COLORADO PERA

Certification of Previous Health Care Coverage

Colorado Public Employees' Retirement Association
P.O. Box 5800, Denver, Colorado 80217-5800
800-759-PERA (7372) • Fax: 303-863-3727 • copera.org

Retiree SSN ___ ___ ___ ___ ___ ___ ___ ___ ___

Submit this form and the appropriate *PERACare Enrollment/Change Form* to Colorado PERA no later than 30 days after the loss of coverage.

Your Information

This section should be completed by the PERA retiree/benefit recipient.

Name _____
Last First MI

Telephone Number ( ) _____ Email Address _____

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

Coverage is ending for (check all that apply):
❑ Me ❑ My Spouse ❑ My Dependent(s)

Type of coverage that is ending (check all that apply):
❑ Health care coverage ❑ Dental coverage ❑ Vision coverage

Reason for Loss of Coverage

❑ COBRA eligibility exhausted

❑ Employer coverage ending involuntarily

❑ Other (please specify): _____

Proof of Loss of Coverage

This section can be completed by a representative of the former employer or COBRA administrator. In lieu of completing this section, you may provide a HIPAA certificate, COBRA letter, or other documentation proving continuous coverage in the prior plan as proof of involuntary loss of coverage. ID cards are not sufficient.

I attest that the above information is correct and that all persons listed were continuously covered through our plan until the date(s) listed below:

Last date of health coverage _____
Month/Day/Year

Last date of dental coverage _____
Month/Day/Year

Last date of vision coverage _____
Month/Day/Year

Employer or COBRA Administrator _____

Representative Title _____ Telephone Number ( ) _____

Representative Email Address _____

Sign Here ➔ **Signature** _____ **Date** _____
Representative of Former Employer or COBRA Administrator