COLORADO PERA

PERACare Program Enrollment/Change Form for Members Receiving Short-Term Disability Benefits

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 ☐☐☐ ☐☐ ☐☐☐☐

You may use this form to enroll or change your health care, dental, or vision coverage. Refer to the *PERACare Health Plan Descriptions For Members Receiving Short-Term Disability Payments* booklet for information on plans that are available to you.

Your Information

Name _____
Last First MI

Date of Birth ____/____/____ Daytime Telephone (____) _____

Email Address _____

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

Effective Date

I am requesting that coverage be effective _____ 1, _____.
Month Year

Health Plan Selection

Which plan would you like to enroll in? Check one plan:

- ❑ Kaiser Permanente HMO #1
- ❑ Kaiser Permanente HMO #2
- ❑ Kaiser Permanente HDHP

Dental Plan Selection

Which plan would you like to enroll in? Check one plan:

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

* If you are enrolling in the Cigna Dental HMO, please select your dentist and indicate the provider office number below. Provider office numbers can be obtained by calling Cigna at 1-877-635-PERA (7372).

Cigna Dental HMO Provider Office Number: ☐☐☐☐☐☐

Vision Plan Selection

Which plan would you like to enroll in? Check one plan:

- ❑ VSP PPO #1
- ❑ VSP PPO #2
- ❑ VSP PPO #3

Signature Certification

By signing this form, I am certifying and agreeing with the following: I have carefully reviewed the information about PERACare. I am eligible to enroll in the Program. The information I have provided on this form is correct and complete. Finally, I agree that, if I wish to cancel this coverage, I will provide Colorado PERA with a 30-day advance written notice.

Sign Here → **Signature** _____ **Date** _____