

PERACare Enrollment/Change Form**Medicare Coverage**

Colorado Public Employees' Retirement Association

PO Box 5800 Denver, Colorado 80217-5800

303-832-9550 or 1-800-759-7372 (PERA) • Fax: 303-863-3727 • www.copera.org



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

Your SSN

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Last Name	First Name	MI	Date of Birth	()	Daytime Telephone Number

Signature _____ **Date** _____

Spouse's Signature (if enrolling/changing) _____ **Date** _____

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 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 Colorado PERA with a 30-day advance written notice.

Effective Date

I would like to request my effective date to enroll, make changes, or cancel coverage to be _____, 2012.*

*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) with Medicare (your spouse and/or dependent child) and be sure that your spouse signs above. If you are adding coverage for a dependent(s) under age 65 who does not have Medicare, do not use this form. Use the *PERACare Combination Pre-Medicare and Medicare Coverage Enrollment/Change Form* instead.

Spouse's Last Name	First Name	MI	Date of Birth	SSN	M/F
Child's Last Name	First Name	MI	Date of Birth	SSN	M/F

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.)**

I have or have applied for	<input type="checkbox"/> Medicare Part B only	<input type="checkbox"/> Both A and B	Medicare No. _____
My spouse has or has applied for	<input type="checkbox"/> Medicare Part B only	<input type="checkbox"/> Both A and B	Medicare No. _____
My child has or has applied for	<input type="checkbox"/> Medicare Part B only	<input type="checkbox"/> Both A and B	Medicare No. _____

Important Additional Medical Questions for All Health Plan Enrollees (If you answer "Yes" to any of the following questions, Colorado PERA may contact you to provide more information.)

1. Do any enrollees currently have End-Stage Renal Disease (ESRD) and receive routine dialysis treatment? Yes No
2. Will any enrollees have additional medical coverage (outside PERACare)? Yes No
3. Will any enrollees have other prescription drug coverage (outside PERACare)? Yes No

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

