COLORADO PERA

PERACare Enrollment/Change Form
Medicare Coverage—2016

Colorado Public Employees' Retirement Association
PO Box 5800, Denver, Colorado 80217-5800
1-800-759-PERA (7372) • Fax: 303-863-3727 • www.copera.org

Your SSN ☐☐☐ ☐☐ ☐☐☐☐

Complete and return this form if you want to add coverage(s), make changes, or cancel coverage(s).

Your Information

Name _____
Last First MI

Permanent Residence Street Address _____
(PO Box is not allowed)

City _____ State _____ ZIP Code _____

Daytime Phone Number (____) _____ Email Address _____

Sign up for electronic delivery of PERA information? ❑ Yes ❑ No

Signature Certification

By signing the form, I am certifying and agreeing with the following: I have reviewed the information about PERACare. 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. The information I provided on this form is correct and complete. If applicable, I authorize release of Medicare claims information to Anthem Blue Cross and Blue Shield to allow payment of any complementary benefit either to myself or to the party who accepts assignment. If applicable, by joining a Medicare HMO plan, I acknowledge that the Medicare HMO 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. By the health plan election on this form, I authorize cancellation of any prior arrangements for coverage in the PERA Health Care Program and also agree that I will terminate any other private Medicare coverage as of the effective date of my new election. 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** _____

Sign Here ➔ **Spouse's Signature** _____ **Date** _____

Effective Date

I would like to request my effective date to enroll, make changes, or cancel coverage to be _____ 1, 2016.*

* If this date is not your retirement effective date, a *Certification of Previous Health Care Coverage* form may be required. See the PERACare Enrollment Eligibility Chart in the *PERACare Health Benefits Program Medicare Coverage* booklet.

Dependent Enrollment Information

Complete this section if you are adding coverage(s) for your dependent(s) and be sure that your spouse signs above. If you are adding health plan coverage for a dependent who does not have Medicare, use the *PERACare Combination Pre-Medicare and Medicare Coverage Enrollment/Change Form*.

Spouse's Last Name	First Name	MI	Birthdate (__/__/____)	SSN	M/F

Child's Last Name	First Name	MI	Birthdate (__/__/____)	SSN	M/F

Select your health, dental, and vision plans on the reverse

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Your Name _____ **Your SSN**_____

Medicare Information

For health plan enrollments only

Complete this section if you are enrolling in a health plan or changing health plans.
Send a photocopy of your Medicare card(s) as soon as you receive it.

I have ❑ Medicare Part B only ❑ Both A and B Medicare No. _____
My spouse has ❑ Medicare Part B only ❑ Both A and B Medicare No. _____
My child has ❑ Medicare Part B only ❑ Both A and B Medicare No. _____

Health Plan Selection

1. What do you want to do? (Check only one box.)

❑ **Keep** current PERACare health care coverage
❑ **Add** or **change** coverage as indicated below
❑ **Cancel** current PERACare health care coverage

2. Check yes or no to the following important medical questions for all enrollees:

Do any enrollees currently receive dialysis treatment or have End-Stage Renal Disease (ESRD)? ❑ Yes ❑ No
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

3. Select a coverage level:

❑ Benefit Recipient (BR) Only
❑ BR+Spouse
❑ BR+Child(ren)
❑ BR+Spouse+Child(ren)

4. Select a health plan:

❑ Anthem MS #1*
❑ Anthem MS #2*
❑ Anthem MS #3*
❑ Kaiser Permanente
❑ Rocky Mountain Health Plans**
❑ UnitedHealthcare**

* Express Scripts Medicare (PDP) provides pharmacy benefits for the Anthem Medicare Supplement Plans.

** If you are enrolling in Rocky Mountain Health Plans or UnitedHealthcare, please indicate your physician's provider ID(s) below. Provider ID(s) can be obtained by calling the plan(s).

HMO Provider ID(s): _____ (Benefit Recipient) _____ (Spouse) _____ (Child(ren))

Dental Plan Selection

1. What do you want to do? (Check only one box.)

❑ **Keep** current PERACare dental coverage
❑ **Add** or **change** coverage as indicated below
❑ **Cancel** current PERACare dental coverage

2. Select a coverage level:

❑ Benefit Recipient (BR) Only
❑ BR+Spouse
❑ BR+Child(ren)
❑ BR+Spouse+Child(ren)

3. Select a dental plan:

❑ Cigna Dental PPO
❑ Cigna Dental HMO*
❑ Delta Dental PPO

* If you are enrolling in the Cigna Dental HMO, please indicate your dentist's provider office number(s) below. Provider office numbers can be obtained by calling Cigna.

Cigna Dental HMO Office Number(s): _____ (Benefit Recipient) _____ (Spouse) _____ (Child(ren))

Vision Plan Selection

1. What do you want to do? (Check only one box.)

❑ **Keep** current PERACare vision coverage
❑ **Add** or **change** coverage as indicated below
❑ **Cancel** current PERACare vision coverage

2. Select a coverage level:

❑ Benefit Recipient (BR) Only
❑ BR+Spouse
❑ BR+Child(ren)
❑ BR+Spouse+Child(ren)

3. Select a vision plan:

❑ 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.