COLORADO PERA

# PERACare Enrollment/Change Form
## Combination Pre-Medicare and Medicare Coverage—2023

Colorado Public Employees' Retirement Association
PO Box 5800, Denver, Colorado 80217-5800
1-800-759-PERA (7372) • Fax: 303-863-3727 • www.copera.org

**Your SSN** ☐☐☐ ☐☐ ☐☐☐☐

**Complete and return this form if you want to enroll in, change, or cancel coverage(s).** This form is used for "combination coverage" only. Combination coverage applies when you are covering your spouse and/or child(ren) and one of you is on Medicare, but others are still under age 65.

## 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 and agree with the following: 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. By joining a PERACare Medicare plan, I acknowledge that the Medicare plan will release my information to Medicare and other plans as is necessary for treatment, payment, and health care operations. 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 written 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, 2023.* This *Enrollment/Change Form* must be signed prior to the requested effective date, but cannot be signed more than 90 days in advance.

* 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 in the *PERACare Health Benefits Program Medicare Coverage* booklet.

## 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.

| 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)***

**PERACare Enrollment/Change Form**

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**Your Name** _____ **Your SSN** _____

## Medicare Information

Complete this section if you are enrolling in a health plan or changing health plans. You do not need to complete this section if you are adding only dental and/or vision 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.)**

❑ **Enroll** or **change** coverage as indicated below
❑ **Do not change** PERACare health care coverage
❑ **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)+Spouse
❑ BR+Child(ren)
❑ BR+Spouse+Child(ren)

**4. Select a health plan:**

❑ UMR PPO #1/UnitedHealthcare MA #1
❑ UMR PPO #2/UnitedHealthcare MA #1
❑ UMR PPO #1/UnitedHealthcare MA #2
❑ UMR PPO #2/UnitedHealthcare MA #2
❑ Kaiser Permanente Deductible HMO/Med HMO
❑ Kaiser Permanente HDHP/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.)**

❑ **Enroll** or **change** coverage as indicated below
❑ **Do not change** PERACare dental coverage
❑ **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 PPO
❑ 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 1-877-635-PERA (7372) or visit copera.org and select "Health Benefits (PERACare)" under the "Retiree" menu, then click on "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.)**

❑ **Enroll** or **change** coverage as indicated below
❑ **Do not change** PERACare vision coverage
❑ **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.*