COBRA SUMMER ENROLLMENT FORM

ERS® Employees Retirement System of Texas

You may either enter your changes using your online account at **www.ers.texas.gov** or send this completed form to:
Employees Retirement System of Texas
P.O. Box 13207
Austin, Texas 78711-3207
(866) 399-6908 Toll-free

If you do not need to make any changes, it is not necessary to complete this form or contact ERS.

Information provided to the 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: COBRA PARTICIPANT DATA *(To be completed by the COBRA participant.)*

COBRA Participant Name: First, MI, Last	Last 4 digits of Social Security Number/National ID (SSN)	Phone Number ☐ Home ☐ Cell
	XXX-XX-	( )

Email Address	Mailing Address ☐ Check if New	City	State	ZIP Code	Eligibility County

SECTION B: INSURANCE COVERAGE *(Mark boxes to indicate the coverage changes you want starting September 1, 2023.)*

Medical Coverage	☐ Waive*	☐ HealthSelect of Texas®	☐ Consumer Directed HealthSelect℠
	☐ Enroll/Add/Drop** Dependent (See Section C)		
Optional Benefits *(May be elected without being enrolled in health coverage.)*			
Dental	☐ Waive ☐ State of Texas Dental Choice Plan℠ ☐ DeltaCare® USA DHMO ☐ Enroll/Add/Drop Dependent (See Section C)		
Vision	☐ Waive ☐ State of Texas Vision℠ ☐ Enroll/Add/Drop Dependent (See Section C)		
Tobacco-User Certification: If you are enrolled in a Texas Employees Group Benefits Program (GBP) health plan, have you used any type of tobacco product five or more times in the last three months? This includes but is not limited to cigarettes, cigars, pipe tobacco, chewing tobacco, snuff, dip, and all e-cigarettes / vaping products. ☐ Yes ☐ No			

*COBRA participants who waive medical coverage may not re-enroll at a later date.
**If a dependent drops medical coverage they cannot re-enroll at a later date.

SECTION C: DEPENDENT PERSONAL DATA *(and coverage choices.)*

Dependent Tobacco-User Certification: If your dependents are enrolled in a GBP health plan, you must certify below if your dependent used any type of tobacco product five or more times in the last three months. This includes but is not limited to cigarettes, cigars, pipe tobacco, chewing tobacco, snuff, dip, and all e-cigarettes / vaping products.

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	Vision	Tobacco User
☐ Sp ☐ D ☐ S ☐ O		☐ M ☐ F		XXX-XX-	☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
☐ Sp ☐ D ☐ S ☐ O		☐ M ☐ F		XXX-XX-	☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
☐ Sp ☐ D ☐ S ☐ O		☐ M ☐ F		XXX-XX-	☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
☐ Sp ☐ D ☐ S ☐ O		☐ M ☐ F		XXX-XX-	☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
☐ Sp ☐ D ☐ S ☐ O		☐ M ☐ F		XXX-XX-	☐ No	☐ 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.texas.gov** or call ERS.
**If a dependent drops medical coverage they cannot re-enroll at a later date.

SECTION D: AUTHORIZATION *(Carefully read the statements below before you sign and date.)*

I authorize the appropriate deductions from my annuity or through bank draft 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 on persons covered when needed to verify eligibility or to process an insurance claim or complaint. **I certify all information provided above is valid and true to the best of my knowledge. I understand I may be asked to show documentation to support my selection, and/or to prove eligibility for any newly added dependents.** False information could lead to expulsion from the Texas Employees Group Benefits Program (GBP) and/or criminal prosecution.

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 User Certification: I certify my understanding and agreement to the following: "Tobacco Products" 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/About-ERS/Policies/Tobacco-Policy-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 ERS OnLine account at **www.ers.texas.gov**.

I understand that if I as a COBRA participant waive my medical coverage, I cannot re-enroll in medical coverage at a future date. If all coverage is waived, medical and optional coverage, I cannot re-enroll at any future date.

Participant's Signature:_____ Date Signed:_____

(Parent or legal guardian may sign for minor child) (mm-dd-yyyy)