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

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	Relationship
			☐ Male ☐ Female	☐ 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 _____/_____/_____	☐ Employee Only ☐ Employee/Spouse ☐ Employee/Child(ren) ☐ Employee/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: HealthSelect WWW.BCBSTX.COM/HS

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

☐ Dependent Lives Out-of-Area ☐ Dependent Lives in Different Network or Service Area	Social Security No.	Dependent's Name (First Middle Last)	Birth Date (mm-dd-yyyy)

Mailing Address	City	State	ZIP Code	County

Employee's Signature _____ **Date:** _____

EMPLOYEES RETIREMENT SYSTEM OF TEXAS
Texas Employees Group Benefits Program (GBP) Supplemental Information Form for Employees

Information provided to the Employees Retirement System of Texas (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 your benefits coordinator or ERS.

GENERAL INSTRUCTIONS

This GBP Supplemental Information Form is NOT an enrollment form. Enrollment forms are submitted to the Employees Retirement System of Texas (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 at the Health & Dental link on the ERS website 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

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

FirstCare
(800) 884-4901
Mail Supplemental Information Forms to:
FirstCare Enrollment Dept.
12940 N. Highway 183
Austin, TX 78750

Mercy Health Plans
(800) 617-3433
Mail Supplemental Information Forms to:
Mercy Health Plans
5901 McPhearson Suite 1 & 2 B
Laredo, TX 78041

Scott & White Health Plan
Bryan/College Station: (800) 791-8777
Temple/Waco: (800) 321-7947
Round Rock: (800) 758-3012
Mail Supplemental Information Forms to:
Scott & White Health Plan
2401 South 31st Street
Temple, TX 76508

Valley Baptist Health Plans
(800) 829-6440
Mail Supplemental Information Forms to:
Valley Baptist Health Plans
Enrollment Dept.
12940 N. Highway 183
Austin, TX 78750