



# EMPLOYEES RETIREMENT SYSTEM OF TEXAS



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

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: RETIREE DATA

<b>National ID/SSN</b>	<b>Retiree Name</b>	<b>Birth Date</b> (mm-dd-yyyy)	<b>Home Telephone No.</b>  (    )		
<b>Mailing Address</b>		<b>City</b>	<b>State</b>	<b>ZIP Code</b>	<b>Eligibility County</b>

### SECTION B: MEDICARE COVERAGE INFORMATION (Complete only if you or your family has Medicare.)

Are you or a dependent covered by Medicare?  Yes  No If so, please complete this section.

<b>Name of Medicare Beneficiary</b>	<input type="checkbox"/> Medicare Part A (Hospital) Effective Date ____/____/____	<b>Medicare No. (From Medicare Card)</b>
	<input type="checkbox"/> Medicare Part B (Medical) Effective Date ____/____/____	
<b>Name of Medicare Beneficiary</b>	<input type="checkbox"/> Medicare Part A (Hospital) Effective Date ____/____/____	<b>Medicare No. (From Medicare Card)</b>
	<input type="checkbox"/> Medicare Part B (Medical) Effective Date ____/____/____	

### SECTION C: OTHER INSURANCE DATA (Complete if you or your family have other coverages.)

Do you or a dependent have any other health insurance?  Yes  No If so, please complete this section.

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</b> (mm-dd-yyyy)	<b>Gender</b> <input type="checkbox"/> Male <input type="checkbox"/> Female	<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 ____/____/____	<b>Level of Coverage</b>	
		Will Coverage Be Continued <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Employee Only <input type="checkbox"/> Employee/Spouse <input type="checkbox"/> Employee/Child(ren) <input type="checkbox"/> Employee/Family	
		If No, Expected Cancel Date ____/____/____		

Name(s) of person(s) covered : \_\_\_\_\_

### 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	Birthdate (mm-dd-yyyy)	PCP	PCP No.	Existing Patient?
Employee						
Spouse						
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

<b>Social Security No.</b>	<b>Dependent's Name (First Middle Last)</b>		<b>Birthdate</b> (mm-dd-yyyy)		
<b>Mailing Address</b>	<b>City</b>	<b>State</b>	<b>ZIP Code</b>	<b>County</b>	

**Retiree's Signature** \_\_\_\_\_ **Date:** \_\_\_\_\_

# EMPLOYEES RETIREMENT SYSTEM OF TEXAS

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

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. Use this form only to designate your primary care physician. This form will facilitate the receipt of your health care identification card.

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

Complete all applicable sections of this form in detail. In Section D refer to your HealthSelect or Health Maintenance Organization (HMO) provider directory at the Customer Service link on the ERS website at [www.ers.state.tx.us](http://www.ers.state.tx.us) when completing this section. Write the name of your chosen health plan primary care physician (PCP) and provider code, facility, or physician group for yourself and each covered dependent, even if you are selecting the same physician for all covered persons. Indicate if you are an existing patient or not (Y/N).

In Section E:

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.

Call your health plan if you have questions. Once completed, mail this form to your carrier's address listed below.

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Enroll online at [www.ers.state.tx.us](http://www.ers.state.tx.us), and you will not need to complete this form.

### 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

Georgetown: (800) 758-3012

Mail Supplemental Information Forms to:

Scott & White Health Plan

2401 South 31<sup>st</sup> 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