



## Employees Retirement System of Texas TexFlex Enrollment/Change Form

Employee name: _____	SSN: _____	ERS OnLine EmplID: _____
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**Only for participants with active employee benefits.**

1. I have experienced a qualifying life event (QLE) of \_\_\_\_\_ that allows me to enroll in or change my Flex Spending account. The event date of this QLE is: \_\_\_\_\_ (MM/DD/YYYY).

**Flex Spending – Health** for eligible medical and dental out-of-pocket costs excluding insurance premiums, which has a minimum annual pledge of \$180 and a maximum annual pledge of \$5000 per tax year. Enrollment/change must be made within 31 days of my employment or QLE. If you do not check this box, you will not be enrolled in this account.

<b>Section A: (always complete)</b>	
I want my monthly deduction to be (not to exceed \$416 per month):	\$ .00
Number of months left in the plan year (09/01 – 08/31):	x
Annual pledge:	\$ .00
<b>Section B: (complete only if increasing annual pledge)</b>	
Additional pledge amount (annual pledge above):	\$ .00
Current contributions to date:	+ \$ .00
Adjusted annual pledge:	\$ .00

**Flex Spending – Dependent Day Care** for eligible child or adult dependent day care expenses, which has a minimum annual pledge of \$180 and a maximum annual pledge of either \$5000 or the lesser of my or my spouse's annual income that is below \$5000, whichever is lower. Enrollment/change must be made within 31 days of my employment or QLE. If you do not check this box, you will not be enrolled in this account.

<b>Section A: (always complete)</b>	
I want my monthly deduction to be (not to exceed \$416 per month):	\$ .00
Number of months left in the plan year (09/01 – 08/31):	x
Annual pledge:	\$ .00
<b>Section B: (complete only if increasing annual pledge)</b>	
Additional pledge amount (annual pledge above):	\$ .00
Current contributions to date:	+ \$ .00
Adjusted annual pledge:	\$ .00

2. I would like to use the PayFlex<sup>SM</sup> Debit Card for an annual fee of \$16 (pro-rated for new participants), which will be deducted from my Flex Spending account automatically during my first month of enrollment.

Yes (If you already have a card, continue to use that card; otherwise, one will be mailed to you.)  No

**3. Authorization:**

I understand my Flex Spending - Health enrollment is irrevocable for the plan year, even if I take a leave of absence, terminate employment, or retire during the plan year unless I have a qualifying life event that makes me eligible to change my enrollment. I understand my Flex Spending – Dependent Day Care enrollment is irrevocable for the plan year, unless I have a qualifying life event, and ends upon termination of employment or retirement.

I authorize payroll deductions for the amount listed on this form. I understand that if I am increasing my annual pledge, the additional money can only be used for eligible expenses incurred on or after the first of the month following my QLE date listed above and not before. Claims incurred prior to the QLE date may not be eligible for reimbursement.

I must file all eligible claims for reimbursement by December 31 of the associated plan year in order to utilize any remaining balance from my account(s). I understand that if I do not use all of the money in my account by the appropriate deadline for that plan year, I will forfeit that money. I understand that Flex Spending Account eligibility, enrollment, and benefits information is available from my employer and the ERS website at [www.ers.state.tx.us](http://www.ers.state.tx.us). I certify that I have read and agree to all of the conditions and participation rules for this program.

Sign: \_\_\_\_\_ Date: \_\_\_\_\_

**Use for participant termination only.**

**1. Termination of Flex Spending - Dependent Day Care**

I have experienced a QLE of \_\_\_\_\_ that allows me to stop participating in my Flex Spending - Dependent Day Care account. The event date of this QLE is: \_\_\_\_\_ (MM/DD/YYYY)

**2. Termination of Flex Spending – Health**

I have experienced the following QLE that allows me to stop participating in my Flex Spending - Health account:

- Termination of employment - termination date: \_\_\_\_\_ (MM/DD/YYYY)
- Retirement – retirement date: \_\_\_\_\_ (MM/DD/YYYY)
- Death of Dependent – date of death: \_\_\_\_\_ (MM/DD/YYYY)
- Leave of absence in accordance with Family Medical Leave Act of 1993 (FMLA) – date of leave of absence: \_\_\_\_\_ (MM/DD/YYYY)

**Remaining Pledge**

- I agree to have the remaining annual pledge balance of my Flex Spending – Health account annual pledge deducted before taxes from my last paycheck.
- I decline the pre-tax deduction for the remaining balance of my Flex Spending – Health account. I understand I am responsible for the paying the remaining balance of my annual pledge and will submit after-tax payment(s) to ERS.

Sign: \_\_\_\_\_ Date: \_\_\_\_\_

Information provided to 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 enter the change or correction in ERS OnLine, submit your form, and/or notify your benefits coordinator or contact ERS.



## Employees Retirement System of Texas TexFlex Enrollment/Change Form

For agency use only	
Agency name:	
Department ID:	
Type of employee: <input type="checkbox"/> 9-month <input type="checkbox"/> 12-month	
Date of hire (if the participant is a new hire or rehire):	
Reason for enrollment or change: <input type="checkbox"/> New Hire <input type="checkbox"/> Rehire <input type="checkbox"/> Post Hire Change <input type="checkbox"/> Family Status Change (FSC) reason code (see the FSC chart below): _____ <input type="checkbox"/> Termination of employment	
Begin date*: _____	
<p>*The begin date will differ depending on the reason for the enrollment or change.</p> <ol style="list-style-type: none"> <li>1. New Hire - First active duty date (FADD), if signed on the FADD. Otherwise it's the first of the month (FOM) following the FADD.</li> <li>2. Rehire - FOM following the FADD.</li> <li>3. Post hire change (PHC) - FOM following the signature date on the form.</li> <li>4. Family status change (FSC) - FOM following the event date.</li> <li>5. Termination/Retirement - FOM following the last day on the payroll.</li> </ol>	
<input type="checkbox"/> Submit TexFlex Reimbursement Accounts Notification of Payroll Adjustments form to ERS for a terminating participant.	
Family Status Change (FSC) Reference Chart	
<p>A qualifying life event (QLE) is an eligible event that allows you to change your enrollment elections within 31 days of that event. The following are a list of QLEs that correspond with a particular change in your employment or family status.</p>	
REASON CODE	DESCRIPTION
ADP	Adoption/Foster placement of new dependent
BIR	Birth of a new dependent
DEP	Dependent becomes eligible or loses eligibility for GBP insurance coverage
DGM	Dependent marriage
DIV	Participant divorce or annulment
DMV	Dependent moves out of the GBP health or dental plan service area
DOD	Participant gains or loses dependent through death
DWP	Dependent becomes eligible for insurance through another program after a waiting period
ESC	Participant or dependent experiences a change in employment status
MAR	Participant marriage
MDG	Participant or dependent gains Medicare/Medicaid/SKIP/HIPP eligibility
MDL	Participant or dependent loses Medicare/Medicaid/SKIP/HIPP eligibility
MSD <sup>2</sup>	Participant loses requirement to provide coverage for child/spouse <sup>1</sup>
MSO	Participant gains requirement to provide coverage for child/spouse <sup>1</sup>
SCC	Significant cost change for a dependent's health or dental plan (excluding GBP) or by day care provider
XMO	Other (X) child moves out of a participant's household
<sup>1</sup> Eligibility rules apply for these dependents. <sup>2</sup> Active employees must contact the benefits coordinator to drop dependent(s) added with an MSO/NMSN. Other participants must contact ERS to drop dependent(s) added with an MSO/NMSN.	

**You may either enter your changes on ERS OnLine at [www.ers.state.tx.us](http://www.ers.state.tx.us) or send this form to your benefits coordinator.**