COLORADO PERA

PERACare Enrollment/Change Form
Pre-Medicare Coverage—2024

Colorado Public Employees' Retirement Association
P.O. Box 5800, Denver, Colorado 80217-5800
800-759-PERA (7372) • copera.org

Your SSN ___ ___ ___ ___ ___ ___ ___ ___ ___

Only complete and return this form if you want to enroll in, change, or cancel coverage(s).

Please do not complete this form if you are not making any changes to your 2024 PERACare coverage.

Your Information

Name _____
Last First MI

Phone Number ( ) _____ Email _____

Sign up for electronic delivery of PERA information? ❑ Yes ❑ No

Signature Certification

By signing the form, I certify and agree with the following: I am eligible to enroll in the Program, and if I am enrolling my spouse and/or dependents, I certify that they also are eligible to be enrolled. I authorize Colorado PERA to deduct from my monthly benefit the premium for my coverage. Finally, I agree that, if I wish to cancel this coverage, I must provide PERA with a 30- day advance written notice.

Sign Here ➔ **Your Signature** _____ **Date** _____

Effective Date

I would like to request my effective date to enroll in, change, or cancel coverage to be _____ 1, 2024.*

* See the PERACare Enrollment Eligibility Chart in the front of this booklet to determine if a Certification of Previous Health Care Coverage is required.

Dependent Enrollment Information

Complete this section if you are adding coverage(s) for your Pre-Medicare spouse and/or dependent children. If you are adding coverage for dependents with Medicare, use the *PERACare Enrollment/Change Form Combination Pre-Medicare and Medicare Coverage—2024.*

Spouse's Last Name	First Name	MI	Birthdate	SSN	M/F
			/ /		

Child's Last Name	First Name	MI	Birthdate	SSN	M/F
			/ /		

Child's Last Name	First Name	MI	Birthdate	SSN	M/F
			/ /		

Child's Last Name	First Name	MI	Birthdate	SSN	M/F
			/ /		

(Continued on reverse)

PERACare Enrollment/Change Form
Pre-Medicare Coverage—2024 (Page 2)

Your Name _____ **Your SSN** _____

Health Plan Selection

Complete this section to enroll in, change, or cancel health care coverage

1. What do you want to do? (Check only one box.)

- ❑ **Enroll in or change** coverage as indicated below
- ❑ **Do not change** PERACare health coverage
- ❑ **Cancel** current PERACare health coverage

2. Select a coverage level, and then → **3. Select a health plan:**

- ❑ Benefit Recipient (BR) Only
- ❑ BR+Spouse
- ❑ BR+Child(ren)
- ❑ BR+Spouse+Child(ren)

- ❑ UMR PPO #1
- ❑ UMR PPO #2
- ❑ Kaiser Permanente EDCP
- ❑ Kaiser Permanente HDHP

Dental Plan Selection

Complete this section to enroll in, change, or cancel dental coverage

1. What do you want to do? (Check only one box.)

- ❑ **Enroll in or change** coverage as indicated below
- ❑ **Do not change** PERACare dental coverage
- ❑ **Cancel** current PERACare dental coverage

2. Select a coverage level, and then → **3. Select a health plan:**

- ❑ Benefit Recipient (BR) Only
- ❑ BR+Spouse
- ❑ BR+Child(ren)
- ❑ BR+Spouse+Child(ren)

- ❑ Cigna Dental HMO*
- ❑ Delta Dental PPO

* If you are enrolling in the Cigna Dental HMO, indicate the six-digit DHMO office number(s) below. To obtain this number, call Cigna at 877-635-PERA (7372) or visit copera.org and select "Health Benefits (PERACare)" under the "Retiree" menu, then click on "PERACare Carriers," then "Cigna Dental."

Cigna Dental HMO Office Number(s):

Benefit Recipient | Spouse | Child(ren)

Vision Plan Selection

Complete this section to enroll in, change, or cancel vision coverage

1. What do you want to do? (Check only one box.)

- ❑ **Enroll in or change** coverage as indicated below
- ❑ **Do not change** PERACare vision coverage
- ❑ **Cancel** current PERACare vision coverage

2. Select a coverage level, and then → **3. Select a health plan:**

- ❑ Benefit Recipient (BR) Only
- ❑ BR+Spouse
- ❑ BR+Child(ren)
- ❑ BR+Spouse+Child(ren)

- ❑ VSP PPO #1
- ❑ VSP PPO #2
- ❑ VSP PPO #3

Note: If you select a coverage level but do not select a plan, you will be enrolled in VSP PPO #1.