

PERACare Program Cancellation

Colorado Public Employees' Retirement Association
PO Box 5800 Denver, Colorado 80217-5800
303-832-9550 • 1-800-759-PERA (7372) • Fax: 303-863-3727
www.copera.org



Instructions: A benefit recipient may cancel PERACare coverage at any time by completing this form and returning it to PERA. The cancellation date will be the last day of the month. You should submit this form to PERA no less than 30 days before you wish your coverage to be canceled. For example, if you want your coverage to be canceled as of July 31, you should submit this form no later than July 1. Do not staple, tape, or glue items to this form. Print your Social Security number (SSN) clearly in the first row of boxes.

SSN

□ □ □ - □ □ - □ □ □ □

Deceased PERA member/retiree's SSN if different

□ □ □ - □ □ - □ □ □ □

Your Name _____
Last First MI

Address _____
City State ZIP Code

Daytime Telephone Number () _____

All cancellations are effective the last day of the month and require 30-days advance written notice.

Cancel coverage effective the last day of: _____
Month/Year

Cancel the following PERACare plans (check all that apply):

- Health Care
- Dental
- Vision

Cancel coverage for the following participants (check all that apply):

Myself (*Note:* If the benefit recipient cancels coverage, spouse and dependent coverage must also be canceled.)

My spouse Spouse's name _____

My dependent child(ren) Child's name _____

Child's name _____

Child's name _____

Signature _____ **Date** _____