University of Colorado
Boulder | Colorado Springs | Denver | Anschutz Medical Campus
EMPLOYEE SERVICES

CU Benefits Enrollment/Change Form — Plan Year 2023-2024

Classified Staff

- This form cannot be completed in a web browser.
  1. **Download** the form to your desktop from the web browser.
  2. **Open** the form in Adobe or Adobe Reader before completing.
- If you are a new employee/newly eligible, please enroll in your employee portal (https://my.cu.edu/).
- You have 31 days from your date of benefits eligibility or Qualifying Life Change to complete and send in this enrollment/change form.
- Plan information and current rate information are available on the CU Benefits website (www.cu.edu/benefits).
- If you are enrolling any dependents in medical, dental, vision, optional life and/or voluntary AD&D plans, who have **not** previously completed dependent eligibility verification (DEV), you must complete the DEV form in your employee portal in addition to completing and sending this Benefits Enrollment/Change Form. For more information on DEV, visit the CU DEV website (https://www.cu.edu/node/116040).
- The words underlined in blue are hyperlinks. To select the link, please press Ctrl + click the link to view the corresponding webpage or document.
- Incomplete, illegible, incorrect or unsigned forms will not be processed. Consequently, your benefits could be delayed, or you could risk losing enrollment eligibility for certain benefits. All sections of this form must be completed.

Type of Enrollment

Check one box only.

☐ New Hire/Newly Eligible
Date of hire or new eligibility: _____
mm/dd/yyyy

☐ Qualifying Life Change (QLC)
Date of QLC: _____
mm/dd/yyyy

If applicable, select your QLC from the list below:

☐ Birth or adoption
☐ Change from Classified Staff to Faculty/University Staff
☐ Change in dependent care needs (DCFSA change)
☐ Change of residence out of health plan's network
☐ Death of a spouse or partner
☐ Death of a child
☐ Dependent gaining eligibility
☐ Dependent losing eligibility
☐ Divorce or legal separation
☐ Employee gaining eligibility
☐ Employee losing eligibility
☐ Marriage or Partnership
☐ Medical child support order
☐ Other - Please contact a benefits professional @ 303-860-4200, Option 3

Allowable changes to benefit elections are limited based on the Qualifying Life Change. To learn what changes are permissible visit the CU Qualifying Life Changes website (www.cu.edu/employee-services/benefits-wellness/current-employee/life-changes).

Employee Information

Completion of all sections is required.

Employee ID Number – **required** | Name (Last) | (First) | (Middle Initial)

?

Preferred Telephone | Preferred Email Address

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EMPLOYEE SERVICES

Name: _____ ID# _____

Section 1: Medical, Dental, and Vision Plan Options

Reminder: Select your health plans according to your tax preference: *before tax or after tax*. For more information, visit the CU Before or After Tax webpage (https://www.cu.edu/docs/before-or-after-tax). This designation may only be changed during Open Enrollment after the initial election has been made for the plan year.

CU Medical Plan Options

Choose your plan - *must select one box*

- ☐ Exclusive* – before tax
- ☐ Exclusive* – after tax
- ☐ Extended – before tax
- ☐ Extended – after tax
- ☐ High Deductible – before tax
- ☐ High Deductible – after tax
- ☐ Kaiser* – before tax
- ☐ Kaiser* – after tax
- ☐ waive medical coverage
- ☐ no change

Choose your coverage level - *must select one box*

- ☐ employee only
- ☐ employee + spouse**
- ☐ employee + child(ren)
- ☐ family (employee+spouse**+child(ren)
- ☐ waive
- ☐ no change

CU Dental Plan Options

Choose your plan - *must select one box*

- ☐ Essential – before tax
- ☐ Essential – after tax
- ☐ Choice – before tax
- ☐ Choice – after tax
- ☐ waive dental coverage
- ☐ no change

Choose your coverage level - *must select one box*

- ☐ employee only
- ☐ employee + spouse**
- ☐ employee + child(ren)
- ☐ family (employee+spouse**+child(ren)
- ☐ waive
- ☐ no change

CU Vision Plan Options

Choose your plan - *must select one box*

- ☐ Vision – before tax
- ☐ Vision – after tax
- ☐ waive vision coverage
- ☐ no change

Choose your coverage level - *must select one box*

- ☐ employee only
- ☐ employee + spouse**
- ☐ employee + child(ren)
- ☐ family (employee+spouse**+child(ren)
- ☐ waive
- ☐ no change

*CU Health Plan Exclusive is only available to Colorado residents & CU Health Plan - Kaiser is available in specific geographic regions in Colorado.

**spouse, common-law spouse, domestic partner or civil union partner

Name: _____ ID# _____

Section 1 (cont.): Medical, Dental and Vision Plan Participants

! **Complete** all information. If not applicable, write N/A.

Enrolling dependents in medical, dental, vision, who have not previously completed dependent eligibility verification requires the completion of the DEV form in the employee portal in addition to this form. For more information on DEV, or for alternate submission instructions, visit the CU DEV website (https://www.cu.edu/node/116040).

CU Health Plan – Exclusive enrollments require the selection of a Primary Care Physician (PCP), or one will be assigned. To find a PCP and their ID# go to Anthem's website. If known, please include your PCP number below.

Employee

_____

Employee Name (Last) (First) (Middle Initial) Date of Birth

_____

PCP# (if applicable)

Action
- ☐ add
- ☐ remove
- ☐ no change

Gender (please check one – required for insurance enrollment)
- ☐ male
- ☐ female

Spouse, Common Law, Domestic or Civil Union Partner

_____

Spouse/Partner Name (Last) (First) (Middle Initial) Date of Birth

_____

Social Security Number - **required** Employee ID of CU Spouse/Partner (if applicable) PCP# (if applicable)

Relationship to Employee: ☐ spouse ☐ common law spouse ☐ domestic partner ☐ civil union partner

Action
- ☐ add
- ☐ remove
- ☐ no change

Gender (please check one – required for insurance enrollment)
- ☐ male
- ☐ female

? Is your domestic/civil union partner your qualified tax dependent for health coverage?

- ☐ Yes, complete the Tax Certification of Dependency Form (https://www.cu.edu/node/164116) with your enrollment.
- ☐ No, you will be subject to imputed income (taxable income). For more information, go to the CU Imputed Tax website (http://www.cu.edu/node/56944).

Name: _____ ID# _____

Section 1 (cont.): Medical, Dental, and Vision Plan Participants

Child 1

_____
Child's Name (Last) (First) (Middle Initial) Date of Birth

_____
Social Security Number PCP# (if applicable)

Relationship to Employee: ☐ biological/adopted ☐ stepchild ☐ child for whom you have legal responsibility relationship: _____

Action
☐ add
☐ remove
☐ no change

Gender (please check one – required for insurance enrollment)
☐ male
☐ female

☐ Is your domestic/civil union partner your qualified tax dependent for health coverage?

☐ Yes, complete the Tax Certification of Dependency Form (https://www.cu.edu/node/164116) with your enrollment.

☐ No, you will be subject to imputed income (taxable income). For more information, go to the CU Imputed Tax website (http://www.cu.edu/node/56944).

Child 2

_____
Child's Name (Last) (First) (Middle Initial) Date of Birth

_____
Social Security Number PCP# (if applicable)

Relationship to Employee: ☐ biological/adopted ☐ stepchild ☐ child for whom you have legal responsibility relationship: _____

Action
☐ add
☐ remove
☐ no change

Gender (please check one – required for insurance enrollment)
☐ male
☐ female

☐ Is your domestic/civil union partner your qualified tax dependent for health coverage?

☐ Yes, complete the Tax Certification of Dependency Form (https://www.cu.edu/node/164116) with your enrollment.

☐ No, you will be subject to imputed income (taxable income). For more information, go to the CU Imputed Tax website (http://www.cu.edu/node/56944).

Name: _____ ID# _____

Section 1 (cont.): Medical, Dental, and Vision Plan Participants

Child 3

_____
Child's Name (Last) (First) (Middle Initial) Date of Birth

_____
Social Security Number PCP# (if applicable)

Relationship to Employee: ☐ biological/adopted ☐ stepchild ☐ child for whom you have legal responsibility
relationship: _____

Action
☐ add
☐ remove
☐ no change

Gender (please check one – required for insurance enrollment)
☐ male
☐ female

? Is your domestic/civil union partner your qualified tax dependent for health coverage?

☐ Yes, complete the Tax Certification of Dependency Form (https://www.cu.edu/node/164116) with your enrollment.

☐ No, you will be subject to imputed income (taxable income). For more information, go to the CU Imputed Tax website (http://www.cu.edu/node/56944).

Child 4

_____
Child's Name (Last) (First) (Middle Initial) Date of Birth

_____
Social Security Number PCP# (if applicable)

Relationship to Employee: ☐ biological/adopted ☐ stepchild ☐ child for whom you have legal responsibility
relationship: _____

Action
☐ add
☐ remove
☐ no change

Gender (please check one – required for insurance enrollment)
☐ male
☐ female

? Is your domestic/civil union partner your qualified tax dependent for health coverage?

☐ Yes, complete the Tax Certification of Dependency Form (https://www.cu.edu/node/164116) with your enrollment.

☐ No, you will be subject to imputed income (taxable income). For more information, go to the CU Imputed Tax website (http://www.cu.edu/node/56944).

Additional Children? If you need to add more children, please make copies of this page.

Name: _____ ID# _____

Section 2: Pretax Savings

! **Flexible Spending Accounts (FSA)** - You must make a new FSA election for each Plan Year. You do not need to be enrolled in a medical plan to elect the HCFSA. Flexible Spending Account elections are irrevocable for the Plan Year. FSA elections can only be made as a new hire/newly eligible, during Open Enrollment or due to a Qualifying Life Change. For more information visit:

- Heath Care Flexible Spending Account (https://www.cu.edu/node/153399).
- Dependent Care Flexible Spending Account (https://www.cu.edu/node/153400).

Health Care Flexible Spending Account (HCFSA)

You may not exceed $3,050 in a calendar plan year.

Must select one box.

☐ I elect $_____ to enroll for plan year (July 1-June 30). I understand my election will be divided by 12 months. The plan election minimum is $120/year, and the maximum is $3,050 per employee in a calendar and/or plan year.

☐ I waive enrollment.

Dependent Care Flexible Spending Account (DCFSA)

You may not exceed $5,000 per household in a calendar year.

Must select one box

☐ I elect $_____ to enroll for plan year (July 1-June 30). I understand my election will be divided by 12 months. The plan election minimum is $120/year, and the maximum is $5,000 per household in a calendar and/or plan year.

☐ I waive enrollment.

Health Savings Account (HSA)

HSA contributions can be updated at any time during the Plan Year. For more information see the Health Savings Account Fact Sheet (PDF) (https://www.cu.edu/node/153374).

- You must be enrolled in the CU Health Plan-High Deductible to enroll in the HSA.
- Your contributions may not exceed $4,150 for single coverage or $8,300 for family coverage in the calendar year (January-December 2024).
- If you are age 55 or older, you can make an additional contribution of $1,000.
- If you are a current CU Health Plan-High Deductible plan participant and want to enroll in the HSA or are a current HSA participant and want to update your HSA, please call Employee Services at 303-860-4200, option 3 or complete the HSA Authorization Form (https://www.cu.edu/node/115949).
- If you are enrolling in the CU Health Plan-High Deductible for the first time and want to enroll in the Health Savings Account, please continue and complete Attachment A.

Name: _____ ID# _____

Section 3: Basic Term Life with AD&D, Optional Life and Voluntary AD&D

Beneficiary Information

- If you do **not** designate a beneficiary for your life insurance plans, benefits will be paid according to the provisions of the group policy.
- Beneficiary designations on your most current form revoke all prior designations.
- The employee is automatically the sole beneficiary for all dependent life insurance plans.
- Primary beneficiary – receives the benefit in the event of your death.
- Contingent beneficiary – receives the benefit only if your primary beneficiary(ies) are deceased.
- If you name more than one primary or contingent beneficiary, indicate the percentage assigned to each and make sure the total in each category equals 100 percent. Use whole numbers only, no decimals.

  To learn more about **beneficiary designation**, visit the CU How to Manage Life Insurance Beneficiaries website (https://www.cu.edu/employee-services/how-manage-life-insurance-beneficiaries).

Life Insurance Resources

- The **Medical History Statement** can be found in the CU Document Library online (https://www.cu.edu/node/115428).
- **Dependent eligibility verification** documents are required unless your dependent has previously completed dependent eligibility verification. Information can be found on the CU DEV website (https://www.cu.edu/node/116040).

Basic Term Life with AD&D

Enrollment for the **$50,000** policy is automatic and premiums are paid by CU.

Change or designate your primary and contingent beneficiaries:

☐ primary ☐ contingent _____
Name (Last) (First) (MI) Relationship Date of Birth %

☐ primary ☐ contingent _____
Name (Last) (First) (MI) Relationship Date of Birth %

☐ primary ☐ contingent _____
Name (Last) (First) (MI) Relationship Date of Birth %

☐ primary ☐ contingent _____
Name (Last) (First) (MI) Relationship Date of Birth %

Section 3 (cont.): Basic Term Life with AD&D, Optional Life and Voluntary AD&D

Depending on if you are a new hire or experiencing a Qualifying Life Change, the amount you are eligible to elect for Optional Life insurance may vary. Please refer to the corresponding Qualifying Life Change guide (https://www.cu.edu/node/153130) or call the benefits office at 303-860-4200, option 3 to determine election amounts.

Optional Term Life with AD&D – Employee Enrollment

Must select one box.

- ☐ I elect to enroll in Optional Term Life/AD&D in the amount of $_____ ($1,000 increments).
  - ☐ Standard Rate (tobacco use in the last 12 months)
  - ☐ Discount Rate (no tobacco use in the last 12 months)
- ☐ No change in current coverage level.
- ☐ I waive enrollment.

Change or designate your primary and contingent beneficiaries:

☐ primary ☐ contingent _____
Name (Last) (First) (MI) Relationship Date of Birth %

☐ primary ☐ contingent _____
Name (Last) (First) (MI) Relationship Date of Birth %

☐ primary ☐ contingent _____
Name (Last) (First) (MI) Relationship Date of Birth %

☐ primary ☐ contingent _____
Name (Last) (First) (MI) Relationship Date of Birth %

Optional Term Life with AD&D – Dependent Enrollment

Spouse/Partner – *Must select one box.*

- ☐ I elect to enroll my Spouse/Partner in Optional Term Life/AD&D in the amount of $_____ ($1,000 increments).
  - ☐ Standard Rate (tobacco use in the last 12 months)
  - ☐ Discount Rate (no tobacco use in the last 12 months)
- ☐ No change in current coverage level.
- ☐ I waive enrollment.

Children – You can elect flat amounts of $5,000 or $10,000. No Medical History Statement needed. Employee's Optional Life enrollment amount must be equal to or greater than the flat amount elected for the child benefit to elect this benefit.

Must select one box.

- ☐ I elect to enroll my child(ren) for $5,000 per child.
- ☐ I elect to enroll my child(ren) for $10,000 per child.
- ☐ No change in current coverage level.
- ☐ I waive enrollment.

Name: _____ ID# _____

Section 3 (cont.): Basic Term Life with AD&D, Optional Life and Voluntary AD&D

Voluntary Accidental Death and Dismemberment – Employee Enrollment

You can elect in $10,000 increments up to 10x your annual salary or $250,000, whichever is less. Enrollment available as a new hire/newly eligible and certain Qualifying Life Changes. No medical history necessary.

Must select one box.

- ☐ I elect to enroll in Voluntary AD&D in the amount of $_____ ($10,000 increments).
- ☐ No change in current coverage level.
- ☐ I waive enrollment.

Change or designate your primary and contingent beneficiaries:

☐ primary ☐ contingent _____
Name (Last) (First) (MI) Relationship Date of Birth %

☐ primary ☐ contingent _____
Name (Last) (First) (MI) Relationship Date of Birth %

☐ primary ☐ contingent _____
Name (Last) (First) (MI) Relationship Date of Birth %

☐ primary ☐ contingent _____
Name (Last) (First) (MI) Relationship Date of Birth %

Voluntary Accidental Death and Dismemberment – Dependent Enrollment

You can elect in $10,000 increments up to $250,000. Coverage cannot exceed employee's Voluntary AD&D coverage amount. Spouse/Partner cannot enroll unless the employee is enrolled. Enrollment available as a new hire/newly eligible and certain Qualifying Life Changes. No medical history necessary.

Spouse/Partner

Must select one box.

- ☐ I elect to enroll my spouse/partner in Voluntary AD&D in the amount of $_____ ($10,000 increments).
- ☐ No change in current coverage level.
- ☐ I waive enrollment.

Child(ren) – cannot enroll unless the employee is enrolled.

Must select one box.

- ☐ I elect to enroll my child in Voluntary AD&D in the flat amount of $5,000.
- ☐ No change in current coverage level.
- ☐ I waive enrollment.

Name: _____ ID# _____

Section 4: Disability and Retirement

Section 4: Short and Long Term Disability

Short Term Disability – Classified employees are automatically enrolled in Short Term Disability. CU pays the premium.

Long Term Disability – You can apply at any time. To apply for coverage, you must complete the Medical History Statement (https://www.cu.edu/node/115428) and sent it to The Standard Insurance Company for approval. You must work a minimum of 30 hours/week.

Must select one box.

☐ I waive enrollment.

☐ No change.

Visit the CU Disability website (http://www.cu.edu/node/153406) to learn more about CU Disability.

You must contact Employee Services if you become vested with PERA. Upon notification, you will be enrolled in the vested rate on the next available pay period.

Section 5: Retirement Plans

Visit the CU Mandatory Retirement Plans website (http://www.cu.edu/node/153123) for information on eligibility and placement.

Visit the CU Voluntary Retirement Plans website (http://www.cu.edu/node/153431) for information on how to enroll in the plans.

Name: _____ ID# _____

General Fraud Statement

Any employee, employee's dependent(s), or other individual(s) who knowingly provides false, incomplete, or misleading facts or information on any Benefits Enrollment/Change Form, benefits enrollment website, affidavit, or other document for the purpose of defrauding or attempting to defraud the university's benefits plans hereto commits a fraudulent act. Any such person will be subject to civil and/or criminal penalties, fines, denial of enrollment in any or all the university's benefits plans, or as provided in regulations, statutes, and applicable written directives.

Authorization and Signature – Read, Sign and Send in

I certify that by completing, signing and returning this form, I agree to abide by the eligibility, enrollment and election procedures for my University of Colorado benefits as outlined on the Employee Services website (www.cu.edu/benefits).

By signing this form, I attest that I have reviewed the dependent eligibility definitions and that the information I am sending is true and accurate. I understand that if I have knowingly provided false or misleading information related to the enrollment of an ineligible dependent in a benefits plan, I may be subject to discipline, and the university may be required to take action to recover funds expended due to fraud or fiscal misconduct.

I certify that I have been given the opportunity to enroll for group benefits insurance as offered by and through the University of Colorado. I understand that I cannot change certain elections until the next Open Enrollment period unless I have a Qualifying Life Change.

I agree to utilize the appeal procedure(s) established by the carrier(s)/administrator for resolving claims disputes. Depending on the conditions set forth by the carrier, this agreement may require binding arbitration instead of a court trial for dispute resolution.

I acknowledge that carriers may release certain information about me and/or my dependent(s) when required under federal or state law, or pursuant to legal process, and may release and obtain medical information to or from other carriers, providers, and public agencies for the purpose of providing health care services, to facilitate payment for these services, and conduct related administrative operations.

I hereby authorize the University of Colorado to deduct the necessary premiums, if any, from my paycheck or bill me directly.

Signature: _____ Date: _____

Action Required

If you are enrolling in the CU Health Plan High Deductible for the first time and want to enroll in the Health Savings Account, please continue and complete Attachment A.

OR

If you are ready to complete your enrollment, go to page 13.

Name: _____ ID# _____

Attachment A: Health Savings Account (HSA) Authorization

Only complete if enrolling in the CU Health Plan-High Deductible for the **first time.**
If you are a current CU Health Plan-High Deductible plan participant and want to enroll in the HSA or are a current HSA participant and want to update your HSA, please call Employee Services at 303-860-4200, option 3 or complete the HSA Authorization Form (https://www.cu.edu/node/115949).

- You must be enrolled in the CU Health Plan-High Deductible as a primary member to enroll in the HSA.
- Visit the CU HSA website (www.cu.edu/node/153425) for current calendar year (Jan.- Dec. 2024) **contribution limits**.
- Once your account is opened, you will receive a welcome packet from Optum Bank in the mail with information about using your HSA, creating an online account and the agreements governing your account.
- Send this form to Employee Services (ES) by the 10th of the month in which the change is to be effective to ensure that your election is entered for that monthly pay cycle.

Employee Information

Employee ID#: _____ First Name: _____ Last Name: _____

Middle Initial: _____ Phone Number: _____ Email: _____

Enrollment Type – New Enrollment

Deduction - For current calendar year limits, refer to our HSA webpage (www.cu.edu/node/153425).

☐ I elect to enroll in an annual pledge of $_____.

☐ I understand that my annual pledge amount entered above includes any deductions already taken in the current calendar year plus any pending deductions.

Acknowledgment - I understand and agree to the following:

1. I would like to open an Optum Bank HSA, and I am eligible to contribute to an HSA.
2. I authorize the University of Colorado to act as my agent to open an Optum Bank HSA for me and to send my name, residential address, date of birth, Social Security Number/Individual Taxpayer Identification Number, phone number, email address, country of citizenship and residency status to Optum Bank. As an agent on my behalf, the University of Colorado will receive a notice from Optum Bank, which explains that Optum Bank will obtain, verify and record information to identify me before it opens my HSA. Optum Bank does this to help the United States government fight money laundering activities and terrorism funding.
3. I agree that the University of Colorado will be my agent until the first of three events occurs:
    - I receive my HSA welcome packet from Optum Bank. • I give the University of Colorado my written notice that I do not want the University of Colorado to act as my agent, and the University of Colorado has enough time to act on my notice. • I receive a notice from Optum Bank that my application for an HSA has been declined.
4. I also authorize Optum Bank to make any inquiries it considers appropriate to determine if it should open and maintain my HSA. This may include obtaining information from a credit reporting agency for identity verification and fraud protection.

Once your account is opened, you'll receive a welcome packet in the mail with information about using your HSA, creating an online account and the agreements governing your account. If you no longer want an HSA, you'll have seven business days after receiving your welcome packet to cancel the account. If you have other questions or would like to review the agreements, visit https://www.optumbank.com/ or call 1-844-326-7967.

Authorization and Signature
By my signature below, I agree that for amounts paid after the date this agreement is effective, my salary will be reduced by the dollar amount elected herein. I am eligible to enroll in an HSA, and I have reviewed, understand and agree to the provisions listed under the Acknowledgement section of this agreement.

Employee Signature: _____ Date: _____

Name: _____ ID# _____

Complete Your Enrollment Through Secure Upload

Upload your Benefits Enrollment/Change Form electronically for a fast and secure method to complete your enrollment:

1. **Complete** and **sign** (page 11).
2. **Save** this form to your device.
3. **Upload** your saved form and supporting documents if applicable. You will be prompted to sign into your employee portal if you are not already signed in.

If you **do not** have access to the employee portal, securely **upload your form**.

Dependent eligibility verification (DEV)

If you are enrolling a **new** dependent that has not previously completed dependent eligibility verification with Employee Services, you may upload your supporting documents with this Benefits Enrollment/Change Form or you will need to complete the DEV form in your employee portal within 31 days of your hire date or Qualifying Life Change.

Alternate Ways to Complete Enrollment

In the event you are unable to complete your enrollment electronically, you may do so in the ways described below. Note that these methods do take longer to process.

Make a copy and mail the original to:

Employee Services
University of Colorado
1800 Grant Street, Suite 400
Denver, CO 80203

By fax

Fax to 303-860-4299 (retain a copy of the fax transmission)

By email

Documents with personal information should never be emailed for security reasons.

Alternate DEV submission

If you are unable to access your portal and need to submit DEV documentation, go to the DEV website (https://www.cu.edu/node/116040). This is only recommended in the rare case you do not have access to your employee portal. DEV submitted this way will take longer to process.