



PERACare Program Cancellation

Colorado Public Employees' Retirement Association
P.O. Box 5800, Denver, Colorado 80217-5800
800-759-PERA (7372) • Fax: 303-863-3727 • copera.org



Your SSN

_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|

To cancel PERACare coverage, please submit this form to Colorado PERA by the 15th of the month you wish to cancel your coverage. For example, if you want your coverage to be canceled as of July 31, you should submit this form no later than July 15. PERA will send you a letter to confirm your plan termination.

Your Information

Name _____
Last First MI

Telephone Number () _____ Email Address _____

Cancellation Information

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

My dependent(s): Name _____

Name _____

Name _____

Sign Here → Signature _____ Date _____

