INSURANCE MULTIPURPOSE FORM
Employees Retirement System of Texas

Section A: Employee Data *(Consult your Benefits Coordinator for assistance.)*

National ID/SSN: ______________________ **EmplID:** _______________________ **Effective Date:** ________________ (mm/dd/yyyy) **First Active Duty Date:** ______________ (mm/dd/yyyy)

Employee Name: ____ (First, Middle, Last) **Gender:** ☐ M ☐ F **Birth Date:** ________________ (mm/dd/yyyy)

☐ Check if New Address

Mailing Address: ________________________________ **City:** ____________________ **State:** _____ **Eligibility County:** _____________ **ZIP Code:** _________

Telephone Number: ____________________________ **E-Mail Address:** ____ **Insurance Pay Rate:** _____________

Change Employee Name: ____ **Change Birthdate:** ________________ (mm/dd/yyyy)

Employee Previously Covered Under Natl. ID/SSN: _______________________ **Employee Natl. ID/SSN: Correction:** ________________

Agency Name: ____ **DeptID:** _________________ **Employee Class:** ____________

Section B: Action Code *(Consult your Benefits Coordinator for assistance)*

HIR ☐ New Hire REH ☐ Rehire TER ☐ Termination PHC ☐ Post Hire Change FSC ☐ Family Status Change EOI ☐ Evidence of Insurability
LOA ☐ Leave of Absence (LWP) LOA ☐ Leave of Absence (FML) ☐ DTA FTE to PTE or PTE to FTE RFL ☐ Return from LWP/FML
RED ☐ Reduction

Section C: Qualifying Life Event *(Read instructions before completing. Consult your Benefits Coordinator for assistance.)*

Complete for changes during the plan year. Action Code __________ Reason Code: _________ Event Date ________________ (mm-dd-yyyy)

Section D: Insurance Coverage *(Mark appropriate choices. Consult your Benefits Coordinator for assistance.)*

Medical Coverage (New hire health coverage will be effective the first day of the month following the 90-day waiting period.)

☐ Waive ☐ HealthSelect ☐ HMO Name/City______________________ ☐ Add/Drop Dependent (See Section E)

Optional Coverage (Newly hired employees may elect coverage on First Active Duty Date or within 30 days of hire without enrolling in Medical coverage.)

Dental	☐ Waive	☐ Dental Maintenance Plan	☐ Dental Choice Plan		☐ Add/Drop Dependent (See Section E)
Optional Life	☐ Waive	OL1 ☐ Election I	OL2 ☐ Election II	OL3 ☐ Election III *	OL4 ☐ Election IV *
AD/D	☐ Waive	☐ Mbr Only	☐ Mbr+Fam	Amount $____________________	
Dependent Life	☐ Waive	☐ Elect	☐ Add/Drop Dependent (See Section E)		
Disability	Short-Term	☐ Waive	☐ Elect	Long-Term ☐ Waive	☐ Elect

* Always requires Evidence of Insurability (EOI). EOI form is available at www.ers.state.tx.us or from your Benefits Coordinator.

Section E: Dependent Coverage *(Read instructions before completing. Consult your Benefits Coordinator for assistance.)*

Name (Last, First, Middle)		Birth Date (mm-dd-yyyy)	Dep. National ID/SSN (Required for 12 months or older)	Relationship*	Health	Dental	Dep. Life
	☐ M ☐ F			☐ Sp ☐ D ☐ S ☐ O	☐ Enroll ☐ Drop	☐ Enroll ☐ Drop	☐ Enroll ☐ Drop
	☐ M ☐ F			☐ Sp ☐ D ☐ S ☐ O	☐ Enroll ☐ Drop	☐ Enroll ☐ Drop	☐ Enroll ☐ Drop
	☐ M ☐ F			☐ Sp ☐ D ☐ S ☐ O	☐ Enroll ☐ Drop	☐ Enroll ☐ Drop	☐ Enroll ☐ Drop
	☐ M ☐ F			☐ Sp ☐ D ☐ S ☐ O	☐ Enroll ☐ Drop	☐ Enroll ☐ Drop	☐ Enroll ☐ Drop
	☐ M ☐ F			☐ Sp ☐ D ☐ S ☐ O	☐ Enroll ☐ Drop	☐ Enroll ☐ Drop	☐ Enroll ☐ Drop
	☐ M ☐ F			☐ Sp ☐ D ☐ S ☐ O	☐ Enroll ☐ Drop	☐ Enroll ☐ Drop	☐ Enroll ☐ Drop

Dependent(s) Previously Covered Under National ID/SSN: ______________________________

*Relationship Code: Sp - Spouse D or S - Natural or adopted Daughter or Son
O - Other-than-natural-or-adopted child (Attach form GI-1.081)

Section F: Authorization *(Carefully read the statement below and sign and date)*

I authorize payroll deductions for the elections indicated on this Insurance Multipurpose Form. I understand that all insurance premiums are deducted on a pre-tax basis, except Dependent Life and Disability. I understand that my insurance coverages may be cancelled if I do not pay the required amounts 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/complaint. I understand that insurance participation rules and enrollment and benefits information are available from my Benefits Coordinator. I understand that double coverage is not allowed for health and dental coverage in the Texas Employees Group Benefits Program (GBP). I understand that State law does not permit me to receive more than one State insurance contribution as either an employee, retiree or dependent. I understand that acceptance of a premium does not constitute valid enrollment of the ineligible person nor waive the eligibility requirements for coverage. I understand that my GBP coverages will remain in effect for the plan year unless I have a qualifying life event (QLE) and that a QLE does not always allow me to make changes to my insurance coverages because the insurance change must be allowable under the GBP rules, AND be consistent with the QLE. I understand that any fraudulent statements made by me on this form may be cause for expulsion from the GBP. I understand that the inability to adequately substantiate the event and the event date could result in adverse federal income tax consequences to me. I understand that if I or my dependent(s) do not enroll in HealthSelect during our initial period of eligibility, evidence of insurability may be required to enroll in such health plan. I certify that all information provided on this form is valid and true to the best of my knowledge.

Employee's Signature ____ **Date Signed (MM-DD-YYYY)** ______________________

Instructions to Complete the Insurance Multipurpose Form

Information provided to the Employees Retirement System of Texas (ERS) is maintained for the administration of your benefits. If you have questions about your information, or believe that information provided to ERS may be incorrect, please notify ERS.

This form may be used to:

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

You may contact your Benefits Coordinator for assistance

Remember, insurance rules will determine if you can enroll in or make the insurance changes you want. You may notify your Benefits Coordinator when you move or have a change in family status (qualifying life event), or you may enter the event into ERS OnLine at www.ers.state.tx us and make your election changes. If you do not make changes within 30 days, you may not be eligible to make the changes you want.

New Employees:

- May elect health coverage at time of hire; however, this coverage will be effective the first day of the month following the 90-day waiting period.
- May elect optional coverage on First Active Duty Date without being enrolled in medical coverage.
- Complete this form in its entirety. Consult your Benefits Coordinator for assistance.
- Read the authorization in Section F, then sign and date.

Rehire:

- Complete this form in its entirety. Consult your Benefits Coordinator for assistance.
- May elect optional coverage without being enrolled in medical coverage.
- Read the authorization in Section F, then sign and date.

Employees making changes to their insurance coverage and during the plan year:

- Use this form to indicate only the changes you want to make (consult your Benefits Coordinator).
- Complete this form on or within 30 days after your qualifying life event (new hire, marriage, etc.).
- Using the chart below, identify a Reason Code (required in Section C) when changing insurance coverage(s). A family status change (FSC) is not required when making eligible changes through EOI.
- Read the authorization in Section F, then sign and date.

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

Family Status Change (FSC) Reference Table

Event	Qualifying Life Events Example	Reason
Employee Marital Status Change	Marriage	MAR
	Divorce or Annulment	DIV
	Death of spouse	DOD
Dependent Status Change	Birth of new dependent	BIR
	Adoption/Foster placement of new dependent	ADP
	Employee gains or loses dependent(s) through death	DOD
	Dependent becomes eligible or loses eligibility for insurance coverage	DEP
	Other (X) Child Moves Out	XMO
	Dependent Gets Married	DGM
Employment Status Change	Employee/Dependent Employment Status Change	ESC
	Dependent becomes eligible for insurance through employment	DWP
Address Change that changes Dependent Eligibility	Dependent moves out of health plan service area	DMV
	Dependent moves out of dental plan service area	DMV
	NOTE: *Employee address change opens an event only if eligibility county changes.*	
Medicare or Medicaid Status Change	Employee/Dependent gains Medicare/Medicaid eligibility	MDG
	Employee/Dependent loses Medicare/Medicaid eligibility	MDL
Significant Change in Cost/Coverage Imposed by Third Party	Significant cost change by day care provider	SCC
	Significant change in cost/coverage of dependent's health plan (excludes GBP)	SCC
	Significant change in cost/coverage of dependent's dental plan (excludes GBP)	SCC
Court Ordered Coverage Change	Employee gains requirement to provide coverage for child/spouse	MSO
	Employee denied requirement to provide coverage for child/spouse	MSD*

* Members must contact their Benefits Coordinator to drop dependent(s) added with an MSO.

You may either enter your changes on ERS OnLine at www.ers.state.tx.us
or send this form to your Benefits Coordinator.