ERS®
EMPLOYEES RETIREMENT SYSTEM OF TEXAS

SUMMER ENROLLMENT FORM

Information provided to the Employees Retirement System of Texas (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.

Return the completed form to your agency benefits coordinator.

SECTION A: EMPLOYEE DATA *(For assistance, contact your benefits coordinator.)*

Last 4 digits of Social Security Number (SSN)	Agency Name	Dept ID/Agency Number	Effective Date
XXX-XX-			September 1, 2023

Employee Name: First, MI, Last	Phone Number	Email Address
	☐ Home ☐ Cell ( )	

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

Important: Summer Enrollment allows you to make changes or apply for benefits and TexFlex for the new plan year. During the plan year, a qualifying life event (QLE) must occur before you can make changes to certain benefits. Changes due to QLEs must be requested within 31 days of the event.

SECTION B: BENEFITS OPTIONS *(Mark appropriate choices.)*

Health Coverage	Optional Benefits (May be elected without being enrolled in health coverage.)					
Health	**Dental**	**Vision**	**Optional Term Life Insurance***	**Voluntary AD&D**	**Dependent Term Life Insurance***	**Short-term Disability***
☐ Waive ☐ HealthSelect of Texas® ☐ Consumer Directed HealthSelect℠ ☐ Enroll/Add/Drop Dependent (See Section C) ☐ Waive + Opt-Out Credit *(By checking Waive + Opt Out Credit, you also certify that you have comparable coverage. See back of form for important information.)*	☐ Waive ☐ State of Texas Dental Choice Plan℠ ☐ DeltaCare® USA DHMO ☐ Enroll/Add/Drop Dependent *(See Section C)*	☐ Waive ☐ State of Texas Vision℠ ☐ Enroll/Add/Drop Dependent *(See Section C)*	☐ Waive ☐ Enroll Elect coverage level ☐ OL1 Election 1 ☐ OL2 Election 2 ☐ OL3 Election 3 ☐ OL4 Election 4 Decrease Level to ☐ OL1 Election 1 ☐ OL2 Election 2 ☐ OL3 Election 3	☐ Waive ☐ You Only ☐ You + Family $____________ Amount up to $200,000 in increments of $5,000	☐ Waive ☐ Enroll/Add/Drop Dependent *(See Section C)*	☐ Waive ☐ Enroll **Long-term Disability*** ☐ Waive ☐ Enroll

*Adding or increasing this coverage will require evidence of insurability (EOI). Initiate the EOI process by signing in to your online account at **www.ers.texas.gov**, or contact your benefits coordinator/HHS Employee Service Center.

Employee 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. ☐ Yes ☐ No

SECTION C: DEPENDENT PERSONAL DATA *(and benefits 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
☐ Sp ☐ D ☐ S ☐ O		☐ M ☐ F			☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
☐ Sp ☐ D ☐ S ☐ O		☐ M ☐ F			☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
☐ Sp ☐ D ☐ S ☐ O		☐ M ☐ F			☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
☐ Sp ☐ D ☐ S ☐ O		☐ M ☐ F			☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
☐ Sp ☐ D ☐ S ☐ O		☐ M ☐ F			☐ Yes ☐ No	☐ Yes ☐ 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. 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 by calling ERS. For dependents newly enrolled in health coverage, you may be required to provide documentation to Alight Solutions to verify your dependents' eligibility.

Continue to next page to complete form.

NOTE: You may enter your changes using your online account at **www.ers.texas.gov**, contact your benefits coordinator/HHS Employee Service Center or contact ERS.

Last 4 digits of Employee SSN xxx-xx-_____ Employee Name: First, MI, Last _____

SECTION D: TEXFLEX℠ flexible spending account (FSA) ENROLLMENT

Sign up for TexFlex for PY24 (September 1, 2023 - August 31, 2024). There will be an "administrative fee holiday" again this plan year. You will receive a TexFlex debit card when you enroll in the TexFlex health care FSA or TexFlex limited-purpose FSA if you were not enrolled last plan year. There is no annual fee for the debit card. The TexFlex debit card cannot be used for the TexFlex dependent care account.

☐ TexFlex health care FSA beginning September 1, 2023 (Minimum $180/maximum $3,050 per plan year)	$ _____.00 Annual Contribution	If you had a TexFlex account in Plan Year 2023, you will be automatically re-enrolled for the same annual amount up to the current maximum amount unless you change your selection during Summer Enrollment. If you have elected Consumer Directed HealthSelect℠ you are not eligible to enroll in the health care account.
☐ TexFlex dependent care FSA beginning September 1, 2023 (Minimum $180/maximum $5,000 per plan year)	$ _____.00 Annual Contribution	
☐ TexFlex limited-purpose FSA beginning September 1, 2023 (Minimum $180/maximum $3,050 per plan year)	$ _____.00 Annual Contribution	Only applicable with enrollment in the Consumer Directed HealthSelect℠ plan.

☐ **My annual salary is paid in less than 12 months.**
(If checked, you will have a 9 month election. If not checked, your selection will default to 12 months.)

☐ I want to stop my enrollment in the TexFlex health care FSA for Plan Year 2024.

☐ I want to stop my enrollment in the TexFlex dependent care FSA for Plan Year 2024.

☐ I want to stop my enrollment in the TexFlex limited-purpose FSA for Plan Year 2024.

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

I authorize payroll deductions for the elections indicated on this Summer Enrollment Form. My insurance coverage may be cancelled if I do not pay the required amount 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 or complaint. My Texas Employees Group Benefits Program (GBP) coverage will remain in effect for the plan year unless I have a qualifying life event (QLE).

I have reviewed and understand the TexFlex account enrollment rules as explained on the ERS website. I understand I must have a QLE in order to increase or decrease my TexFlex account amount during the plan year. I understand my TexFlex dependent care account election is irrevocable for the plan year, and I must have a QLE in order to change my TexFlex dependent care account election or amount. I certify that all information provided on this form is valid and true to the best of my knowledge. I understand I will be asked to show documentation to support my selection and/or to prove eligibility for any newly added dependents and that all documentation must be dated prior to the enrollment date. False information could lead to expulsion from the 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/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 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 $5,000 Basic Term Life policy. 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 (dental, vision and/or Voluntary Accidental Death and Dismemberment (AD&D). 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 into my online account at **www.ers.texas.gov**.

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

Signature:_____ Date Signed (mm-dd-yyyy) :_____

To make your Summer Enrollment benefit changes online, go to **www.ers.texas.gov**.

More information available at:
Employees Retirement System of Texas
(866) 399-6908 toll-free
www.ers.texas.gov