



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**

<b>Employee Name: First, MI, Last</b>		<b>Social Security Number (SSN)</b>		<b>DeptID/Agency Number</b>	<b>Phone Number</b> <input type="checkbox"/> Home <input type="checkbox"/> Cell
<b>Mailing Address</b>		<b>City</b>	<b>State</b>	<b>ZIP Code</b>	<b>Eligibility County</b>
					<b>Work Phone Number</b>

**SECTION B: OTHER INSURANCE DATA**

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

<b>Name of Policyholder</b>	<b>ID Number</b>	<b>Birth Date (mm-dd-yyyy)</b>	<b>Gender</b> <input type="checkbox"/> M <input type="checkbox"/> F	<b>Relationship</b> <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child
<b>Name and Address of Other Insurance Company, TPA, HMO</b>	<b>Group or Policy</b>	Effective Date ____/____/____	Will Coverage Be Continued <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Level of Coverage</b> <input type="checkbox"/> You Only <input type="checkbox"/> You/Spouse <input type="checkbox"/> You/Child(ren) <input type="checkbox"/> You/Family
		If No, Expected Cancel Date ____/____/____		

Name(s) of person(s) covered:

**SECTION C: MEDICARE COVERAGE INFORMATION**

<b>Name of Medicare Beneficiary</b>	Medicare Part A (Hospital) Effective Date ____/____/____	<b>Medicare No. (From Medicare Card)</b>
	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	NPI or PCP No.	Existing Patient?
Employee		<input type="checkbox"/> M <input type="checkbox"/> F				
Spouse		<input type="checkbox"/> M <input type="checkbox"/> F				
Child		<input type="checkbox"/> M <input type="checkbox"/> F				
Child		<input type="checkbox"/> M <input type="checkbox"/> F				
Child		<input type="checkbox"/> M <input type="checkbox"/> F				
Child		<input type="checkbox"/> M <input type="checkbox"/> F				

**SECTION E: OTHER COVERED DEPENDENT NOT LIVING IN THE HOUSEHOLD**

<input type="checkbox"/> Dependent Lives Out-of-Area <input type="checkbox"/> Dependent Lives in Different Network or Service Area	<b>Dependent Name: First, MI, Last</b>	<b>Social Security Number (SSN)</b>	<b>Birth Date (mm-dd-yyyy)</b>
<b>Mailing Address</b>	<b>City</b>	<b>State</b>	<b>ZIP Code</b>
			<b>County</b>

Participant's Signature

Date Signed (mm-dd-yyyy)

**EMPLOYEES RETIREMENT SYSTEM OF TEXAS**  
**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.

**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 primary care physician selection prior to receiving services. Refer to your HealthSelect or Health Maintenance Organization (HMO) provider directories at [www.ers.state.tx.us](http://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<sup>SM</sup> of Texas**

**Blue Cross and Blue Shield of Texas**

**(800) 252-8039**

**Mail Supplemental Information Forms to:**

P. O. Box 660044

Dallas, TX 75266-0044

**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