



**PERACare Enrollment/Change Form  
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

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 advance 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. If you are adding health plan coverage for a dependent who does not have 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

(Continued on reverse)



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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. *Send a photocopy of your Medicare card(s) as soon as you receive it.*

For health plan enrollment(s) only

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.)  Do not change PERACare health care coverage  
 Enroll in or change coverage as indicated below  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 **→** 4. Select a health plan:  
 Benefit Recipient (BR) Only  UnitedHealthcare MA #1  
 BR+Spouse  UnitedHealthcare MA #2  
 BR+Child(ren)  Kaiser Permanente Med HMO  
 BR+Spouse+Child(ren)

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 in 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  Cigna Dental PPO  
 BR+Spouse  Cigna Dental HMO\*  
 BR+Child(ren)  Delta Dental PPO  
 BR+Spouse+Child(ren)

\* 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): 

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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 in 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  VSP PPO #1  
 BR+Spouse  VSP PPO #2  
 BR+Child(ren)  VSP PPO #3  
 BR+Spouse+Child(ren)

Note: If you select a coverage level but do not select a plan, you will be enrolled in VSP PPO #1.