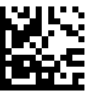
PERACare Enrollment/Change Form
Pre-Medicare Coverage—2024

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).

Your Information

Name ____
Last First MI

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. 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** ______________

Effective Date

I would like to request my effective date to enroll in, change, or cancel coverage to be

______________________________1, 2024.*

* 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 Pre-Medicare spouse and/or dependent children. If you are adding coverage for dependents with 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** ______________________

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

Coverage level	Health plan
Benefit Recipient (BR) Only	UMR PPO #1
BR+Spouse	UMR PPO #2
BR+Child(ren)	Kaiser Permanente EDCP
BR+Spouse+Child(ren)	Kaiser Permanente HDHP

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:**

Coverage level	Health plan
Benefit Recipient (BR) Only	Cigna Dental HMO*
BR+Spouse	Delta Dental PPO
BR+Child(ren)	
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 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:**

Coverage level	Health 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.