DERP Denver Employees Retirement Plan

Powering Your Future, Together.

2026 Health Insurance Election Form

Complete this form if...	Form Submission Deadline	Benefits Effective Date
1. **You're a new retiree**	Within 30 days of your retirement date	Your retirement date
2. **You've experienced a qualifying life event in the past 30 days**	Within 30 days after your event	The first of the month after your event

You must submit proof of dependency along with your Health Insurance Election Form.

- ✓ If you're covering your spouse, a marriage certificate or common law affidavit is required.
- ✓ If you're covering your child(ren) a certified birth certificate or Letters of Guardianship is required.
- ✓ When you've experienced a qualifying life event, you must submit proof of the event.

Refer to the 2026 DERP Retiree Health Insurance Guide to select the benefits that are right for you and your dependents.

Step 1 – Provide Your Information (All fields must be populated.)

Name (First, Middle Initial, Last) _____

DERP ID (call DERP if you don't know your ID) _____

Address and/or P.O. Box, City, State, Zip Code _____

Personal Email Address _____

Personal Phone Number _____

Step 2 – Tell Us Why You're Completing This Form

☐ **I'm a new retiree**

My retirement date is: _____

☐ **I've had a qualifying life event**

Date of my qualifying life event is: _____

Select the qualifying life event and attach proof of the event

- ☐ Eligible for Medicare
- ☐ Moved out of service area
- ☐ Change in marital status
- ☐ Involuntary loss of health insurance

(303) 839-5419
Help@DERP.org
777 Pearl St.
Denver, CO 80203
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MyDERP.org

Step 3 – Select a Non-Medicare Medical Plan and/or a Medicare Advantage Medical Plan for Yourself and/or Your Dependents

You can choose a mix of non-Medicare and/or a Medicare Advantage medical plan(s).

Non-Medicare Medical Plans

- ✓ Available to you and/or your dependents under age 65.
  Eligible dependents include:
  - Your spouse
  - Your child(ren) to age 26
- ✓ Everyone under age 65 must be enrolled in the same plan.

Medicare Advantage Medical Plans

- ✓ Available to you and/or your dependents who are Medicare eligible due to age (65) or disability (any age).
  Eligible dependents include:
  - Your spouse
  - Your dependent child(ren) physically or mentally unable to care for themselves
- ✓ Includes Part D, Prescription Drug Coverage. Do not enroll in a separate Part D plan as this will cause you and/or your dependent to be cancelled from the DERP Medicare Advantage
- ✓ You and your dependents can select different plans.
- ✓ You must provide a copy of Medicare card(s) for each person enrolled.
- ✓ A signature is required for each person enrolled.

Populate this table for yourself and each dependent.

Relation	Name (First, Middle Initial, Last)	Gender	Birth Date	SSN	Non-Medicare Medical					Medicare Advantage Medical	
					Kaiser		UnitedHealthCare			Kaiser	Humana
					HDHP	DHMO	HDHP	Colorado Only: Colorado Doctor's Plan	Colorado Only: Denver Health PPO	Colorado HMO	PPO
Self		M F									
Spouse		M F									
Child		M F									
Child		M F									
Child		M F									

Did you or your dependents enroll in a Medicare Advantage Medical Plan?

If so, each person enrolled in a Medicare Advantage Medical Plan must acknowledge their enrollment with their signature in the table below.

Relation	Member / Dependent Signature (First, Middle Initial, Last)	Date
Self		
Spouse		
Child		
Child		
Child		

Did you or your dependents enroll in UnitedHealthcare Colorado Doctor's Plan?

If so, you must select a Primary Care Physician (PCP) for each person enrolled. If you do not select a PCP, one will be assigned based on your address.

Member / Dependent Name (First, Middle Initial, Last)	PCP Name	UHC Provider ID

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Step 4 – Select Your Dental Plan

Populate this table for yourself and each dependent. Everyone must be enrolled in the same plan.

Relation	Name (First, Middle Initial, Last)	Gender	Birth Date	SSN	Cigna			Delta		
					DHMO*	PPO Low	PPO High	EPO	PPO Low	PPO High
Self		M F								
Spouse		M F								
Child		M F								
Child		M F								
Child		M F								

***Did you select Cigna DHMO?**

If so, you must choose a dentist and enter the Provider Code below for yourself and/or your dependents. Provider codes can be found on the Cigna website (cigna.com) or by calling Cigna Dental (1-800-244-6224).

Relation	Name (First, Middle Initial, Last)	Dentist Name	Provider ID
Self			
Spouse			
Child			
Child			
Child			

Step 5 – Select Your Vision Plan

DERP offers one vision plan with VSP.
Do you want to enroll in VSP?

☐ **Yes**, I want to enroll in VSP for myself and/or my dependents.

☐ **No**, I do not want to enroll in VSP for myself or my dependents.

Populate this table for yourself and each dependent enrolled in VSP.

Relation	Name (First, Middle Initial, Last)	Gender	Birth Date	SSN
Self		M F		
Spouse		M F		
Child		M F		
Child		M F		
Child		M F		

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Step 6 – Certification

Your Health Insurance Election Form will not be processed without a handwritten signature. Electronic signatures are not accepted.

By signing this form, I certify I understand and agree with the following statements:

- ✓ The information I provided on this form is accurate.
- ✓ The health insurance elections I've made are correct.
- ✓ My health insurance elections cannot be changed until the next Open Enrollment period, unless I experience a qualifying life event.
- ✓ My health insurance deductions are post-tax and deducted from my monthly DERP Pension Benefit payment.
- ✓ If my health insurance deductions exceed my monthly DERP Pension Benefit payment, I must complete and submit a Direct Withdrawal Authorization form so the balance can be deducted each month from my bank account.
- ✓ I'm responsible for notifying DERP of any changes in eligibility for myself, my spouse, and/or my dependents.
- ✓ DERP is not responsible for informing me of my rights, benefits, and services under the selected insurance provider.
- ✓ I must complete and submit to DERP the Health Insurance Disenrollment Form 30 days before I wish to cancel coverage.

Member Signature _____ Date _____

Step 7 – Submit Your Health Insurance Election Form

Send us the following documents:

- ✓ Completed and signed **Health Insurance Election Form**.
- ✓ **Proof of dependency** for the dependents you're covering:
  - Spouse – marriage certificate or common law affidavit
  - Child – certified birth certificate or Letters of Guardianship
- ✓ **Copy of Medicare cards** for each person enrolled in a Medicare Advantage Medical Plan.

How to submit:

- ✓ **Email:**
  Help@DERP.org
- ✓ **Mail:**
  DERP
  777 Pearl St.
  Denver, CO 80203
- ✓ **Drop off**:
  - **Use the mail slot** in the front door.
  - **Put in the secure drop box inside the vestibule** if the front door is unlocked.
- ✓ **Fax:**
  (303) 839-9525

Need to visit us in person? Schedule an appointment. Walk-in visits aren't available.

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