COLORADO PERA

PERACare Enrollment/Change Form
Combination Pre-Medicare and Medicare Coverage—2024

Colorado Public Employees' Retirement Association
P.O. Box 5800, Denver, Colorado 80217-5800
800-759-PERA (7372) • copera.org

Your SSN ___-___-____

Complete and return this form if you want to enroll in, change, or cancel coverage(s). This form is used for "combination coverage" only. Combination coverage applies when you are covering your spouse and/or child(ren) and one of you is on Medicare, but others are still under age 65.

Your Information

Name _____
Last First MI

Permanent Residence Street Address _____
(P.O. 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 that if I am enrolling my spouse and/or dependents, they are eligible to be enrolled. I acknowledge that the Medicare plan will release my information to Medicare and other plans as in necessary for health plan 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 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, 2024*
This *Enrollment/Change Form* must be signed prior to the requested effective date, but cannot be signed more than 90 days in advance.

* See the PERACare Enrollment Eligibility Chart in the front of this booklet to determine if a Certification of Previous Health Care Coverage is required.

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—2024*.

_____ __/__/__ _____ _____
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. 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.*

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.)

○ **Enroll in or change** coverage as indicated below ○ **Do not change** PERACare health coverage ○ **Cancel** current PERACare health 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
- ○ BR+Spouse
- ○ BR+Child(ren)
- ○ BR+Spouse+Child(ren)

- ○ UMR PPO #1/United Healthcare MA #1
- ○ UMR PPO #2/United Healthcare MA #1
- ○ UMR PPO #1/United Healthcare MA #2
- ○ UMR PPO #2/United Healthcare MA #2
- ○ Kaiser Permanente EDCP/Med HMO
- ○ Kaiser Permanente HDHP/Med HMO

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.)

○ **Enroll in or change** coverage as indicated below ○ **Do not change** PERACare dental coverage ○ **Cancel** current PERACare dental coverage

2. Select a coverage level, and then → 3. Select a health plan:

- ○ Benefit Recipient (BR) Only
- ○ BR+Spouse
- ○ BR+Child(ren)
- ○ BR+Spouse+Child(ren)

- ○ 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 877-635-PERA (7372) or visit copera.org and select "Health Benefits (PERACare)" under the "Retiree" menu, then click on "PERACare Carriers," then "Cigna Dental."

Cigna Dental HMO Office Number(s): ☐☐☐☐☐☐ 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.)

○ **Enroll in or change** coverage as indicated below ○ **Do not change** PERACare vision coverage ○ **Cancel** current PERACare vision coverage

2. Select a coverage level, and then → 3. Select a health plan:

- ○ Benefit Recipient (BR) Only
- ○ BR+Spouse
- ○ BR+Child(ren)
- ○ BR+Spouse+Child(ren)

- ○ 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.