

Certification of Previous Health Care Coverage

Colorado Public Employees' Retirement Association
PO Box 5800, Denver, Colorado 80217-5800
303-832-9550 or 1-800-759-PERA (7372)



Type or print in black ink, and sign below. Print your Social Security number (SSN) clearly in the first row of boxes. *If you are not the PERA retiree*, print the SSN of the deceased PERA member/retiree in the second row of boxes and print his or her name on the line below:

SSN

SSN input boxes: [][][] - [][] - [][][][]

SSN of PERA Member/Retiree (if different)

SSN of PERA Member/Retiree input boxes: [][][] - [][] - [][][][]

Your Name _____

Address _____
City State ZIP Code

Daytime Telephone Number () _____

Instructions: You may enroll in or add a dependent to the PERACare program based upon first Medicare eligibility, the completion of COBRA coverage, or loss of coverage. (Your canceling coverage for which you are eligible is not considered a loss of coverage.) Complete this form and attach a HIPAA certificate, a COBRA letter, or other documentation proving continuous coverage in the prior plan or have your employer or COBRA administrator complete the verification below. Submit this certification and the *PERACare Enrollment/Change Form* to PERA up to 60 days before, but no later than 30 days after, you are requesting PERA's coverage to be effective.

Reason I am requesting enrollment for health care, dental, and/or vision coverage:

1. Reaching age 65/Medicare eligibility on _____
Month/Day/Year
2. COBRA coverage began on _____ and is ending on _____
Month/Day/Year Month/Day/Year
3. Losing other coverage on _____ Reason for loss of coverage _____
Month/Day/Year

I attest to continuous (check all that apply)

_____ Health Care Coverage _____ Dental Coverage _____ Vision Coverage

Signature _____ Date _____

Spouse's Signature _____ Date _____

Verification of previous health care coverage:

Employer or COBRA Administrator should complete if a HIPAA certificate, COBRA letter, or other documentation proving continuous coverage in prior plan is not available.

I attest that the above information is correct and that the person was continuously covered through our plan.

The last date of health care coverage is/was _____
Month/Day/Year

Employer or COBRA Administrator _____ Telephone Number () _____

Signature _____ Title _____ Date _____