# Workers' Compensation Claims for State Active Duty – Texas Air National Guard

**08 October 2021**

# TEXAS MILITARY DEPARTMENT STRATEGY

## VISION:

*America's premier state military comprised of mission-ready professionals fully engaged with our communities, and relevant through the 21st century.*

## MISSION:

*Provide the Governor and President with ready forces in support of state and federal authorities at home and abroad.*

### *PEOPLE FIRST – Invest in our human capital*

- Diverse & Engaged Force Sustained Through Effective Retention & Recruiting
- Trained Ethical Professionals
- Resilient Professionals & Families, Supported By Robust Services
- Clearly Communicated Opportunities For Professional & Personal Development

### *RELEVANT & READY – Provide right force at the right time*

- Force Structure Optimized For Federal & State Missions
- Modern Training Areas & Facilities That Support Our Mission
- Effective Resource Management & Protection
- Enhanced Joint, Interagency, Intergovernmental & Multinational Capabilities

### COMMUNICATE & PARTNER – Deliver our message and build lasting relationships

- Effective Communication Assets & Channels
- Partnered & Informed Communities
- Engaged & Educated Government Partners
- Strong Department of Defense Relationships

# Why is it important to get it right?

## *ALL TMD*

| FY | Total | Accepted | Denied |
|---|---|---|---|
| FY17 | 76 | 55 | 21 |
| FY18 | 103 | 75 | 28 |
| FY19 | 16 | 13 | 3 |
| FY20 | 40 | 27 | 13 |
| FY21 | 71 | 52 | 19 |

## *TXANG (SAD) - claims only*

| | Total | Accepted | Denied |
|---|---|---|---|
| FY22* | 0 | 0 | 0 |

**FY21 – Current as of 30 September 2021*

***NOTE***: *Beginning FY21, data is available per section at the agency level.*

# What happens when SORM denies a claim?

- Delay or denial of benefits
- Unpaid medical bills
- Potential loss of wages
- Frustration and potential hardship for the injured person

# Why are claims being denied?

- Delays in submitting required forms
- Incomplete or missing information *(not showing how the incident/injury is related to mission)*
- Poor documentation *(such as using these words on the forms - I don’t know what happened, It happened sometime on mission, or just “on mission”)*
- Confusion about what’s covered

# What is Worker’s Compensation?

- State-regulated insurance benefit program
- Pays medical bills
- *May* replace *a percentage* of lost wages from full or part time work outside of duty for state active duty members with a qualifying injury or occupational illness

- Replacement or secondary insurance plan for injuries or illnesses that occur outside of the course and scope of employment
- Not a payout for injury or illnesses

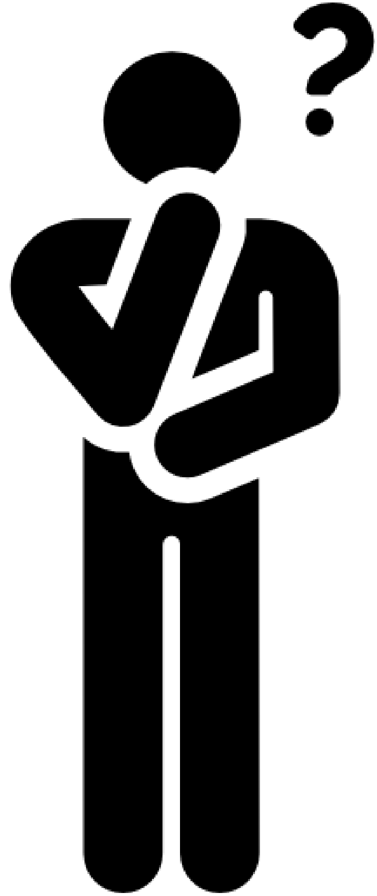
| Claim | Vs. | Incident |
|---|---|---|
| Medical bill<br>**AND/OR**<br>Lost time from work | | No bill<br>**AND**<br>No lost time from work |

*Submit forms **NLT 5 days** of event to Workers Compensation Coordinator*

***Don't forget to follow your chain of command***

# Responsibilities

# Who Does What?



| Injured Person | Supervisor<br>(or person responsible for the injured person) |
|---|---|
| • Notify Supervisor **immediately** of all emergencies<br>• Notify Supervisor of *ALL* incident/injury<br>• **Complete and submit ALL required forms within 3 - 5 days of the incident/injury**<br>• Seek medical treatment in the CareWorks network, *if needed*<br>• Inform the doctor this is a work-related incident/injury<br>• Report *ALL* work status changes immediately<br>• Keep all follow-up appointments | • Notify the TMD State Workers' Compensation Coordinator (WCC) ***within 24 hours*** of incident/injury<br>• ***IMMEDIATELY*** notify TMD WCC of hospitalization or death<br>• Assist the injured person with obtaining forms, if needed<br>• Report work status changes to WCC, especially when going off mission and/or unable to perform full time work<br>• Notify WCC of any issues or concerns<br>• Assist the injured person with return to work |

# *Remember…*

Delays in reporting may result in a denied claim or delay of benefits for the injured person

# Forms Guidance

# Required Forms

**NOTE**: Forms should be **emailed** to the Workers' Compensation Coordinator (WCC) *as soon as possible*. Additionally, fines may occur if the agency neglects to report an injury or status change timely.

**Employee**

- ❑ SORM 29 – Employee's Report of Injury
- ❑ SORM 16 – Authorization for Release of Information
- ❑ Network Acknowledgement Form
- ❑ ***Don't forget a copy of the orders***

**Supervisor**

- ❑ SORM 703 – Investigation Form
- ❑ DWC1s – Employer's Report of Injury

**Witness**

- ❑ SORM 74 – Witness Form

# Injured Person's Forms

# SORM Form 29

## EMPLOYEE'S REPORT OF INJURY

Dear Employee:

We received a report that you were injured in the course of your employment. To process your claim efficiently, please fill in all lines completely and print legibly. **Attach additional sheets if necessary.**

Name: Zesleep, John (Last / First / M.I. / Maiden)
Social Security: 789-22-4560 Gender: ☒M ☐F
Address: 546 On the Rocks Blvd
Date of Injury: 09/07/2021
City: Shaky State: TX ZIP: 77701
Employer: TMD, TXARNG
Primary Phone Number: 741-852-0963
Job Title: Mechanic
Secondary Phone Number: n/a
Work Schedule: 8am-5pm, Mon-Fri
Email address: johnneedzesleep@hotmail.com

1) What was the exact location of the accident? Include street address if possible:
147 OhNo Ave, Corona, TX 03218 - mechanic shop, bldg 101

2) What was happening at the time? What was going on around you, what were you doing, what were other people doing?:
Soldiers were preparing to go out on mission. As we were doing a final check on the vehicles, someone noticed liquid coming from underneath a truck.

3) Briefly describe what exactly caused the injury:
As I approached the truck, I was unable to see anything. When I bent over to get a better look, I felt a pop in my back.

4) What areas of your body were injured? low back

5) When and to whom did you report your injury? Date 09/07/2021 Time 0900
Name: Gerry Attrick Title CPT Phone Number: 333-852-0179

6) List all known witnesses (continue on back if necessary): 1. Name Penny Okeo Phone: 798-123-5046
2. Name n/a Phone: n/a 3. Name: n/a Phone: n/a

7) Who is your Primary Care Physician or family doctor? Name: Dr Oscar Nono Phone: 654-908-7312

8) Please list the names and phone numbers of all doctors or treatment providers you have seen for your injury:
Name: pending Phone: n/a
Name: Phone:
Name: Phone:

9) Has a doctor taken you off work? ☐ Yes ☒ No If Yes, when was the first day you missed work? n/a

10) If the doctor took you off of work, have you returned to work? ☐ Yes ☐ No If No, when do you think you will return to work? n/a

11) Date of Last Appointment: n/a Date of Next Appointment: pending

12) Have you had previous workers compensation injuries? ☐ Yes ☒ No If Yes, please enter injury dates and body parts injured:
N/A

*By affixing my signature, I attest that all information on this form is accurate and true:*

Signature: [signature] Date: 09/07/2021

SORM-29f Rev. 3/16

Training Example

# SORM Form 16

**AUTHORIZATION FOR RELEASE OF INFORMATION**

Patient: John Zesleep

TO WHOM IT MAY CONCERN:

You are hereby expressly authorized to release and furnish to the State Office of Risk Management (SORM), and/or any associate, assistant, representative, agent, or employee thereof, any and all desired information (including, but not limited to, office records, medical reports, memos, hospital records, laboratory reports, including results of any and all tests including alcohol and/or drug tests, X-rays, X- ray reports, including copies thereof) pertaining to the physical and/or mental condition which is the basis of my workers' compensation claim. This includes not only all current and/or future information but also all past medical information which is related to the injury or injuries which form the basis of my claim.

(Print name) John Zesleep

Photostatic copies of this signed authorization will be considered as valid as the original. This is not a release of claims for damages.

SIGNED: DATED: 09/07/2021

*PLEASE SIGN THE ABOVE MEDICAL AUTHORIZATION AND RETURN IT, SO WE MAY SECURE RELEASE OF YOUR MEDICAL RECORDS.*

THANK YOU.
STATE OFFICE of RISK MANAGEMENT

Training Packet
Training Example

SORM-16 Rev 3/16

# Network Acknowledgment Form

CareWorks Managed Care Services
10535 Boyer Blvd., Ste 100
Austin, TX 78758

P: 800.580.1314
F: 800.580.3123
E: Compkey@careworksmcs.com

CareWorks

## Workers Compensation Network Acknowledgement

I have received information that tells me how to get health care under workers' compensation insurance.

**If I am hurt on the job and live in the service area described in this information, I understand that:**

1. I must choose a treating doctor from the list of doctors in the network.
2. I may ask my HMO primary care physician to agree to serve as my treating doctor.
3. I must go to my treating doctor for all health care for my injury. If I need a specialist, my treating doctor will refer me. If I need emergency care, I may go anywhere.
4. The insurance carrier will pay the treating doctor and other network providers.
5. I might have to pay the bill if I get health care from someone other than a network doctor without network approval.

[signature] — Signature | 09/07/2021 — Date

John Z Sleep — Printed name

546 On The Rocks Blvd — Street Address

Shaky — City | Tx — State | 77701 — Zip code | Hazard — County

TMD — Name of employer

CAREWORKS HCN — Name of network

Training Example

Behind every good outcome — CAREWORKS.COM

# Don’t forget a copy of the orders

This helps SORM clarify that you were on mission at the time of the incident/claim.

# Supervisor Forms

# DWC1-s Form Guidance (Supervisor)

## DWC1S – Employer's Report of Injury

- Boxes 1 – 41 are required
- If any box (1-41) is empty, the form will be returned for completion or additional information will be requested
- This is required information when it's entered in the system

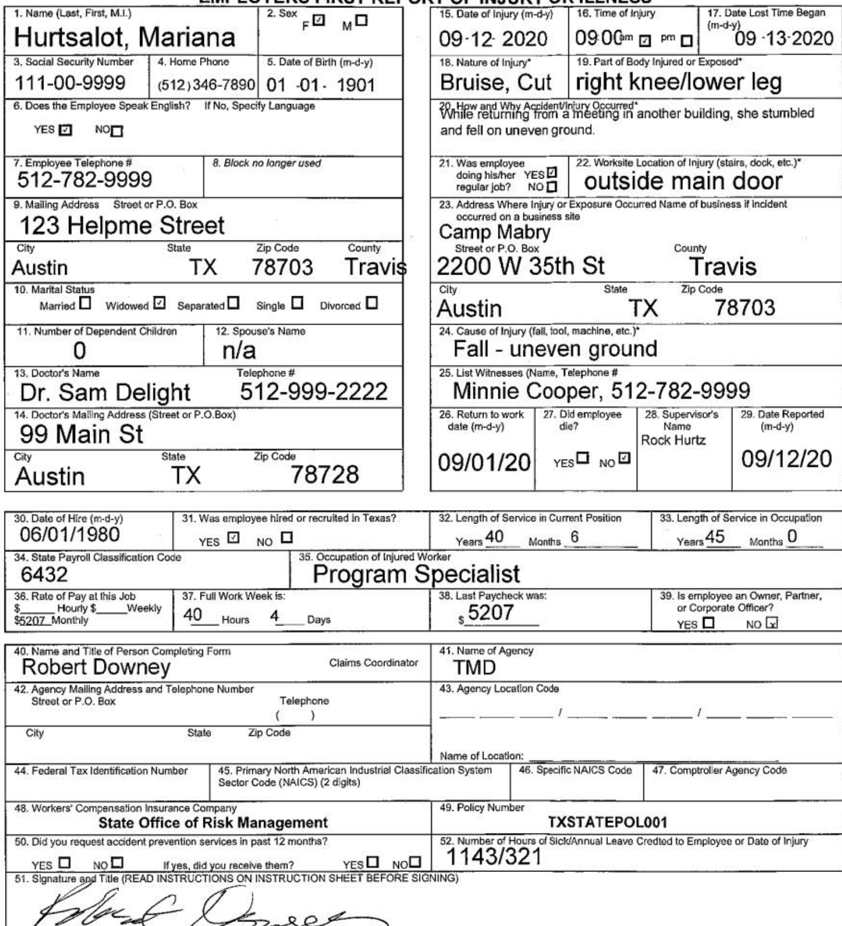
*NOTE*: Incomplete forms may result in a ***delay or denial*** of benefits to the injured employee.

- ❑ **Boxes 1 – 12**: Employee logistics
- ❑ **Boxes 13 – 14**: WC doctor information
- ❑ **Boxes 15 – 27**: Injury/Incident information
- ❑ **Box 28**: Supervisor
- ❑ **Box 29**: Date you knew about the injury
- ❑ **Boxes 30 – 39**: Employment information
- ❑ **Box 40**: Name of person completing form
- ❑ **Box 41**: Employer (TMD)
- ❑ **Box 42**: 2200 W 35th St, Austin TX 78703
- ❑ **Box 51**: Signature of person completing form

# SORM – 703 Form Guidance (Supervisor)

| SORM 703 – Investigation Form<br>NOTE: ALL blocks are required | | | |
|---|---|---|---|
| **Block A** | **Block B** | **Block C** | **Block D** |
| Forms Description | Forms Description | Forms Description | Forms Description |
| Employee and supervisor information | Give specific information about the incident/accident<br>• What specific area did this occur? Hallway, restroom, etc.?<br>• What activities were happening? Roofing work, construction, loading truck, etc.?<br>• How did the incident/injury happen? Tripped and fell, lost balance, unstable ladder, etc.?<br>• Did injury occur? What body parts were involved? | Bottom line cause of injury<br>Inappropriate or inadequate training, violation of safety or work procedure, etc.? | Answer **both** questions and sign the form<br>• How are you addressing the cause of this incident? Recommend refresher training, complete job safety analysis, etc.?<br>• Are you handling this recommendation personally? Are you routing this recommendation up the chain of command? Has management been made aware of the recommendation? Did you notify the Safety Officer and Risk Manager? |

# DWC1S Form



Mail this form to:
STATE OFFICE OF RISK MANAGEMENT
P. O. Box 13777
Austin, Texas 78711

Please read instruction sheet CAREFULLY, giving special attention to items marked with an asterisk (*).

CLAIM # ______________________

SORM CLAIM # ______________________

**EMPLOYERS FIRST REPORT OF INJURY OR ILLNESS**

| Field | Entry |
|---|---|
| 1. Name (Last, First, M.I.) | Hurtsalot, Mariana |
| 2. Sex | F ☑ M ☐ |
| 3. Social Security Number | 111-00-9999 |
| 4. Home Phone | (512) 346-7890 |
| 5. Date of Birth (m-d-y) | 01 - 01 - 1901 |
| 6. Does the Employee Speak English? If No, Specify Language | YES ☑ NO ☐ |
| 7. Employee Telephone # | 512-782-9999 |
| 8. Block no longer used | |
| 9. Mailing Address Street or P.O. Box | 123 Helpme Street |
| City / State / Zip Code / County | Austin / TX / 78703 / Travis |
| 10. Marital Status | Married ☐ Widowed ☑ Separated ☐ Single ☐ Divorced ☐ |
| 11. Number of Dependent Children | 0 |
| 12. Spouse's Name | n/a |
| 13. Doctor's Name / Telephone # | Dr. Sam Delight / 512-999-2222 |
| 14. Doctor's Mailing Address (Street or P.O.Box) | 99 Main St |
| City / State / Zip Code | Austin / TX / 78728 |
| 15. Date of Injury (m-d-y) | 09-12-2020 |
| 16. Time of Injury | 09:00 am ☑ pm ☐ |
| 17. Date Lost Time Began (m-d-y) | 09-13-2020 |
| 18. Nature of Injury* | Bruise, Cut |
| 19. Part of Body Injured or Exposed* | right knee/lower leg |
| 20. How and Why Accident/Injury Occurred* | While returning from a meeting in another building, she stumbled and fell on uneven ground. |
| 21. Was employee doing his/her regular job? | YES ☑ NO ☐ |
| 22. Worksite Location of Injury (stairs, dock, etc.)* | outside main door |
| 23. Address Where Injury or Exposure Occurred Name of business if incident occurred on a business site | Camp Mabry |
| Street or P.O. Box / County | 2200 W 35th St / Travis |
| City / State / Zip Code | Austin / TX / 78703 |
| 24. Cause of Injury (fall, tool, machine, etc.)* | Fall - uneven ground |
| 25. List Witnesses (Name, Telephone #) | Minnie Cooper, 512-782-9999 |
| 26. Return to work date (m-d-y) | 09/01/20 |
| 27. Did employee die? | YES ☐ NO ☑ |
| 28. Supervisor's Name | Rock Hurtz |
| 29. Date Reported (m-d-y) | 09/12/20 |
| 30. Date of Hire (m-d-y) | 06/01/1980 |
| 31. Was employee hired or recruited in Texas? | YES ☑ NO ☐ |
| 32. Length of Service in Current Position | Years 40 Months 6 |
| 33. Length of Service in Occupation | Years 45 Months 0 |
| 34. State Payroll Classification Code | 6432 |
| 35. Occupation of Injured Worker | Program Specialist |
| 36. Rate of Pay at this Job | $____ Hourly $____ Weekly $5207 Monthly |
| 37. Full Work Week is: | 40 Hours 4 Days |
| 38. Last Paycheck was: | $ 5207 |
| 39. Is employee an Owner, Partner, or Corporate Officer? | YES ☐ NO ☑ |
| 40. Name and Title of Person Completing Form | Robert Downey, Claims Coordinator |
| 41. Name of Agency | TMD |
| 42. Agency Mailing Address and Telephone Number | Street or P.O. Box; Telephone ( ); City; State; Zip Code |
| 43. Agency Location Code | ___ ___ ___ / ___ ___ ___ / ___ ___ ___; Name of Location: ____ |
| 44. Federal Tax Identification Number | |
| 45. Primary North American Industrial Classification System Sector Code (NAICS) (2 digits) | |
| 46. Specific NAICS Code | |
| 47. Comptroller Agency Code | |
| 48. Workers' Compensation Insurance Company | State Office of Risk Management |
| 49. Policy Number | TXSTATEPOL001 |
| 50. Did you request accident prevention services in past 12 months? | YES ☐ NO ☐; If yes, did you receive them? YES ☐ NO ☐ |
| 51. Signature and Title (READ INSTRUCTIONS ON INSTRUCTION SHEET BEFORE SIGNING) | [signature] |
| 52. Number of Hours of Sick/Annual Leave Credited to Employee or Date of Injury | 1143/321 |

DWC FORM-1S (Rev. 10/05) Page 1 — DIVISION OF WORKERS' COMPENSATION

**TRAINING EXAMPLE ONLY**

# SORM Form 703

*Page 1*

**State Office of Risk Management**
**Incident/Accident Investigation Form 703**

| **A. Employee Data** | | | Claim # (if known): | | |
|---|---|---|---|---|---|
| Date of incident: | 09-12-2020 | | Time: | 09:00 | (A.M) P.M. |
| Employee Name: | Hurtsalot, Mariana | | | | |
| Working Title: | Program Specialist | | Dept. | CFMO | |
| Employee Contact #: | Hm. 512-346-7890 | Wk. 512-782-9999 | Other | N/A | |
| Supervisor Contact: | Robert Downey | | Wk | 512-782-5555 | |

**B. Incident Description**

***Obtain written and/or recorded statements from injured employee. What happened? What caused the accident? What were the contributing factors? Reconstruct the sequence of events that led to the injury. Attach additional sheets if necessary. This document becomes a legal accounting of the facts surrounding the incident/accident. When documenting the facts, include answers to the following questions:***

1. Where did the incident happen? Provide a full description of the surroundings of the location.
2. What was happening at the time of the incident? What were the events leading up to the incident?
3. What exactly caused the physical injury? What were the mechanics involved? Or, if a physical injury was avoided, what could have happened to cause an injury?
4. Describe any injury incurred by the employee, what body part/s and what kind/s of injury/ies. If there are no injuries, so state.

1. Outside the main door on the north side of building 359. The area has gravel with some degradation due to environmental issues.
2. Mariana was returning to the building after a meeting. Her hands were full with her copies and personal items.
3. Someone called out her name. She turned her head at the time she took her next step. She was wearing 3-inch heels and stumbled causing her to fall on her knees. The left leg and knee landed on the papers she dropped while her right leg and knee hit the ground.
4. She immediately experienced multiple cuts and bruises to her right knee and lower leg area.

SORM 703 Form

**TRAINING EXAMPLE ONLY**

# SORM Form 703

*Page 2*



**C. Incident Findings**

After review of all facts, what was the hazardous condition, unsafe work practice or other root cause of the incident/ injury?

uneven ground

**D. Corrective Action**

What is recommended to prevent this type of incident/accident from occurring again?

level the ground or provide a safer path to enter the building

Actions taken to ensure recommendations are considered:

Review recommendation with management to determine the safest option.

**Signature of Accident Investigator** Robert [illegible] **Date** 09-12-20 **Time** 09:30

**Internal Distribution:** Original: Agency Risk Manager or Risk Management Contact

Copies: Agency Safety Officer
Employee's Supervisor
Director/Manager of Department or Section

**Maintain one copy in any retrievable format in the site file for a minimum of 3 years, or in the case of an occupational illness or injury, for 30 years.**

**Note: If a workers' compensation claim is filed, send:**

- **Fax a copy to the State Office of Risk Management (SORM) Claims Department at 512-472-0237.**



**TRAINING EXAMPLE ONLY**

# Texas Military Department Workers' Compensation Contacts

**Workers' Compensation Coordinator (WCC)**
*Helena La Fleur*
O (512) 782-5306
F (512) 374-0299
Helena.lafleur@military.texas.gov

***OR***

benefits@military.texas.gov

**Backup Contact**
*Angela Hawley*
benefits@military.Texas.gov
O (512) 782 - 3385
F (512) 374 - 0299

# References – *Where do we get the rules?*

- Texas Workers Compensation Act
- State Office of Risk Management (SORM)
- Texas Administrative Code
- Occupational Health and Safety Act
- Risk Management Guidelines (SORM)
- Life Safety Code
- Texas Labor Code
- Texas Department of Insurance - Division of Workers' Compensation

# References – *A few clarifying points (TWCA)*

**Per the Texas Workers' Compensation Act, here are a few important reminders.**

**Sec. 409.006. RECORD OF INJURIES; ADMINISTRATIVE VIOLATION**. (a) An employer shall maintain a record of each employee injury as reported by an employee or otherwise made known to the employer.

**Sec. 501.024. EXCLUSIONS FROM COVERAGE – (1)**a person performing personal services for the state as an independent contractor or volunteer; **(2)** a person who at the time of injury was performing services for the federal government and who is covered by some form of federal workers' compensation insurance; **(3)** a prisoner or inmate of a prison or correctional institution, other than a work program participant participating in a Texas Correctional Industries contract described by Section 497.006, Government Code; **(4)** a client or patient of a state agency;

**CHAPTER 451. DISCRIMINATION PROHIBITED Sec. 451.001. DISCRIMINATION AGAINST EMPLOYEES PROHIBITED.** A person may not discharge or in any other manner discriminate against an employee because the employee has: (1) filed a workers' compensation claim in good faith;

**A few confusing definitions clarified in the Texas Workers' Compensation Act**

**"Injury"** means damage or harm to the physical structure of the body and a disease or infection naturally resulting from the damage or harm. The term includes an occupational disease.

**"Compensable injury"** means an injury that arises out of and in the course and scope of employment for which compensation is payable under this subtitle.

**"Compensation"** means payment of a benefit.

**"Course and scope of employment"** means an activity of any kind or character that has to do with and originates in the work, business, trade, or profession of the employer and that is performed by an employee while engaged in or about the furtherance of the affairs or business of the employer. The term *includes* an activity conducted on the premises of the employer or at other locations. *The term does not include:* (A) transportation to and from the place of employment **unless**: (i) the transportation is furnished as a part of the contract of employment or is paid for by the employer; (ii) the means of the transportation are under the control of the employer; or (iii) the employee is directed in the employee's employment to proceed from one place to another place; or (B) travel by the employee in the furtherance of the affairs or business of the employer if the travel is also in furtherance of personal or private affairs of the employee **unless**: (i) the travel to the place of occurrence of the injury would have been made even had there been no personal or private affairs of the employee to be furthered by the travel; and (ii) the travel would not have been made had there been no affairs or business of the employer to be furthered by the travel.

**"Occupational disease**" means a disease arising out of and in the course of employment that causes damage or harm to the physical structure of the body, including a repetitive trauma injury. The term includes a disease or infection that naturally results from the work-related disease. ***The term does not include an ordinary disease of life to which the general public is exposed outside of employment, unless that disease is an incident to a compensable injury or occupational disease.***

# Health Benefits for State Active Duty

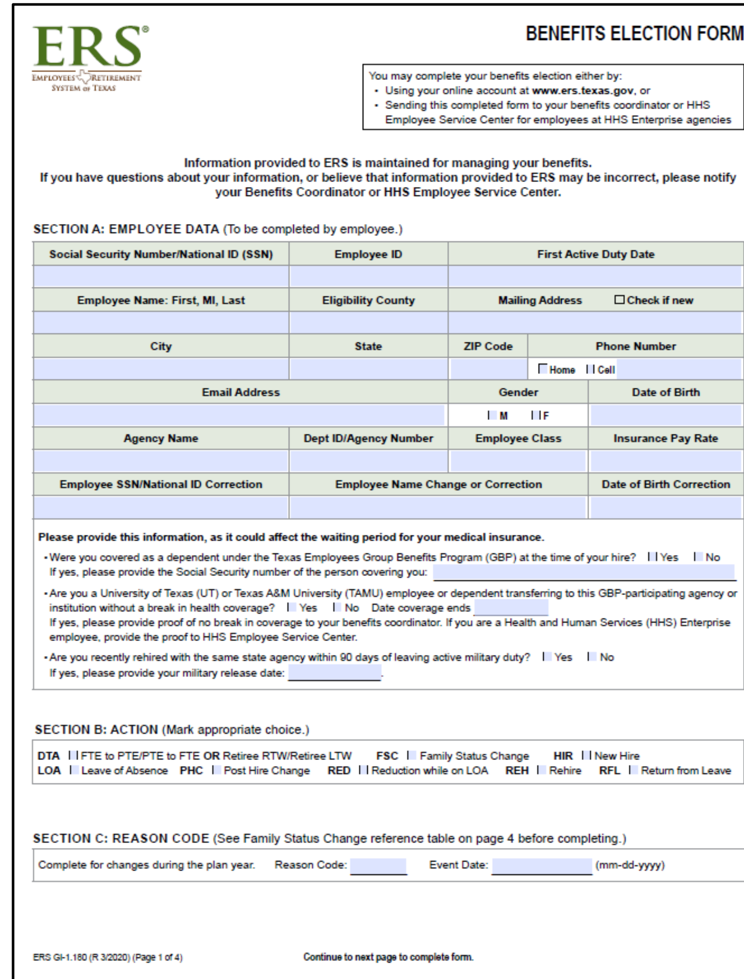
After you've been on mission for 60 days, health benefits are available

***<u>NOTE</u>**: This is regular health insurance*

# How Do I Sign Up?

- Send a completed Benefits Enrollment Form to the benefits coordinator.
- She will enroll you in the ERS system.
- Contact Angela Hawley


Angela.Hawley@military.Texas.gov
O (512) 782 - 3385
F (512) 374 - 0299

ERS® EMPLOYEES RETIREMENT SYSTEM OF TEXAS

**BENEFITS ELECTION FORM**

You may complete your benefits election either by:
- Using your online account at **www.ers.texas.gov**, or
- Sending this completed form to your benefits coordinator or HHS Employee Service Center for employees at HHS Enterprise agencies

**Information provided to 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 your Benefits Coordinator or HHS Employee Service Center.**

**SECTION A: EMPLOYEE DATA** (To be completed by employee.)

| Social Security Number/National ID (SSN) | Employee ID | First Active Duty Date | |
|---|---|---|---|
| | | | |
| Employee Name: First, MI, Last | Eligibility County | Mailing Address ☐ Check if new | |
| | | | |
| City | State | ZIP Code | Phone Number |
| | | | ☐ Home ☐ Cell |
| Email Address | | Gender | Date of Birth |
| | | ☐ M ☐ F | |
| Agency Name | Dept ID/Agency Number | Employee Class | Insurance Pay Rate |
| | | | |
| Employee SSN/National ID Correction | Employee Name Change or Correction | | Date of Birth Correction |
| | | | |

**Please provide this information, as it could affect the waiting period for your medical insurance.**
- Were you covered as a dependent under the Texas Employees Group Benefits Program (GBP) at the time of your hire? ☐ Yes ☐ No
  If yes, please provide the Social Security number of the person covering you: ______
- Are you a University of Texas (UT) or Texas A&M University (TAMU) employee or dependent transferring to this GBP-participating agency or institution without a break in health coverage? ☐ Yes ☐ No Date coverage ends ______
  If yes, please provide proof of no break in coverage to your benefits coordinator. If you are a Health and Human Services (HHS) Enterprise employee, provide the proof to HHS Employee Service Center.
- Are you recently rehired with the same state agency within 90 days of leaving active military duty? ☐ Yes ☐ No
  If yes, please provide your military release date: ______

**SECTION B: ACTION** (Mark appropriate choice.)

**DTA** ☐ FTE to PTE/PTE to FTE **OR** Retiree RTW/Retiree LTW **FSC** ☐ Family Status Change **HIR** ☐ New Hire
**LOA** ☐ Leave of Absence **PHC** ☐ Post Hire Change **RED** ☐ Reduction while on LOA **REH** ☐ Rehire **RFL** ☐ Return from Leave

**SECTION C: REASON CODE** (See Family Status Change reference table on page 4 before completing.)

Complete for changes during the plan year. Reason Code: ______ Event Date: ______ (mm-dd-yyyy)

ERS GI-1.180 (R 3/2020) (Page 1 of 4) **Continue to next page to complete form.**

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

| Health Coverage | Optional Benefits (Newly hired employees may elect benefits on first active duty date or within 31 days of hire/rehire without enrolling in health coverage.) Effective date, if different from hire/rehire date ______ (mm-dd-yyyy) | | | | | |
|---|---|---|---|---|---|---|
| **Health** | **Dental*** | **Vision** | **Optional Term Life Insurance**** | **Voluntary AD&D*** | **Dependent Term Life Insurance**** | **Short-term Disability**** |
| ☐ Waive<br>☐ HealthSelect of Texas®<br>☐ Consumer Directed HealthSelect℠<br>☐ HMO Name ______<br>☐ Enroll/Add/Drop Dependent (See Section E)<br>☐ Waive + Opt-Out Credit* *(By checking Waive + Opt Out Credit, you also certify that you have comparable coverage. See page 3 for important information.)* | ☐ Waive<br>☐ State of Texas Dental Choice Plan℠<br>☐ DeltaCare USA DHMO<br>☐ Enroll/Add/Drop Dependent *(See Section E)* | ☐ Waive<br>☐ State of Texas Vision<br>☐ Enroll/ Add/Drop Dependent *(See Section E)* | ☐ Waive<br>☐ Enroll<br>Elect coverage level<br>☐ OL1 Election 1<br>☐ OL2 Election 2<br>☐ OL3 Election 3<br>☐ OL4 Election 4<br>Decrease Level to<br>☐ OL1 Election 1<br>☐ OL2 Election 2<br>☐ OL3 Election 3 | ☐ Waive<br>☐ You Only<br>☐ You + Family<br>$______<br>Amount up to $200,000 in increments of $5,000 | ☐ Waive<br>☐ Enroll/Add/ Drop Dependent *(See Section E)* | ☐ Waive<br>☐ Enroll<br>**Long-term Disability****<br>☐ Waive<br>☐ Enroll |

**If you want to elect a TexFlex health, dependent care, or limited account as a new enrollee or due to a qualifying life event, you must complete the TexFlex Enrollment Change Form.**

*A monthly credit of up to $60 (or $30 for part-time participants) can be applied to optional coverage (dental, vision and AD&D).
**To add this coverage will require evidence of insurability (EOI). Initiate the EOI process online by signing into your online account at **www.ers.texas.gov**, or contact your benefits coordinator/HHS Employee Service Center.

**Employee Tobacco-User Certification:** If you are enrolling in the 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, pipes, cigars, cigarillos, snuff or chewing tobacco products.
☐ Yes ☐ No

**SSN** ______ **Employee Name: First, MI, Last** ______

**SECTION E: 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, pipes, cigars, cigarillos, snuff or chewing tobacco 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 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 by calling ERS. For dependents newly enrolled in health coverage, you will be required to provide documentation to verify your dependents' eligibility.

Did your dependent have GBP coverage under ERS through another member within the last 31 days? ☐ Yes ☐ No
If yes, please provide the Social Security number under which your dependent was covered: ______
Is this dependent a new addition to your household because of this event? Please check one only:
☐ Adoption ☐ Acquisition of other than natural child ☐ Birth ☐ Not newly acquired ☐ Marriage

ERS GI-1.180 (R 3/2020) (Page 2 of 4) **Continue to next page to complete form.**

# Questions?