



Health Care, Dental, and Vision Plans 2010



PERACare Enrollment Form for DPSRS Retirees



Personal. Innovative. Secure.

PERACare Enrollment Form Checklist for DPSRS Retirees

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.

- Did you sign the form?
- If you are enrolling your spouse, did you complete the spouse enrollment information and have your spouse sign the form?
- If you and/or your spouse have Medicare, did you:
 - Include your Medicare number(s) on the form?
 - Include a copy of your Medicare card(s)?
- If you are enrolling in a health plan, did you:
 - Select who you want to cover?
 - Select a plan?

Note: Rocky Mountain Health Plans and Secure Horizons do not offer pre-Medicare or combination coverage.
- If you are enrolling in an HMO plan, is your permanent residence within the HMO's service area?
- If you are enrolling in the Anthem HMO, Rocky Mountain Health Plans Medicare HMO, or Secure Horizons Medicare HMO plans, 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. If applicable, I authorize release of Medicare claims information to Anthem Blue Cross and Blue Shield to allow payment of any complementary benefit either to myself or to the party who accepts assignment. If applicable, by joining a Medicare HMO plan, I acknowledge that the Medicare HMO plan will release my information to Medicare and other plans as is necessary for treatment, payment, and health care operations. I authorize PERA to deduct from my monthly benefit the premium for my health care coverage, if applicable. By the health plan election on this form, I cancel any prior arrangements for coverage in the PERA health care program and also terminate any Medicare managed care coverage as of the effective date of my new election. Finally, I agree that, if I wish to cancel this coverage, I must provide PERA with a 30-day advance written notice.

PERACare Enrollment Form for DPSRS Retirees

Colorado Public Employees' Retirement Association
 PO Box 5800 Denver, Colorado 80217-5800
 1-866-737-2261 • Fax: 303-863-3727 • www.copera.org



Read the information in the *PERACare Health Benefits Program* booklet before completing this form. A DPSRS Retiree should complete this form to enroll in a PERACare plan.

Your SSN

□ □ □ - □ □ - □ □ □ □

SSN of Deceased DPSRS Member/Retiree (if you are not the DPSRS retiree)

□ □ □ - □ □ - □ □ □ □

_____/_____/_____(____)_____
 Last Name First Name MI Date of Birth Daytime Telephone Number

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Signature _____ **Date** _____

Spouse's Signature (if enrolling) _____ **Date** _____

Effective Date

I understand that my coverage will be effective January 1, 2010, since I am enrolling during open enrollment.

Spouse Enrollment Information

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

Medicare Information (if applicable)

Include a photocopy of your Medicare card(s) with this form.

I have/I have applied for Medicare Part B only Both A and B Medicare No. _____

My spouse has/My spouse has applied for Medicare Part B only Both A and B Medicare No. _____

Important Additional Medical Questions for the Medicare Enrollee

If you answer "Yes" to any of the following questions, PERA may contact you to provide more information.

1. Do you currently have End-Stage Renal Disease (ESRD) and receive routine dialysis treatment? Yes No
2. Do you have additional medical coverage (outside PERACare)? Yes No
3. Will you have other prescription drug coverage (outside PERACare)? Yes No



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

