PERACare Enrollment/Change Form
Medicare Coverage

Colorado Public Employees' Retirement Association
PO Box 5800 Denver, Colorado 80217-5800
303-832-9550 or 1-800-759-7372 (PERA) • Fax: 303-863-3727 • www.copera.org

Your SSN ___ ___ ___   ___ ___   ___ ___ ___ ___

Complete and return this form if you want to add coverage(s), make changes, or cancel coverage(s).

Your Information

Name ____
Last First MI

Date of Birth ____/____/____ Telephone Number (____) ______________

E-mail Address ____

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

Signature Certification

By signing the form, I am certifying and agreeing with the following: I have reviewed the information about PERACare. 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. The information I provided on this form is correct and complete. If applicable, I authorize release of Medicare claims information to Anthem Blue Cross and Blue Shield to allow payment of any complementary benefit either to myself or to the party who accepts assignment. If applicable, by joining a Medicare HMO plan, I acknowledge that the Medicare HMO 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. By the health plan election on this form, I authorize cancellation of any prior arrangements for coverage in the PERA Health Care Program and also agree that I will terminate any other Medicare coverage as of the effective date of my new election. Finally, I agree that, if I wish to cancel this coverage, I must provide Colorado PERA with a 30–day advance written notice.

Sign Here → **Your Signature** ______________________________ **Date**______________

Sign Here → **Spouse's Signature** ______________________________ **Date**______________
If enrolling/changing

Effective Date

I would like to request my effective date to enroll, make changes, or cancel coverage to be ______________ 1, 2013.*

*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) with Medicare (your spouse and/or dependent child) and be sure that your spouse signs above. If you are adding coverage for a dependent(s) under age 65 who does not have Medicare, do not use this form. Use the *PERACare Combination Pre-Medicare and Medicare Coverage Enrollment/Change Form* instead.

Spouse's Last Name	First Name	MI	Date of Birth	SSN	M/F
			/ /		

Child's Last Name	First Name	MI	Date of Birth	SSN	M/F
			/ /		

Medicare Information

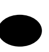
Complete this section if you are enrolling in a health plan or changing health plans. You do not need to complete this section if you are adding only dental and/or vision plans. ***Send a photocopy of your Medicare card(s) as soon as you receive it.***

I have or have applied for ❑ Medicare Part B only ❑ Both A and B Medicare No. ______________

My spouse has or has applied for ❑ Medicare Part B only ❑ Both A and B Medicare No. ______________

My child has or has applied for ❑ Medicare Part B only ❑ Both A and B Medicare No. ______________

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



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Your Name ______________________________ **Your SSN** ______________________

Health Plan Selection

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

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

Answer the following important medical questions for all enrollees:

If you answer "Yes" to any of the following questions, Colorado PERA may contact you to provide more information.

1. Do any enrollees currently have End-Stage Renal Disease (ESRD) and receive routine dialysis treatment? ❑ Yes ❑ No
2. Will any enrollees have additional medical coverage (outside of Medicare and PERACare)? ❑ Yes ❑ No
3. Will any enrollees have other prescription drug coverage (outside of Medicare and PERACare)? ❑ Yes ❑ No

Circle both coverage level and plan below if you are adding or changing coverage.

Select a health care coverage level:

1. Benefit Recipient
2. Benefit Recipient + Spouse
3. Benefit Recipient + Child(ren)
4. Benefit Recipient + Spouse + Child(ren)

Select a health care plan:

1. Anthem MS #1
2. Anthem MS #2
3. Anthem MS #3
4. Kaiser Permanente Medicare HMO
5. Rocky Mountain Health Plans Medicare HMO*
6. UnitedHealthcare Medicare HMO*

*If you are enrolling in Rocky Mountain Health Plans or UnitedHealthcare, please select your Primary Care Physician(s) and indicate their provider code(s) below. Provider codes can be found through Colorado PERA's Web site at www.copera.org or by calling the health plan. For Rocky Mountain Health Plans call 1-888-281-0720 or for UnitedHealthcare call 1-800-610-2660.

HMO Provider Code(s): ____________________ ____________________ ____________________

Benefit Recipient Spouse Child(ren)

Dental Plan Selection

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

❑ **Add** or **change** coverage as indicated below ❑ **Cancel** all dental coverage

Circle both coverage level and plan below if you are adding or changing coverage.

Select a dental coverage level:

1. Benefit Recipient
2. Benefit Recipient + Spouse
3. Benefit Recipient + Child(ren)
4. Benefit Recipient + Spouse + Child(ren)

Select a dental plan:

1. CIGNA Dental PPO
2. CIGNA Dental HMO*
3. Delta Dental PPO

*If you are enrolling in the CIGNA Dental HMO, please select your dentist(s) and indicate their provider code(s) below. Provider codes can be found through Colorado PERA's Web site at www.copera.org or by calling CIGNA at 1-877-635-PERA (7372).

CIGNA Dental HMO Provider Code(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 ❑ **Cancel** all vision coverage

Circle both coverage level and plan below if you are adding or changing coverage.

Select a vision coverage level:

1. Benefit Recipient
2. Benefit Recipient + Spouse
3. Benefit Recipient + Child(ren)
4. Benefit Recipient + Spouse + Child(ren)

Select a vision plan:

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

1. VSP PPO #1
2. VSP PPO #2
3. VSP PPO #3