



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.

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)	Employee ID Number			Phone Number Home Cell	
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 M F		Relationship Self Spouse Child	
Name and Address of Other Insurance Company	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	

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

SECTION D: PRIMARY CARE PROVIDER SELECTION (for HealthSelect of Texas® participants)

Name of your Health Plan:

If you're in HealthSelect of Texas, select your primary care provider (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					Yes
		F					No
Spouse		M					Yes
		F					No
Child		M					Yes
		F					No
Child		M					Yes
		F					No
Child		M					Yes
		F					No
Child		M					Yes
		F					No

SECTION E: OTHER COVERED DEPENDENT NOT LIVING IN THE HOUSEHOLD

Dependent Lives Out-of-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 PROVIDER SELECTION

Complete this section with your primary care provider's (PCP) information. Refer to the HealthSelect of Texas provider finder located on the HealthSelect website 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 provider 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

Complete this section if you are enrolling in HealthSelect (In-Area) and your eligible dependent lives out-of-area.

HEALTH PLAN ADDRESS AND TELEPHONE NUMBER:

HealthSelect of Texas Blue Cross and Blue Shield of Texas

- (800) 252-8039
- www.healthselectoftexas.com

Mail Supplemental Information Forms to:

Blue Cross and Blue Shield of Texas
P. O. Box 660044
Dallas, TX 75266-0044

or

Email Forms to:

ERSMembership@BCBSTX.com