COLORADO PERA

PERACare Subsidy and Change Form

Colorado Public Employees' Retirement Association
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Retiree SSN ☐☐☐ ☐☐ ☐☐☐☐

Complete this form if you are an employer providing a subsidy for a retiree's health care. Type or print in black ink. Do not staple, tape, or glue items to this form.

Retiree Information

Retiree's Name _____
Last First MI

Name of Person Being Subsidized (if different) _____
Last First MI

Retiree's Mailing Address _____
Street, Route, or Box Number, and Apt. Number City State ZIP Code

Subsidy Information

❑ Delete Subsidy: Effective Date _____
Month/Day/Year

❑ New/Change Subsidy: Effective Date _____
Month/Day/Year

Subsidy Amount for Health: $ _____

Subsidy Amount for Dental: $ _____

Subsidy Amount for Vision: $ _____

Employer Information

Employer Name _____ Department Number _____

Additional Comments _____

_____

_____

_____

Sign Here → **Personnel/Payroll Representative Signature** _____

Telephone Number ( ) _____ Date _____
Month/Day/Year