



**PERACare Enrollment/Change Form  
Medicare Coverage—2025**

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



**Open enrollment ends on November 21, 2024**

Your SSN

\_\_\_\_\_|\_\_\_\_\_|\_\_\_\_\_|\_\_\_\_\_|\_\_\_\_\_|\_\_\_\_\_|

**Only complete and return this form if you want to enroll in, change, or cancel coverage(s).**

Please do not complete this form if you are not making any changes to your 2025 PERACare coverage.

**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 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. By joining a PERACare Medicare plan, I acknowledge that the Medicare 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. Finally, I agree that, if I wish to cancel this coverage, PERA must receive my request by the 15th of the month.

**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**

If I enroll in, change, or cancel coverage(s) during open enrollment (October 21–November 21, 2024), the effective date will be January 1, 2025.

**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 coverage for dependent who does not have Medicare, use the *PERACare Enrollment/Change Form Combination Pre-Medicare and Medicare Coverage—2025*.

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.)** Do not change PERACare health coverage  
 Enroll in or change coverage as indicated below 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

**3. Select a coverage level, and then** → **4. Select a health plan:**

Benefit Recipient (BR) Only	UnitedHealthcare MA #1
BR+Spouse	UnitedHealthcare MA #2
BR+Child(ren)	Kaiser Permanente Med HMO
BR+Spouse+Child(ren)	

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

**2. Select a coverage level, and then** → **3. Select a dental 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):	<input type="text"/>	<input type="text"/>	<input type="text"/>
	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.)** Do not change PERACare vision coverage  
 Enroll in or change coverage as indicated below Cancel current PERACare vision coverage

**2. Select a coverage level, and then** → **3. Select a vision 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.*