical coverage.)

Dental	<input type="checkbox"/> Waive <input type="checkbox"/> HumanaDental DHMO <input type="checkbox"/> State of Texas Dental Choice Plan SM <input type="checkbox"/> Drop/Add Dependent (See Section D)
Optional Term Life	<input type="checkbox"/> Waive <input type="checkbox"/> Decrease Level to: <input type="checkbox"/> Election I <input type="checkbox"/> \$10,000
Dependent Life**	<input type="checkbox"/> Waive <input type="checkbox"/> Drop Dependents (See Section D)

**To add or increase this coverage, may require an Evidence of Insurability (EOI) application available at www.ers.state.tx.us or call ERS.

Employee Tobacco User Certification: If you are enrolling in the GBP health plan, have you used any type of tobacco product more than 5 times in the last 3 months? This includes, but is not limited to cigarettes, pipes, cigars, cigarillos, snuff, or chewing tobacco products. Yes No

If you certified yourself as a tobacco user, and a physician says you can't quit, ERS must receive a completed Physician Affidavit available at www.ers.state.tx.us or by calling ERS.

If you previously certified yourself as a tobacco user, and you have stopped using tobacco for three consecutive months, you must complete a Member Affidavit available at www.ers.state.tx.us or by calling ERS.

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

Dependent Tobacco User Certification: If your dependents are enrolled in the GBP health plan, certify below if your dependent used any type of tobacco product more than 5 times in the last 3 months. This includes but is not limited to cigarettes, pipes, cigars, cigarillos, snuff, or chewing tobacco products.

Dependent Relationship*	Dependent's Name (First, MI, Last)	Gender	Date of Birth (mm-dd-yyyy)	Last 4 digit of Dependent SSN (Required for 12 months or older)	Health	Dental	Dep. Life	Tobacco User
<input type="checkbox"/> Sp <input type="checkbox"/> D <input type="checkbox"/> S <input type="checkbox"/> O		<input type="checkbox"/> M <input type="checkbox"/> F		xxx-xx-	<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		xxx-xx-	<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		xxx-xx-	<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		xxx-xx-	<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		xxx-xx-	<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 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.

If you previously certified any of your dependents as a tobacco user, and a physician says your dependent can't quit, ERS must receive a completed Physician Affidavit available at www.ers.state.tx.us or by calling ERS.

If you previously certified any of your dependents as a tobacco user, and your dependent has stopped using tobacco for three consecutive months, you must complete a Member Affidavit available at www.ers.state.tx.us or by calling ERS.

SECTION E: AUTHORIZATION (Carefully read the statement below before you sign and date.)

I authorize the appropriate deductions from my annuity for the benefits selected above, if applicable. If I do not receive an annuity or if my annuity is not sufficient to cover the necessary deductions, I agree to make premium payments when due. I understand that coverage will be cancelled if I do not pay the required premiums. I authorize any provider to release any information about persons covered when such information is deemed necessary to determine eligibility or for the proper disposition of a claim or complaint. I certify all information provided above is valid and true to the best of my knowledge. I understand that fraudulent statements may result in expulsion from the program. **Notice about Insurance** - 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.

Participant's Signature: _____ Date Signed : _____
 (Guardian may sign if participant is a minor child) (mm-dd-yyyy)

EMPLOYEES RETIREMENT SYSTEM OF TEXAS

Instructions to Complete the Retiree/Surviving Dependent Insurance Change/Cancellation Form

Please read the instructions on this page before filling out the form on the other side

This form may be used to:

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

For retirees/surviving dependents 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, a reason code is required in Section B when changing insurance coverage.

A reason code is not required when making eligible changes through EOI.

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

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/coverage of dependent's health or dental plan (excluding GBP)	SCC
Court Ordered Coverage Change (Eligibility rules apply for these dependents)	Retiree requirement to provide coverage for child/spouse(Example: employee receives a medical support order to provide health coverage for his child.)	MSO
	Retiree 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

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

You may either enter using your online account at www.ers.state.tx.us or send this form to ERS.

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 Retiree/Surviving Dependent Insurance Change/Cancellation 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.

Remember, rules will determine if you can enroll in or make the insurance changes you want. You may notify ERS 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

To make your benefit changes online, go to www.ers.state.tx.us and click the sign in button.