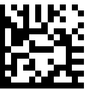
PERACare Enrollment/Change Form
Pre-Medicare Coverage—2025

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

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, PERA must receive my request by the 15th of the month.

Sign Here ➔ **Your Signature** ______________________________ **Date** ____________________

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). If you are adding 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
			/ /		

Child'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.)

- **Do not change** PERACare health coverage
- **Enroll in or change** coverage as indicated below
- **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 National PPO
BR+Spouse	UMR Select Colorado
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.)

- **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:**

Coverage level	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):

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:**

Coverage level	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.