

DEPARTMENT OF PUBLIC SAFETY

ELECTION FORM FOR BENEFIT CONTINUATION DURING MILITARY/FEMA LEAVE

Section I: Personal Information

EMPLOYEE'S FULL NAME: Last First MI

Daytime Phone E-Mail Address CAPPS Empl ID

Military/FEMA Leave (More than one Month) Reason for Completing Form Expected Return to Work Date

Section II: Benefit Elections (May only continue coverage currently enrolled in)

Benefit Programs:	CONTINUE	WAIVE
Medical (including Basic Life)	<input type="checkbox"/>	<input type="checkbox"/>
Dental	<input type="checkbox"/>	<input type="checkbox"/>
Vision	<input type="checkbox"/>	<input type="checkbox"/>
Optional Life Insurance	<input type="checkbox"/>	<input type="checkbox"/>
AD&D	<input type="checkbox"/>	<input type="checkbox"/>
Dependent Life Insurance	<input type="checkbox"/>	<input type="checkbox"/>
Short-Term Disability	<input type="checkbox"/>	<input type="checkbox"/>
Long-Term Disability	<input type="checkbox"/>	<input type="checkbox"/>
TexFlex (Health Care)	<input type="checkbox"/>	<input type="checkbox"/>
TexFlex (Dependent Care)	<input type="checkbox"/>	<input type="checkbox"/>
TexFlex (Limited)	<input type="checkbox"/>	<input type="checkbox"/>

Section III: Payment Election

Indicate payment method for benefits being continued during Military/FEMA Leave:

Payroll Deduction Monthly Direct Payments

Billing Information:

Name Street Address City State Zip

Section III: Payment Election

I have received, read, and understand the material explaining the terms and conditions of the Department of Public Safety Plans. I declare that any individual for whom I am requesting health coverage meets the definition of an eligible dependent as stated in the specific Health Plan Detail, available online at www.ers.texas.gov. I understand that any person who, knowingly and with intent to defraud, applies for coverage or files a claim containing any materially false information is guilty of fraud, which is subject to disciplinary action, up to and including termination of employment. I understand that my elections may not be changed or voluntarily cancelled at any time during the plan year (September 1st through August 31st) unless a qualifying event occurs, as defined by the plan. Human Resources, Benefits and Compliance must receive notification of the change within 31 days or the change must be made by myself online through my ERS self service. I certify that all information provided on this form is true and correct to the best of my knowledge.

Signature of Applicant

Date

Payments are due on the first day of each month during the leave. Make checks payable to TEGBP. If you have questions, contact Human Resources, Benefits and Compliance at: