



PERACare Automatic Payment Authorization

Colorado Public Employees' Retirement Association
P.O. Box 5800, Denver, Colorado 80217-5800
800-759-PERA (7372) • Fax: 303-863-3727 • copera.org



Your SSN

Deceased Retiree's SSN
(if you are not the retiree)

Use this form to request Colorado PERA to automatically withdraw your PERACare premium from your checking or savings account. Authorizations received by the 10th of the month will be effective for that month.

Your Information

Name _____
Last First MI

Telephone Number () _____ Email Address _____

Request Type

I would like to: Request a new automatic payment Change an existing automatic payment

Checking/ Savings Account Information

Please complete the following information.
Your financial institution can provide the routing number to you.

Deduct from my checking account Deduct from my savings account

Name of Financial Institution

9-digit Routing Number of Financial Institution

Your Account Number

() _____
Telephone Number of Financial Institution

Name Shown on Account

Signature Certification

I authorize PERA to deduct my PERACare premiums from my account as instructed above.

I authorize my financial institution to provide PERA with any and all information needed to initiate or modify the electronic deduction of my PERACare premium. Such information may include, but is not limited to, the name on the account, the account number, and the routing number. I understand that a photocopy of this authorization shall be as valid as the original and any information obtained by PERA will be used for the sole purpose of initiating or modifying the electronic deduction of my PERACare premium. My financial institution will debit such account each month until I terminate this agreement.

I understand these premiums will be deducted from my account automatically on the 14th day of every month (or on the next banking day if the 14th is a non-banking day) for the following month's coverage. If this form is received at PERA by the 10th of the month, my first deduction will take place the 14th of the current month for the following month's coverage. If my completed form arrives at PERA after the 10th of the month, my first deduction will take place on the 14th of the following month.

I understand that if my PERACare premium deduction is rejected due to insufficient funds, PERA may attempt to resubmit the deduction and that any PERACare premium deduction not honored by my bank will be considered not paid and could result in cancellation of my PERACare coverage.

I understand that the amount to be deducted will be the monthly premium amount due for PERACare coverage.

I understand that this authorization will remain in effect until PERA receives a new PERACare Automatic Payment Authorization form from me or until my PERACare coverage is canceled.

Sign Here → Signature _____ Date _____

