COLORADO PERA®

PERACare Enrollment/Change Form
Pre-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. 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 Colorado 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, 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 Pre-Medicare Coverage* booklet.

Dependent Enrollment Information

Complete this section if you are adding coverage(s) for your spouse and/or dependent children who are under age 65. If you are adding coverage for dependents over age 65 and/or with 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**
			/ /		
Child'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**
			/ /		

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

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 PPO #1
2. Anthem PPO #2
3. Anthem HDHP
4. Anthem HMO*
5. Kaiser Permanente HMO #1
6. Kaiser Permanente HMO #2
7. Kaiser Permanente HDHP

*If you are enrolling in the Anthem HMO plan, 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 Anthem at 1-877-PERABLU (1-877-737-2258).

Anthem 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