COLORADO PERA

PERACare Enrollment/Change Form
Pre-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).

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 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. 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 written notice.

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, 2023.*

* 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 Pre-Medicare Coverage* booklet.

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—2023*.

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)

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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 Deductible HMO
- ❑ 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 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.)

- ❑ **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.