ERS
EMPLOYEES RETIREMENT SYSTEM OF TEXAS

Texas Employees Group Benefits Program (GBP)
Supplemental Information Form for Employees

Information provided to Employees Retirement System of Texas (ERS) is maintained for managing your benefits. Please mail the completed form to your health plan carrier.

SIGN, DATE, AND MAIL THIS FORM TO YOUR HEALTH PLAN.

SECTION A: EMPLOYEE DATA

New Employee? ☐ Yes ☐ No **Employee Name: First, MI, Last**	**Birth Date (mm-dd-yyyy)**	**Last 4 digits of Social Security Number**	**Phone Number** ☐ Home ☐ Cell
		XXX-XX-	

Mailing Address	**City**	**State**	**ZIP Code**	**Eligibility County**

SECTION B: OTHER INSURANCE DATA

Please check type of coverage: ☐ Employer Group Health ☐ Employer Group Dental ☐ Individual Health ☐ Individual Dental

Name of Policyholder	**ID Number**	**Birth Date (mm-dd-yyyy)**	**Gender**	**Relationship**
			☐ M ☐ F	☐ Self ☐ Spouse ☐ Child

Name and Address of Other Insurance Company, TPA, HMO	**Group or Policy**		**Level of Coverage**
		Effective Date _____/_____/_____ Will Coverage Be Continued ☐ Yes ☐ No If No, Expected Cancel Date ____/____/_____	☐ You Only ☐ You/Spouse ☐ You/Child(ren) ☐ You/Family

Name(s) of person(s) covered:

SECTION C: MEDICARE COVERAGE INFORMATION

Name of Medicare Beneficiary		**Medicare No. (From Medicare Card)**
	Medicare Part A (Hospital) Effective Date _____/_____/_____ Medicare Part B (Medical) Effective Date _____/_____/_____	

SECTION D: PRIMARY CARE PHYSICIAN SELECTION *(Excluding HealthSelect Out-of-Area Participants)*

Name of your Health Plan:

Select your primary care physician (PCP) from your HealthSelect or Health Maintenance Organization (HMO) provider directory. Attach an additional sheet if necessary.

Patient's Name: First, MI, Last	**Social Security Number (SSN)**	**Gender**	**Birth Date (mm-dd-yyyy)**	**PCP Name: First, MI, Last**	**NPI or PCP No.**	**Existing Patient?**
Employee		☐ M ☐ F				
Spouse		☐ M ☐ F				
Child		☐ M ☐ F				
Child		☐ M ☐ F				
Child		☐ M ☐ F				
Child		☐ M ☐ F				

SECTION E: OTHER COVERED DEPENDENT NOT LIVING IN THE HOUSEHOLD

	Dependent Name: First, MI, Last	**Social Security Number (SSN)**	**Birth Date (mm-dd-yyyy)**
☐ Dependent Lives Out-of-Area ☐ Dependent Lives in Different Network or Service Area			

Mailing Address	**City**	**State**	**ZIP Code**	**County**

Participant's Signature

Date Signed (mm-dd-yyyy)

Texas Employees Group Benefits Program (GBP) Supplemental Information Form for Employees

GENERAL INSTRUCTIONS

This GBP Supplemental Information Form is NOT an enrollment form. Enrollment forms are submitted to ERS and coverage is reported to the selected health plan. This form will facilitate the receipt of your health care identification card once your enrollment form has successfully been processed by ERS and your coverage reported to the selected health plan.

This GBP Supplemental Information Form must be completed, signed and dated by you when:
1) enrolling in any GBP health plan, 2) adding a dependent to your current health coverage, or 3) making an eligible health plan change (for example, at Annual Enrollment).

SECTION A: EMPLOYEE DATA
Complete this section and specify your mailing address, ZIP Code, and Eligibility County. Indicate if you are a new employee.

SECTION B: OTHER INSURANCE DATA
Complete this section if you or any member of your family are covered by other health or dental coverage. If more space is needed, please attach a separate sheet.

SECTION C: MEDICARE COVERAGE INFORMATION
Complete this section if you or any member of your family are covered under Medicare Part A and/or Part B. If more space is needed, please attach a separate sheet.

SECTION D: PRIMARY CARE PHYSICIAN SELECTION
Complete this section if you are enrolling in a GBP health care plan requiring a PCP selection prior to receiving services. Refer to your HealthSelect or HMO provider directories at **www.ers.state.tx.us** when completing this section.

1. Write the name of your chosen health plan.
2. Write the full name and provider code of your chosen PCP for yourself and each covered dependent, even if you are selecting the same physician for all covered persons.
3. Indicate if you are an existing patient or not (Y/N).

If you need assistance in completing this section, contact your health plan.

SECTION E: OTHER DEPENDENT INFORMATION

1. Complete this section if you are enrolling in HealthSelect (In-Area) and your eligible dependent lives out-of-area or in another HealthSelect network area.
2. Complete this section if you are enrolling in an HMO and your eligible dependent lives in another Texas service area of the selected HMO.

Health Plan Addresses and Telephone Numbers:

HealthSelect℠ of Texas
UnitedHealthcare
(866) 336-9371
Mail Supplemental Information Forms to:
P. O. Box 30523
Salt Lake City, UT 84130-0523

HMOs:
Community First Health Plans, Inc.
(877) 698-7032
(210) 358-6262
Mail Supplemental Information Forms to:
Community First
12238 Silicon Drive, Suite 100
San Antonio, TX 78249

Scott & White Health Plan
Bryan/College Station: **(800) 791-8777**
Temple: **(800) 321-7947**
Georgetown: **(800) 758-3012**
Waco **(800) 684-7947**
Mail Supplemental Information Forms to:
Scott & White Health Plan
1206 West Campus Drive
Temple, TX 76508