

Request for PERACare Premium Quote

Colorado Public Employees' Retirement Association
1300 Logan Street, Denver, Colorado 80203-2386
303-832-9550 or 1-800-759-PERA (7372) • www.copera.org



Please complete the information requested below and include any supporting data by attachment or by sending it electronically. Send the information to Jessica Linart, Insurance Manager, at the above address or to jlinart@copera.org.

General Information

Employer Name _____

PERA Employer Number _____

PERA Division State School Local Government Judicial

School Districts Only: County and District Number _____

Employer Address _____
Street City State ZIP Code

Employer's Main Telephone () _____ Fax () _____

Contact Person's Name _____ Title _____

Contact Person's Telephone () _____ Fax () _____

Contact Person's E-mail _____

Plan Year Requested January 1, 2010 July 1, 2009 Other _____ (initial year only)

Underwriting Information

Number of PERA-covered employees, retirees, and COBRA.

_____ Employees eligible for benefits	_____ Retirees enrolled in current plan
_____ Full-time employees	_____ COBRA participants enrolled in current plan
_____ Part-time employees	_____ Employee dependents enrolled in current plan
_____ Full-time employees enrolled in current plan	_____ Retiree dependents enrolled in current plan
_____ Part-time employees enrolled in current plan	_____ COBRA dependents enrolled in current plan

Eligibility information. Provide your employer's definition of a full-time employee, a part-time employee, and eligible dependents (spouse, domestic partner, children to age 25, etc.):

Continued on reverse

Current Census Data

Provide the following information for all eligible employees and retirees, including those who are not currently covered:

1. Age
2. Sex
3. Family composition
4. Home ZIP Code
5. Medical plan election
6. Dental plan election
7. Status (active, retired, COBRA)

Medical Carrier History. Starting with your current carrier, list the insurer(s) from whom you have purchased health benefit coverage for your employees over the last three years. Include detailed plan designs for each plan.

	Carrier		Effective Date	Plan Design	# Enrolled
Current Plan		<input type="checkbox"/> Self Funded <input type="checkbox"/> Fully Insured		<input type="checkbox"/> HMO <input type="checkbox"/> PPO <input type="checkbox"/> POS <input type="checkbox"/> HDHP	_____ _____ _____ _____
Prior Plan		<input type="checkbox"/> Self Funded <input type="checkbox"/> Fully Insured		<input type="checkbox"/> HMO <input type="checkbox"/> PPO <input type="checkbox"/> POS <input type="checkbox"/> HDHP	_____ _____ _____ _____
Prior Plan		<input type="checkbox"/> Self Funded <input type="checkbox"/> Fully Insured		<input type="checkbox"/> HMO <input type="checkbox"/> PPO <input type="checkbox"/> POS <input type="checkbox"/> HDHP	_____ _____ _____ _____

Medical Plan Data. Provide the following medical plan data for each of the past two years:

1. Number of employees enrolled by month for each benefit plan
2. Number of total covered lives (employee plus dependents) by month
3. Hospital and medical claims by month
4. Pharmacy claims by month
5. Aggregate premium paid by month
6. Large claims greater than \$5,000 listed by diagnosis (number and dollar amount)
7. Premium history, including the employer contribution for each class of employee