



EMPLOYEES RETIREMENT SYSTEM OF TEXAS

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

IMPORTANT: This form is for providing other insurance information and selecting a primary care physician. It is NOT an enrollment form and does NOT verify eligibility. PLEASE READ INSTRUCTIONS ON BACK BEFORE COMPLETING THIS FORM.

SECTION A: EMPLOYEE DATA

National ID/SSN	Employee Name (First Middle Last)				DeptID/Agency Number
Mailing Address		City	State	ZIP Code	Eligibility County
Daytime Telephone No. ()			Work Telephone No. ()		

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 <input type="checkbox"/> Male <input type="checkbox"/> Female	Relationship <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child
Name and Address of Other Insurance Company, TPA, HMO	Group or Policy	Effective Date ____/____/____	Level of Coverage <input type="checkbox"/> Employee Only <input type="checkbox"/> Employee/Spouse <input type="checkbox"/> Employee/Child(ren) <input type="checkbox"/> Employee/Family	
		Will Coverage Be Continued <input type="checkbox"/> Yes <input type="checkbox"/> No		
		If No, Expected Cancel Date ____/____/____		

Name(s) of person(s) covered : _____

SECTION C: MEDICARE COVERAGE INFORMATION

Name of Medicare Beneficiary	<input type="checkbox"/> Medicare Part A (Hospital) Effective Date ____/____/____	Medicare No. (From Medicare Card)
	<input type="checkbox"/> 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 Middle Last)	National ID/SSN	Gender	Birth Date (mm-dd-yyyy)	PCP	PCP No.	Existing Patient?
Employee						
Spouse						
Child						
Child						
Child						
Child						

SECTION E: OTHER COVERED DEPENDENT NOT LIVING IN THE HOUSEHOLD

<input type="checkbox"/> Dependent Lives Out-of-Area	Social Security No.	Dependent's Name (First Middle Last)	Birth Date (mm-dd-yyyy)		
<input type="checkbox"/> Dependent Lives in Different Network or Service Area					
Mailing Address	City	State	ZIP Code	County	

Employee's Signature _____ Date: _____

EMPLOYEES RETIREMENT SYSTEM OF TEXAS

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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 notify ERS.

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 the 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 Summer Enrollment).

SECTION A: EMPLOYEE DATA

Complete this section and specify your mailing address, ZIP Code, and Eligibility County.

SECTION B: OTHER INSURANCE DATA

Complete this section if you or any member of your family is 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 is 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 primary care physician selection prior to receiving services. Refer to your HealthSelect or Health Maintenance Organization (HMO) provider directories under Customer Service at www.ers.state.tx.us when completing this section.

1. Write the name of your chosen health plan.
2. Write the name and provider code of your chosen primary care physician (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.

Sign, date, and mail this form to your health plan.

Health Plan Addresses and Telephone Numbers:

HealthSelect

Blue Cross and Blue Shield of Texas

(800) 252-8039

Mail Supplemental Information Forms to:

P. O. Box 655730

Dallas, TX 75265-5730

FirstCare

(800) 884-4901

Mail Supplemental Information Forms to:

FirstCare Enrollment Dept.

12940 N. Highway 183

Austin, TX 78750

Scott & White Health Plan

Bryan/College Station: (800) 791-8777

Temple/Waco: (800) 321-7947

Georgetown: (800) 758-3012

Mail Supplemental Information Forms to:

Scott & White Health Plan

2401 South 31st Street

Temple, TX 76508

HMOs:

Community First Health Plans, Inc.

(877) 698-7032

(210) 358-6262

Mail Supplemental Information Forms to:

Community First

4801 NW Loop #1000

San Antonio, TX 78229