ERS®
EMPLOYEES RETIREMENT SYSTEM OF TEXAS

APPLICATION TO REQUEST OR RENEW HEALTH COVERAGE FOR A DISABLED DEPENDENT CHILD (AT AGE 26 AND OVER)

Please mail this completed form to:
Employees Retirement System of Texas
PO BOX 13207, Austin, TX 78711-3207
(877) 275-4377 toll-free

ERS maintains the information provided here, to manage your benefits. If you have questions about your information, or believe that information provided may be incorrect, please notify ERS.

Part I: EMPLOYEE/RETIREE STATEMENT

SECTION A: PERSONAL DATA

Employee/Retiree Name: First, MI, Last		Last 4 digits of SSN	Agency Number
		XXX-XX-	
Mailing Address		**City**	**State** / **ZIP Code**
Phone Number	**Home** ( )	**Work** ( )	**Mobile** ( )

Legal Name of Dependent: First, MI, Last	Dependent SSN	Dependent Date of Birth	Tobacco User
			☐ Yes ☐ No

Dependent Relationship*	Mailing Address	City	State	ZIP Code
☐ daughter ☐ son ☐ other				

*Relationship: Select 'daughter' or 'son' for natural or adopted daughter or son. Select 'other' for all others, including: stepchild, foster child, ward or child under managing conservator.

If you are adding a child not previously covered in the GBP, you must complete and submit along with your application, a Dependent Child Certification form (ERS GI 1.081) available at **http://ers.texas.gov/PDFs/Forms/Dependent_Child_Certification-1081.pdf**. You will be required to provide documentation dated prior to the enrollment date, that proves your dependent's eligibility.

Individuals are required to demonstrate proof of eligibility if you are adding your dependent to medical. Dependents added to medical will be required to demonstrate eligibility through Dependent Eligibility Verification.

SECTION B: COVERAGE INFORMATION

You may submit this application to ERS either: within 90 days before the date your covered dependent turns age 26, within 90 days before the expiration date of your child's disabled dependent GBP coverage, during your Initial Enrollment Period as a new employee, during your Annual Enrollment period, within the first 30 days of a valid qualifying life event (QLE), or within 30 days from the date of your dependent child's first medical treatment related to his or her disability.

Please note: A medical diagnosis of a permanent disability is not the only requirement a dependent must meet to gain coverage under this program. For example, the dependent must also be financially dependent on the employee/retiree and without a self-sustaining employment.

Dependent Coverage Requested:		**Canceled Date** (if applicable)
☐ Medical	Other: ☐ Dental ☐ Vision ☐ Employee and Family AD&D ☐ Dependent Life	

SECTION C: EMPLOYEE/RETIREE STATEMENT

1. Is the dependent mentally or physically disabled to the extent that he/she regularly depends on you for care or support? ☐ Yes ☐ No
   Please describe the care or support you provide: _____
   If yes, what percentage of care or support do you provide? _____%
2. Did you claim the dependent on your last Federal Income Tax Return? ☐ Yes ☐ No
   a. If yes, provide a copy of your last Federal Income Tax Return.
   b. If no, will you claim the dependent on your next Federal Income Tax Return? Yes No
3. Does the dependent share a primary residence with you? ☐ Yes ☐ No
   If no, please list the dependent's primary residence: _____
4. Does the dependent receive Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI) or other disability benefits?
   ☐ Yes ☐ No If yes, provide copy of award letter and most recent monthly statement.
5. Is the dependent covered by Medicaid? ☐ Yes ☐ No Medicaid Number: _____ Effective Date: _____
6. Is the dependent covered by Medicare? ☐ Yes ☐ No Medicare Number: _____ Part A Effective Date: _____
   Part B Effective Date: _____
7. Has the dependent ever been under observation, care or treatment in any hospital, sanitarium or similar institution as an inpatient? ☐ Yes ☐ No
   If yes, please complete the following: Name of hospital(s) or institution(s): _____
   Date of last treatment of care: _____ Number of days _____
8. Nature of the dependent's disability: _____
9. Does this disability prevent the dependent from being able to work and support him/herself? ☐ Yes ☐ No
10. Date of first medical treatment relating to the disability: _____
11. Is your dependent currently employed or previously employed within the last six months? ☐ Yes ☐ No
    If yes, provide a copy of your dependent's most recent W2 and/or 1099 and complete the information below.
12. Employer: _____
13. Job Duties: _____
14. Dates Employed: _____ Earnings: _____

You must also complete the attending physician's statement on the reverse side.

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 26 and over is not guaranteed and is subject to approval by the Employees Retirement System of Texas (ERS). I understand that any fraudulent statements may be cause for my permanent expulsion from the Texas Employees Group Benefits Program (GBP).

I understand and acknowledge that this form is a Governmental Record and it is a criminal offense if I make any false statement in this Application to Request Continuation Of Coverage for a Disabled Dependent Child, at age 26 and Over in an attempt to defraud ERS or any other person.

All of the information provided in this Application to Request Coverage for a Disabled Dependent Child at Age 26 and over, is true and correct and based on my personal knowledge.

Notice about Insurance: Funding for health and other insurance benefits for participants in the 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.

Tobacco-use Certification: I certify my understanding and agreement to the following: "Tobacco Product" is defined as all types of tobacco, including but not limited to, cigarettes, cigars, pipe tobacco, chewing tobacco, snuff, dip, and all e-cigarettes/vaping products, and a "Tobacco User" is a person who has used any Tobacco Products five or more times within the past three consecutive months. If I (or any of my covered dependents): 1) have used Tobacco Products as a Tobacco User; or 2) start using Tobacco Products without notifying ERS, I will be subject to monetary penalties and may be terminated from participation in the GBP. Also, failure to notify ERS will constitute fraud. Under the penalties of perjury, the above information is true and correct. Providing or entering false information may disqualify me from continued coverage in the GBP. If I intentionally misrepresent material facts or engage in fraud, my coverage may be rescinded retroactively to the date of the misrepresentation or fraudulent act. In that event, I will receive thirty days notice before my coverage is rescinded. Further, if I or any of my covered dependents start using Tobacco Products without notifying ERS, I will be subject to monetary penalties and such failure to notify ERS will constitute fraud. If you certified yourself or any of your dependents as a tobacco user, you may be able to participate in Choose to Quit, an alternative to the tobacco-user premium, if it is right for your health status and complies with your doctor's recommendations. For more information about this program, visit, **https://ers.texas.gov/TobaccoPolicy-and-Certification**.

If you previously certified yourself or any of your dependents as a tobacco user, and you or they have stopped using tobacco for three consecutive months, you must complete the Tobacco-User Certification Form (ERS 2.933) available at **https://ers.texas.gov/PDFs/Forms/Tobacco_User_Certification_ERS2933.pdf**, or change the certification using your online account at **www.ers.texas.gov**.

_____	_____/____/_____	( ) _____	( ) _____
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. It is a crime to purposely misrepresent medical facts regarding the patient's condition.*

1. Is the dependent able to work at any occupation on a full-time basis? ☐ Yes ☐ No
   If no, was the dependent incapacitated from all work prior to reaching age 26 and when did the incapacity begin _____
2. Will the dependent be capable of any type of employment in the future? ☐ Yes ☐ No ☐ Questionable
   If yes or questionable, provide explanation and give approximate date and the type of employment (sedentary, light duty, etc.) the dependent will or may be capable of performing; including any limitations **or reasonable accommodations that may be required.**
   _____
3. Nature and extent of incapacity. Please provide a complete diagnosis, including an ICD-9 (International Classification of Diseases) notation. Please provide all pertinent evaluation materials of the overage disabled dependent's medical condition.
   _____
   _____
4. Date dependent was last examined: _____ Abnormal findings at the time of last examination: _____
   Prognosis: _____
5. How long has the patient been under your care? _____
   Provide the date the patient was first diagnosed with the disabling condition: _____
6. How does condition(s) restrict the dependent's ability to engage in normal activities of daily living?
   _____
   _____
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: _____
   (Physician must either be a medical doctor (MD) or doctor of osteopathic (DO) medicine.)
10. Physician Signature: _____ Date: _____
    (Form is invalid without physician's signature and date of signature.)
11. Office Address: _____
12. Physician's Phone Number: _____ Fax Number: _____