



RETIREE SUMMER ENROLLMENT FORM

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: RETIREE DATA (To be completed by retiree.)

Retiree Name: First, MI, Last		Last 4 digits of Social Security Number/National ID (SSN)		Phone Number <input type="checkbox"/> Home <input type="checkbox"/> Cell		
		XXX-XX-		()		
Email Address	Mailing Address <input type="checkbox"/> 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	<input type="checkbox"/> Waive	<input type="checkbox"/> HealthSelect of Texas®	<input type="checkbox"/> Consumer Directed HealthSelect SM
	<input type="checkbox"/> Waive + Opt-Out (For retirees who can certify they have comparable coverage that is not Medicare.)		
	<input type="checkbox"/> Enroll/Add/Drop Dependent (See Section C)		
Optional Benefits (May be elected without being enrolled in health coverage.)			
Dental	<input type="checkbox"/> Waive	<input type="checkbox"/> State of Texas Dental Choice Plan SM	<input type="checkbox"/> DeltaCare® USA DHMO
	<input type="checkbox"/> Enroll/Add/Drop Dependent (See Section C)		
Vision	<input type="checkbox"/> Waive	<input type="checkbox"/> State of Texas Vision SM	<input type="checkbox"/> Enroll/Add/Drop Dependent (See Section C)
Optional Term Life Insurance**	<input type="checkbox"/> Waive	OR	<input type="checkbox"/> Enroll \$10,000 Decrease Level to: <input type="checkbox"/> Election I* <input type="checkbox"/> \$10,000
Dependent Term Life Insurance**	<input type="checkbox"/> Waive	<input type="checkbox"/> Enroll/Add/Drop Dependent (See Section C)	
Tobacco-User Certification: If you are enrolled or enrolling 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. <input type="checkbox"/> Yes <input type="checkbox"/> No			

*You must be currently enrolled in Optional Life x 2. Once you elect to decrease to Level I, you cannot increase the level of Optional Term Life Insurance at a later date.
 **To apply for Dependent Term Life Insurance or the \$10,000 Retiree Fixed Optional Life Insurance coverage, evidence of insurability (EOI), is required. Initiate the EOI process by signing in to your ERS OnLine account at www.ers.texas.gov, or contact ERS.

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	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"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<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"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<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"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<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"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<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"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<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.texas.gov or call ERS. For dependents newly enrolled in health coverage, you may be required to provide documentation to Alight Solutions to verify your dependents' eligibility.

** If your dependent is Medicare eligible, contact ERS and provide their Medicare information. Once their Medicare information is updated, we can review their options.

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 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/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.

If you selected "Waive + Opt-Out Credit":

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 understand waiving my state health insurance will cancel my prescription drug coverage and \$2,500 Retiree Basic Term Life Insurance policy. I will receive a credit of up to \$60 (or \$30 for part-time participants) that will be applied toward the cost of eligible optional coverage (dental and/or vision). The credit is in place of the state contribution for basic health coverage. Due to federal legislation Medicare members cannot receive the Opt-Out Credit. I am able to view the Health Insurance Opt-Out Credit applied toward my eligible optional coverage premium by signing in to my ERS OnLine account at www.ers.texas.gov.

I understand that if I am currently in a waived status, I must have a qualifying life event or wait until the next Summer Enrollment to enroll in medical or optional coverage offered to eligible participants.

Retiree's Signature: _____

Date Signed: _____

(mm-dd-yyyy)