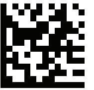
PERACare Program Enrollment/Change Form

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 [ ][ ][ ] [ ][ ] [ ][ ][ ][ ]

Instructions: If you are already enrolled in PERACare and are using this form to make a change, complete only the information that you wish to change. Any coverage that you are not changing will remain in place.

You may use this form for health care, dental, or vision coverage. Refer to the *PERACare Health Plan Descriptions For Active Members* booklet for information on plans that are available to you. You may select different tiers and carriers for each type of coverage. If you are enrolling dependents (spouse and/or children), they will be enrolled in the same plan that you are enrolling yourself in, i.e., the employee determines the coverage and has the ability to add dependents to his/her coverage. If you are enrolling your dependents, complete the "Dependent Enrollment Information" section of the form.

Your Information

Name ______________________________
Last First MI

Birthdate ____/____/____ Telephone (____) ______________

Email Address ______________________________

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

Effective Date

I am requesting that coverage be effective ____________ 1, ____________ .
Month Year

Dependent Enrollment Information

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
			/ /		

Signature Certification

By signing this form, I am certifying and agreeing with the following: I have carefully reviewed the information about PERACare, I am eligible to enroll in the Program, and if I am enrolling my dependents, I certify that they also are eligible to be enrolled. The information I have provided on this form is correct and complete. I authorize my employer to deduct from my paycheck the premium for my health care coverage, if applicable. Finally, I agree that, if I wish to cancel this coverage, I will provide my employer with a 30-day advance written notice.

Sign Here ➔ **Signature** ______________________________ **Date** ______________

Select your health, dental, and vision plans on the reverse

To Be Completed by Employer: ______________ Employer Number ______________________________ Authorized Employer Signature

Your Name ______________________________ **Your SSN** ______________________________

Health Plan Selection

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

❑ **Add** or **change** coverage as indicated below
❑ **Keep** current health care coverage
❑ **Cancel** current health care coverage

Check one box below to select a plan and coverage level if you are adding or changing coverage.
(EE=Employee)

Plan				
Kaiser Permanente HMO #1	❑ EE Only	❑ EE+Spouse	❑ EE+Child(ren)	❑ EE+Spouse+Child(ren)
Kaiser Permanente HMO #2	❑ EE Only	❑ EE+Spouse	❑ EE+Child(ren)	❑ EE+Spouse+Child(ren)
Kaiser Permanente HDHP	❑ EE Only	❑ EE+Spouse	❑ EE+Child(ren)	❑ EE+Spouse+Child(ren)

Dental Plan Selection

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

❑ **Add** or **change** coverage as indicated below
❑ **Keep** current dental coverage
❑ **Cancel** current dental coverage

Check one box below to select a plan and coverage level if you are adding or changing coverage.

Plan				
Cigna Dental PPO	❑ EE Only	❑ EE+Spouse	❑ EE+Child(ren)	❑ EE+Spouse+Child(ren)
Cigna Dental HMO*	❑ EE Only	❑ EE+Spouse	❑ EE+Child(ren)	❑ EE+Spouse+Child(ren)
Delta Dental PPO	❑ EE Only	❑ EE+Spouse	❑ EE+Child(ren)	❑ EE+Spouse+Child(ren)

* If you are enrolling in the Cigna Dental HMO, please select your dentist(s) and indicate their provider office number(s) below. Provider office numbers can be obtained by calling Cigna at 1-877-635-PERA (7372).

Cigna Dental HMO Office Number(s):	Benefit Recipient	Spouse	Child(ren)

Vision Plan Selection

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

❑ **Add** or **change** coverage as indicated below
❑ **Keep** current vision coverage
❑ **Cancel** current vision coverage

Check one box below to select a plan and coverage level if you are adding or changing coverage.

Plan				
VSP PPO #1	❑ EE Only	❑ EE+Spouse	❑ EE+Child(ren)	❑ EE+Spouse+Child(ren)
VSP PPO #2	❑ EE Only	❑ EE+Spouse	❑ EE+Child(ren)	❑ EE+Spouse+Child(ren)
VSP PPO #3	❑ EE Only	❑ EE+Spouse	❑ EE+Child(ren)	❑ EE+Spouse+Child(ren)