



Medicare Plans 2008



PERACare Medicare Enrollment/Change Form



Personal. Innovative. Secure

PERACare 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 covered by Medicare?** If not, use the appropriate *Pre-Medicare* or *Combination Pre-Medicare and Medicare Enrollment/Change Form*.
- ✓ **Did you sign the form?**
- ✓ **If you are enrolling your spouse, did your spouse 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 or 30 days of becoming Medicare eligible?
 - Did you include a *Certification of Previous Health Care Coverage* form?
- ✓ **If you are enrolling your spouse, did you complete the spouse enrollment information?**
- ✓ **Did you include your Medicare number on the form and include a photocopy of your Medicare card if you have not provided one to PERA already?**
- ✓ **If you are enrolling in a health plan, did you:**
 - Select who you want to cover?
 - Select a plan?
- ✓ **If you are enrolling in an HMO, is your permanent residence within the HMO's service area?**
- ✓ **If you are enrolling in Rocky Mountain Health Plans or Secure Horizons, 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?

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/Change Form

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—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 have Medicare and are enrolling others who all have Medicare. There are other enrollment/change forms for pre-Medicare and combination pre-Medicare and Medicare coverage. **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.**

Your SSN

			-			-			
--	--	--	---	--	--	---	--	--	--

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

			-			-			
--	--	--	---	--	--	---	--	--	--

Last Name

First Name

MI

Date of Birth

Daytime Telephone Number

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.

Signature _____ **Date** _____

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

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

Medicare Information

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

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

- Do you (or your spouse, if you are enrolling your spouse) currently have End-Stage Renal Disease (ESRD) and receive routine dialysis treatment? Yes No
- Do you (or your spouse) have additional medical coverage (outside PERACare)? Yes No
- Will you (or your spouse) have other prescription drug coverage (outside PERACare)? Yes No



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

PERACare Enrollment/Change Form
Medicare Coverage—Page 2

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 MS #1
- 2. Anthem MS #2
- 3. Kaiser Permanente Medicare HMO
- 4. Rocky Mountain Health Plans Medicare HMO*
- 5. Secure Horizons Medicare HMO*

***The Medicare HMO plans in Rocky Mountain Health Plans and Secure Horizons require 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 Rocky Mountain Health Plans at 1-800-346-4643 or Secure Horizons at 1-800-771-4347 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 (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

Complete only for child(ren) who have Medicare.

_____ Last Name	_____ First Name	_____ MI	____/____/____ Date of Birth	_____ SSN	_____ M/F	_____ Medicare No.
_____ Last Name	_____ First Name	_____ MI	____/____/____ Date of Birth	_____ SSN	_____ M/F	_____ Medicare No.
_____ Last Name	_____ First Name	_____ MI	____/____/____ Date of Birth	_____ SSN	_____ M/F	_____ Medicare No.