



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: _____

(Last Name, First Name, M.I.)

DERP ID #: _____

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)

*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.

<u>Member / Dependent Name</u> <u>(Last name, First name)</u>	<u>PCP Name</u>	<u>UHC Provider ID</u>

FAMILY MEMBER ENROLLMENT INFORMATION

<u>Last Name, First, MI</u>	<u>Relation</u>	<u>Gender</u>		<u>Date of Birth</u>	<u>SSN</u>	<u>Health?</u>		<u>Dental?</u>		<u>Vision?</u>	
		M	F			Y	N	Y	N	Y	N
	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
	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.