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.

<table>
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<th>Spouse's Last Name</th>
<th>First Name</th>
<th>MI</th>
<th>Birthdate</th>
<th>SSN</th>
<th>M/F</th>
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**PERACare Enrollment/Change Form**  
**Pre-Medicare Coverage—2023 (Page 2)**

**Health Plan Selection**

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. Select a coverage level, and then
   - [ ] Benefit Recipient (BR) only
   - [ ] BR+Spouse
   - [ ] BR+Child(ren)
   - [ ] BR+Spouse+Child(ren)

3. Select a health plan:
   - [ ] UMR PPO #1
   - [ ] UMR PPO #2
   - [ ] Kaiser Permanente Deductible HMO
   - [ ] Kaiser Permanente HDHP

**Dental Plan Selection**

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):

<table>
<thead>
<tr>
<th>Benefit Recipient</th>
<th>Spouse</th>
<th>Child(ren)</th>
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**Vision Plan Selection**

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.