COLORADO PERA

**PERACare Enrollment/Change Form**
**Pre-Medicare Coverage—2024**
Colorado Public Employees' Retirement Association
PO Box 5800, Denver, Colorado 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

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 acknowledge that the Medicare plan will release my information to Medicare and other plans as in necessary for health plan 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 advance notices.

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

## Effective Date

I would like to request my effective date to enroll in, change, or cancel coverage to be _____ 1, 2024.*

* 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 Pre-Medicare spouse and/or dependent children. If you are adding coverage for dependents with 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 |
| Child'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**
**Pre-Medicare Coverage—2024 (Page 2)**

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

## 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** or **change** coverage as indicated below
- ❑ **Cancel** current PERACare health care coverage

**2. Select a coverage level, and then → 3. Select a health plan:**

- ❑ Benefit Recipient (BR) only
- ❑ BR+Spouse
- ❑ BR+Child(ren)
- ❑ BR+Spouse+Child(ren)

- ❑ UMR PPO #1
- ❑ UMR PPO #2
- ❑ Kaiser Permanente EDCP
- ❑ Kaiser Permanente HDHP

## 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** or **change** coverage as indicated below
- ❑ **Cancel** current PERACare dental coverage

**2. Select a coverage level, and then → 3. Select a dental plan:**

- ❑ Benefit Recipient (BR) only
- ❑ BR+Spouse
- ❑ BR+Child(ren)
- ❑ BR+Spouse+Child(ren)

- ❑ 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** or **change** coverage as indicated below
- ❑ **Cancel** current PERACare vision coverage

**2. Select a coverage level, and then → 3. Select a vision plan:**

- ❑ Benefit Recipient (BR) only
- ❑ BR+Spouse
- ❑ BR+Child(ren)
- ❑ BR+Spouse+Child(ren)

- ❑ 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.*