COLORADO PERA

PERACare Enrollment/Change Form
Medicare Coverage—2024
Colorado Public Employees' Retirement Association
PO Box 5800, Denver, CO 80217-5800
800-759-PERA (7372) • copera.org

Your SSN ☐☐☐ ☐☐ ☐☐☐☐

Complete and return this form if you want to enroll in, change, or cancel coverage(s).

Your Information

Name _____
Last First MI

Permanent Residence Street Address _____
(PO Box is not allowed)

City _____ State _____ ZIP Code _____

Phone Number ( ) _____ Email _____

Sign up for electronic delivery of PERA information? ❑ Yes ❑ No

Signature Certification

By signing the form, I certify that if I am enrolling my spouse and/or dependents, they are eligible to be enrolled. I authorize Colorado PERA to deduct from my monthly benefit the premium for my coverage. Finally, I agree that, if I wish to cancel this coverage, I must provide PERA with a 30-day advance notice.

Sign Here → **Your Signature** _____ **Date** _____

Sign Here → **Spouse's Signature** _____ **Date** _____

(Spouse's signature only required if spouse is enrolling in a Medicare health plan)

Effective Date

I would like to request my effective date to enroll in, change, or cancel coverage to be _____ 1, 2024.* This *Enrollment/Change Form* must be signed prior to the requested effective date, but cannot be signed more than 90 days in advance.

* See the PERACare Enrollment Eligibility Chart in the front of this booklet to determine if a Certification of Previous Health Care Coverage is required.

Dependent Enrollment Information

Complete this section if you are adding coverage(s) for your dependent(s). Be sure that your spouse signs above if they are enrolling in a Medicare plan. If you are adding health plan coverage for a dependent who does not have Medicare, use the *PERACare Enrollment/Change Form Combination Pre-Medicare and Medicare Coverage—2024*.

Spouse's Last Name	First Name	MI	Birthdate (/ /)	SSN	M/F

Child's Last Name	First Name	MI	Birthdate (/ /)	SSN	M/F

(Continued on reverse)

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Your Name _____ **Your SSN** _____

Medicare Information

For health plan enrollment(s) only

Complete this section if you are enrolling in a health plan or changing health plans. ***Send a photocopy of your Medicare card(s) as soon as you receive it.***

Check this box if you have not received your Medicare number(s) yet: ❑ **PENDING**

My Medicare No. _____ ❑ Both Medicare Parts A and B ❑ Part B Only

My Spouse's Medicare No. _____ ❑ Both Medicare Parts A and B ❑ Part B Only

My Child's Medicare No. _____ ❑ Both Medicare Parts A and B ❑ Part B Only

Health Plan Selection

Complete this section to enroll in, change, or cancel health care coverage

1. What do you want to do? (Check only one box.)

❑ **Do not change** PERACare health care coverage

❑ **Enroll in** or **change** coverage as indicated below

❑ **Cancel** current PERACare health care coverage

2. Check yes or no to the following important medical questions for all enrollees:

Will any enrollees have additional medical coverage outside of Medicare and PERACare? ❑ Yes ❑ No

Will any enrollees have prescription drug coverage outside of Medicare and PERACare? ❑ Yes ❑ No

Do any enrollees currently receive dialysis treatment or have End-Stage Renal Disease (ESRD)? ❑ Yes ❑ No

Medicare Advantage (MA)

3. Select a coverage level, and then →

❑ Benefit Recipient (BR) Only
❑ BR+Spouse
❑ BR+Child(ren)
❑ BR+Spouse+Child(ren)

4. Select a health plan:

❑ UnitedHealthcare MA #1
❑ UnitedHealthcare MA #2
❑ Kaiser Permanente Med HMO

Dental Plan Selection

Complete this section to enroll in, change, or cancel dental coverage

1. What do you want to do? (Check only one box.)

❑ **Do not change** PERACare dental coverage

❑ **Enroll in** or **change** coverage as indicated below

❑ **Cancel** current PERACare dental coverage

2. Select a coverage level, and then →

❑ Benefit Recipient (BR) Only
❑ BR+Spouse
❑ BR+Child(ren)
❑ BR+Spouse+Child(ren)

3. Select a dental plan:

❑ Cigna Dental HMO*
❑ Delta Dental PPO

* If you are enrolling in the Cigna Dental HMO, indicate the six-digit DHMO office number(s) below. To obtain this number, call Cigna at 877-635-PERA (7372) or visit copera.org and select "Health Benefits (PERACare)" under the "Retiree" menu, then click on "PERACare Carriers," then "Cigna Dental."

Cigna Dental HMO Office Number(s):

Benefit Recipient | Spouse | Child(ren)

Vision Plan Selection

Complete this section to enroll in, change, or cancel vision coverage

1. What do you want to do? (Check only one box.)

❑ **Do not change** PERACare vision coverage

❑ **Enroll in** or **change** coverage as indicated below

❑ **Cancel** current PERACare vision coverage

2. Select a coverage level, and then →

❑ Benefit Recipient (BR) Only
❑ BR+Spouse
❑ BR+Child(ren)
❑ BR+Spouse+Child(ren)

3. Select a vision plan:

❑ VSP PPO #1
❑ VSP PPO #2
❑ VSP PPO #3

Note: If you select a coverage level but do not select a plan, you will be enrolled in VSP PPO #1.