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	Birthdate (mm-dd-yyyy)	Last four 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	Birthdate (mm-dd-yyyy)	Gender	Relationship
			☐ M ☐ F	☐ Self ☐ Spouse ☐ Child

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

SECTION C: MEDICARE COVERAGE INFORMATION

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

SECTION D: PRIMARY CARE PHYSICIAN SELECTION (for HealthSelect℠ of Texas and Community First participants)

Name of your Health Plan:

If you're in HealthSelect of Texas or Community First Health Plans, select your primary care physician (PCP) from the plan's provider directory. Attach an additional sheet if necessary.

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

SECTION E: OTHER COVERED DEPENDENT NOT LIVING IN THE HOUSEHOLD

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

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

Participant's Signature

Date Signed (mm-dd-yyyy)

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 Summer 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 plan requiring a PCP selection prior to receiving services. Refer to the 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:

	HMO:		
HealthSelect℠ of Texas **UnitedHealthcare** (866) 336-9371 **Mail Supplemental Information Forms to:** P. O. Box 30523 Salt Lake City, UT 84130-0523	**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** 1206 West Campus Drive Temple, TX 76508 Temple: (800) 321-7947 Georgetown: (800) 758-3012 Waco (254) 756-8000	**KelseyCare powered by Community Health Choice** 2636 South Loop West, Suite 900 Houston, TX 77054 (713) 295-6792; toll-free (844) 515-4877