TEXAS EMPLOYEES GROUP BENEFITS PROGRAM
CHOOSE TO QUIT CERTIFICATION FORM

Please send this completed form to:
Employees Retirement System of Texas
Choose to Quit
P.O. Box 13207
Austin, Texas 78711-3207
FAX: 512-867-7438
(866) 399-6908 Toll-free

Information provided to the Employees Retirement System of Texas (ERS) is maintained in accordance with the privacy standards of the Health Insurance Portability and Accountability Act (HIPAA) to help manage your benefits. If you have questions about your information, or believe that information provided to ERS may be incorrect, please notify ERS.

Employee/Retiree Name: First, MI, Last	**Last Four Digits of Employee/Retiree's Social Security Number (SSN)**
	XXX-XX-
Participant Name: First, MI, Last (the GBP participant who completed the program)	**Participant Birth Date:** (mm/dd/yyyy)

ERS administers the Texas Employees Group Benefits Program (GBP) on behalf of State of Texas employees, retirees, elected officials, certain higher education employees, their eligible dependents and certain others included in Chapter 1551 of the Texas Insurance Code. Effective January 1, 2012, the Texas Legislature enacted Texas Insurance Code § 1551.3075 to require ERS to implement a monthly tobacco-user premium for GBP participants who use one or more tobacco products. "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 considered to be someone who has used any tobacco product five or more times within the past three consecutive months. In the event your status as a tobacco-user or non-tobacco user changes during the plan year, you should update your tobacco status and your premium will be adjusted accordingly.

In the event a tobacco-user is unable to achieve or maintain a tobacco-free lifestyle, the GBP has established Choose to Quit, an alternative standard for a tobacco-user to meet to avoid the premium associated with tobacco use.

The Choose to Quit program rules are listed below. You will need to:
☐ contact your doctor and establish a cessation program that is right for you; (your doctor must be a licensed M.D. or D.O.)
☐ complete that program;
☐ return to your doctor and have him/her sign your Choose to Quit Certification Form;
☐ submit your properly completed Choose to Quit Certification form to ERS, postmarked by the last day of your plan year.

NOTE: Visits must be for tobacco counseling only and coded by the physician as tobacco counseling sessions to be covered by the GBP health plan at no cost to you.

Once ERS approves the Choose to Quit Certification Form, the tobacco-user premium will be waived for the remainder of the plan year, and any tobacco-user premiums paid during the plan year will be refunded, if applicable. Unless the tobacco-user stops using tobacco products and certifies as a non-tobacco user, the tobacco-user premium will be reinstated at the beginning of the following plan year.

Choose to Quit Physician Certification Form:

I certify that:

- I am a licensed physician (M.D. or D.O.) who oversees the medical care of _____.
  Patient Name
- I am supervising the above-named individual's participation in the Choose to Quit program.
- My patient has satisfied the Choose to Quit program standards by attending at least two physician office visits for tobacco counseling and establishing a course of treatment, under my recommendation and supervision.

Description of course of physician-recommended treatment (regardless of whether treatment was successful):

_____

_____

_____

_____

_____

I understand this certification is made in connection with a tobacco premium differential program required by the State of Texas in accordance with Texas Insurance Code § 1551.3075 and that my certification is intended to qualify as an alternative standard as required for outcomes-based wellness programs in accordance with the Patient Protection and Affordable Care Act (ACA) and HIPAA.*

Physician's Name (Printed): _____

Phone Number: _____ National Provider Identifier (NPI): _____

Practice Group or Hospital: _____

Address/Location of Office: _____

By signing this form, I certify and acknowledge the truth and accuracy of my statements made above.

_____ _____

Physician's Signature Date

Choose to Quit Participant Certification Form:

I certify that I satisfied the Choose to Quit program standards by attending at least two physician office visits for tobacco counseling and establishing a course of treatment, under my physician's recommendation and supervision, described above (regardless of whether treatment was successful).

By signing this form, I certify and acknowledge the truth and accuracy of my statements made above.

_____ _____

Participant's Signature Date

*See ACA and HIPAA wellness program guidelines, 26 CFR § 54.9802–1