Denver Employees Retirement Plan
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INSURANCE ENROLLMENT/CHANGE FORM
Pre-Medicare Medical, Dental, and Vision

☐ New Retiree ☐ Open Enrollment ☐ Life Status Change **Effective Date:**_____

Print name:_____ **DERP ID #:**_____
(Last Name, First Name, M.I.)

Last Four Digits of SSN:_____ **Birth date:** _____ **Gender:** M / F

Residence Address: _____
(Street, Avenue, Road, etc.) *(City, State, Zip Code)* *(County)*

Daytime Telephone Number:_____ **Email Address:**_____

HEALTH PLAN SELECTION:

Which plan do you wish to enroll in? **(Check one)**

☐ Denver Health Medical Plan HDHP ☐ Denver Health Medical Plan DHMO ☐ Kaiser Permanente HDHP
☐ Kaiser Permanente DHMO ☐ United Healthcare HDHP ☐ United Healthcare CDP ***See page 2 for PCP information**

Who do you want to cover? **(Check one)**

☐ Member ☐ Member + Spouse ☐ Member + Child(ren) ☐ Member + Spouse + Child(ren)

DENTAL PLAN SELECTION:

Which plan do you wish to enroll in? **(Check one)**

☐ CIGNA DHMO* ☐ CIGNA PPO Low ☐ CIGNA PPO High ☐ Delta EPO ☐ Delta PPO Low ☐ Delta PPO High

*CIGNA DHMO requires you to select a dentist to enroll. Please complete provider code(s) below. Provider codes can be found through the CIGNA website, www.cignadental.com, or by calling CIGNA Dental at 1-800-244-6224.

Member:_____ Spouse:_____ Child(ren):_____
Provider Code Provider Code Provider Code

Who do you want to cover? **(Check one)**

☐ Member ☐ Member + Spouse ☐ Member + Child(ren) ☐ Member + Spouse + Child(ren)

VISION PLAN SELECTION:

Which plan do you wish to enroll in? **(Check one)**

☐ VSP

Who do you want to cover? **(Check one)**

☐ Member ☐ Member + Spouse ☐ Member + Child(ren) ☐ Member + Spouse + Child(ren)

DERP ID # _____

***United Healthcare CDP Enrollees—If you are enrolling in the UHC CDP plan, you (and your dependents, if applicable) must choose a Primary Care Physician (PCP) that is a Centura Health provider. If you do not select a PCP, one will be assigned to you based on your residence address. Please enter your PCP information below.

Member / Dependent Name (Last name, First name)	**PCP Name**	**UHC Provider ID**

FAMILY MEMBER ENROLLMENT INFORMATION

Last Name, First, MI	**Relation**	**Gender**		**Date of Birth**	**SSN**	**Health?**		**Dental?**		**Vision?**	
	Self	M	F			Y	N	Y	N	Y	N
	Spouse	M	F			Y	N	Y	N	Y	N
	Child*	M	F			Y	N	Y	N	Y	N
	Child*	M	F			Y	N	Y	N	Y	N
	Child*	M	F			Y	N	Y	N	Y	N
	Child*	M	F			Y	N	Y	N	Y	N
	Child*	M	F			Y	N	Y	N	Y	N
	Child*	M	F			Y	N	Y	N	Y	N
	Child*	M	F			Y	N	Y	N	Y	N
	Child*	M	F			Y	N	Y	N	Y	N

***Insurance coverage for dependents terminates at certain ages. Please contact DERP for further information.**

Signature:_____ **Date:**_____

Signature Certification

By signing this form, I am certifying and agreeing with the following: I have reviewed the information about my insurance choices. I affirm I am eligible to enroll in the insurance, and if I am enrolling my spouse and/or dependents, I affirm that they also are eligible to be enrolled. The information I provided on this form is correct and complete. I understand that it is my responsibility to notify DERP of any changes in the eligibility of myself, my spouse and/or dependents and that DERP is not responsible for informing me of all my rights, benefits, and services under the selected insurance provider. I agree that, if I wish to cancel this coverage, I must provide DERP with a 30-day advance written notice.