Denver Employees Retirement Plan
777 Pearl Street
Denver, Colorado 80203-3717
(303) 839-5419 Fax (303) 839-9525
www.derp.org

Health/Dental/Vision Insurance Enrollment Form

❑Change ❑COBRA ❑New Retiree ❑Open Enrollment **Effective Date:**_____

Name:_____**Member #:**_____
Last First M.I.

Social Security number:_____ **Birth date:**_____ **Sex: M / F**

Address:_____
Street City State Zip County

Phone number:_____

HEALTH: Check health care choice:

❑ Member ❑ Member plus Spouse
❑ Member plus Child(ren) ❑ Family

❑ Denver Health (DH) Medical Care
❑ Kaiser ❑ Aetna HMO
❑ Aetna Choice POS

Superior VISION: Check those enrolled:

❑ Member ❑ Member plus Spouse
❑ Member plus Child(ren) ❑ Family

All members eligible for Medicare must enroll in Medicare parts A & B, and enroll in health plans that coordinate with Medicare.

*Health, dental, and vision insurance dependent coverage terminates at certain ages. Please contact the Plan for further information.

CHANGE ENROLLMENT:

❑**Add dependent(s)**_____
❑**Delete dependent(s)**_____
❑**Cancel** _____
❑**Other**_____
❑**To Medicare** _____

CIGNA Dental:

❑Single ❑Two-party ❑Family
❑**Network** ❑**PPO High** ❑**PPO Low**

❑**Dental office # :**_____
❑New Patient ❑Current Patient

FAMILY MEMBER INFORMATION:

Last Name, First, M.I.	Relation	Sex	Add/ Delete	Birth date	Social Security No.	Primary Physician/Facility	Existing Patient
	Self	M / F	A / D				Y / N
	Spouse	M / F	A / D				Y / N
	Child*	M / F	A / D				Y / N
	Child*	M / F	A / D				Y / N
	Child*	M / F	A / D				Y / N
	Child*	M / F	A / D				Y / N
	Child*	M / F	A / D				Y / N
	Child*	M / F	A / D				Y / N

I understand that it is my responsibility to notify the Plan of any changes in the eligibility of my dependents and that the Plan is not responsible for informing me of all my rights, benefits and services under the selected healthcare provider.

Signature: _____ **Date:**_____

For office use only: Carrier Code:_____ GROUP NUMBER:_____

Rev. 1/09