



PERACare Pre-Medicare Enrollment/Change Form



Personal. Innovative. Secure

PERACare Pre-Medicare Enrollment/Change Form Checklist

Check the following list to be sure you have completed all of the information needed for enrollment. Tear the enrollment form at the perforation and send it to PERA, or you may fax it to 303-863-3727.

- ✔ **Is everyone you are enrolling pre-Medicare?** If not, use the appropriate *Medicare* or *Combination Pre-Medicare and Medicare Enrollment/Change Form*.
- ✔ **Did you sign the form?**
- ✔ **If you are enrolling at a time other than retirement or open enrollment:**
 - Is it within 30 days of the date you are losing coverage?
 - Did you include a *Certification of Previous Health Care Coverage* form?
- ✔ **If you are enrolling your spouse, did you complete the spouse enrollment information?**
- ✔ **If you are enrolling in a health plan, did you:**
 - Select who you want to cover?
 - Select a plan?
- ✔ **If you are enrolling in the Anthem HMO plan, did you include a provider code for your Primary Care Physician (PCP) selection?** (Provider codes are required for enrollment.)
- ✔ **If you are enrolling in a dental or vision plan, did you:**
 - Select who you would like to cover?
 - Select a plan?
 - Include a provider code if you are enrolling in CIGNA Dental HMO?
- ✔ **If you are enrolling children, did you complete the dependent children enrollment information?**

Signature Certification

By signing the form, I am certifying and agreeing with the following: I have reviewed the information about PERACare. 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. The information I provided on this form is correct and complete. I agree that, if I wish to cancel this coverage, I must provide PERA with a 30-day advance written notice.

PERACare Enrollment/Change Form

Pre-Medicare Coverage

Colorado Public Employees' Retirement Association

PO Box 5800 Denver, Colorado 80217-5800

303-832-9550 or 1-800-759-7372 (PERA) • Fax: 303-863-3727 • www.copera.org



Read the *PERACare 2008 Health Benefits Program—Pre-Medicare Coverage* booklet before completing this form. The benefit recipient should complete this form to enroll in a PERACare plan, or to make changes such as adding dependents or changing plans. This form is for benefit recipients who are pre-Medicare (under age 65) and enrolling others who are all pre-Medicare. There are other enrollment/change forms for Medicare and combination pre-Medicare and Medicare coverage.

Your SSN

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SSN of Deceased PERA Member/Retiree (if you are not the PERA member)

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Last Name	First Name	MI	Date of Birth	Daytime Telephone Number

Signature _____ **Date** _____

Signature Certification

By signing the form, I am certifying and agreeing with the following: I have reviewed the information about PERACare. 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. The information I provided on this form is correct and complete. I agree that, if I wish to cancel this coverage, I must provide PERA with a 30-day advance written notice.

Instructions for Completing Form

If you are already enrolled in PERACare and are using this form to make a change, complete only the information that you wish to change. Any coverage that you are not changing will remain in place.

You may use this form for pre-Medicare (under age 65) health care, and for dental or vision coverage. Refer to the *PERACare 2008 Health Benefits Program—Pre-Medicare Coverage* booklet for information on plans that are available to you. You may select different tiers and carriers for each type of coverage. If you are enrolling your spouse and/or children, they will be enrolled in the same plan that you are enrolling yourself in, i.e., the benefit recipient determines the coverage and has the ability to add family members to his/her coverage. If you are enrolling your spouse and/or children, complete those sections of the form. If you are not enrolling your spouse or children, leave those sections blank.

Effective Date

I am requesting that coverage be effective * _____ 1, 2008.

*If this date is not your retirement effective date, a *Certification of Previous Health Care Coverage* form may be required. See the PERACare Enrollment Eligibility Chart.

Spouse Enrollment Information

Last Name	First Name	MI	Date of Birth	SSN	M/F



Select your health, dental, and vision plans on the reverse

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Retiree Name _____ SSN _____

Health Plan Selection

Who do you want to cover for health care? Circle one:

- 1. Benefit Recipient
- 2. Benefit Recipient + Spouse
- 3. Benefit Recipient + Child(ren)
- 4. Benefit Recipient + Spouse + Child(ren)

Which plan would you like to enroll in? Circle one plan:

- 1. Anthem HMO*
- 2. Anthem PPO #1
- 3. Anthem PPO #2
- 4. Anthem HDHP
- 5. Kaiser Permanente HMO #1
- 6. Kaiser Permanente HMO #2
- 7. Kaiser Permanente HDHP

***The Anthem HMO plan requires you to select a Primary Care Physician to enroll.** Please complete provider code(s) below. Provider codes can be found through the PERA Web site (www.copera.org) under Retirees/Benefit Recipients, then PERACare from the left-hand bar, then Provider Directories from the top bar. You may also call Anthem at 1-877-PERABLU (1-877-737-2258) for provider codes.

Benefit Recipient: _____ Spouse: _____ Child(ren): _____
Provider Code Provider Code Provider Code

Dental Plan Selection

Who do you want to cover for dental care? Circle one:

- 1. Benefit Recipient
- 2. Benefit Recipient + Spouse
- 3. Benefit Recipient + Child(ren)
- 4. Benefit Recipient + Spouse + Child(ren)

Which plan would you like to enroll in? Circle one plan:

- 1. CIGNA Dental PPO
- 2. CIGNA Dental HMO*

***CIGNA Dental HMO requires you to select a dentist to enroll.** Please complete provider code(s) below. Provider codes can be found through the PERA Web site at www.copera.org under Retirees/Benefit Recipients, then PERACare from the left-hand bar, then Provider Directories from the top bar. You may also call CIGNA Dental at 1-877-635-PERA (7372) for provider codes.

Benefit Recipient: _____ Spouse: _____ Child(ren): _____
Provider Code Provider Code Provider Code

Vision Plan Selection

Who do you want to cover for vision care? Circle one:

- 1. Benefit Recipient
- 2. Benefit Recipient + Spouse
- 3. Benefit Recipient + Child(ren)
- 4. Benefit Recipient + Spouse + Child(ren)

Which plan would you like to enroll in? Circle one plan:

- 1. VSP PPO #1
- 2. VSP PPO #2
- 3. VSP PPO #3

Dependent Child(ren) Enrollment Information

_____ Last Name	_____ First Name	_____ MI	_____/_____/_____ Date of Birth	_____ SSN	_____ M/F
_____ Last Name	_____ First Name	_____ MI	_____/_____/_____ Date of Birth	_____ SSN	_____ M/F
_____ Last Name	_____ First Name	_____ MI	_____/_____/_____ Date of Birth	_____ SSN	_____ M/F