

EMPLOYEES RETIREMENT SYSTEM OF TEXAS

Uniform Group Insurance Program (UGIP) 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.

SECTION A: RETIREE DATA

Social Security No.	Retiree Name	Birthdate	Home Telephone No.		
			()		
Mailing Address		City	State	ZIP Code	County

SECTION B: MEDICARE COVERAGE INFORMATION

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

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

SECTION C: OTHER INSURANCE DATA

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

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

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), Facility, or Physician Group from your HealthSelect, HealthSelect Plus or Health Maintenance Organization (HMO) provider directory. If required by your HMO, select an OB/GYN also. Attach an additional sheet if necessary.

Patient's Name	Social Security Number	Gender	Birthdate	PCP, Facility or Group	PCP No.	Existing Patient?	OB/GYN (HMO only)
Retiree							
Spouse							
Child							
Child							
Child							

SECTION E: OTHER DEPENDENT INFORMATION

<input type="checkbox"/> Dependent Lives Out-of-Area <input type="checkbox"/> Dependent Lives in Different Network or Service Area	Social Security No.	Dependent's Name	Birthdate		
Mailing Address		City	State	ZIP Code	County

Retiree's Signature _____

Date: _____

EMPLOYEES RETIREMENT SYSTEM OF TEXAS
Uniform Group Insurance Program (UGIP) Supplemental Information Form for Retirees

GENERAL INSTRUCTIONS

This UGIP 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 or your coverage reported to the selected health plan.

This UGIP 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.

SECTION A: RETIREE DATA

Complete this section and specify your mailing address, ZIP code, and county.

SECTION B: 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 C: 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 D: PRIMARY CARE PHYSICIAN SELECTION

Complete this section if you are enrolling in a UGIP health care plan requiring a primary care physician selection prior to receiving services. Refer to your HealthSelect, HealthSelect Plus, or Health Maintenance Organization (HMO) provider directory when completing this section.

1. Write the name of your chosen health plan.
2. Write the name of your chosen primary care physician (PCP), facility, or physician group for yourself and each covered dependent, even if you are selecting the same physician for all covered persons.

NOTE: Some HMOs may require female participants to designate an OB/GYN prior to accessing health care services. Contact your HMO to determine their requirements.

3. Write the PCP number(s) found in the health plan's provider directory, if applicable, and, 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 HealthSelect Plus and your eligible dependent lives in another HealthSelect Plus service area.
3. 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 and date this form and send it to your health plan.