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

Benefits Enrollment/Change Form

2018-2019 Benefit Plan Year
Faculty, Officers, and University Staff

IMPORTANT - READ FIRST

- **You have 31 days from your date of benefits eligibility or qualifying life event to complete and submit the enrollment/change form.**
- **If enrolling any dependents in medical, dental, vision, optional life, and/or voluntary AD&D plans who have not previously been verified, you *must* attach the required documents as listed on the Employee Services website to demonstrate dependent eligibility. Your dependents will not be enrolled in benefits if the correct documents are not attached.**
- **The form must be legible, each section must be completed in its entirety, and all necessary documentation must be attached.**
- **Incomplete and/or incorrect forms will not be processed. Consequently, your benefits could be delayed or you could risk losing enrollment eligibility for certain benefits.**

ENROLLMENT TYPE - *CHECK ONE BOX ONLY*

☐ **NEWLY HIRED/NEWLY ELIGIBLE** Date of hire _____ (mm/dd/yyyy) or date of new eligibility _____ (mm/dd/yyyy)

☐ **QUALIFYING LIFE EVENT**
Type of qualifying life event _____ Date of qualifying life event _____ (mm/dd/yyyy)

☐ **BENEFICIARY(IES) UPDATE** Effective the date of employee's signature on this form.

EMPLOYEE INFORMATION - *YOU ARE REQUIRED TO COMPLETE ALL SECTIONS*

Employee ID Number— **REQUIRED** | Name (Last) | (First) | (Middle Initial)

Personal Telephone | Campus Telephone | Email Address

Employee ID Number— **REQUIRED** Name (Last) (First) (Middle Initial)

SECTION 1: MEDICAL/DENTAL/VISION Check one box under CU Health Plan Options, one box under Dental Plan Options, one box under Vision Plan Options, and elect your Coverage Levels.

CU Health Plan Options:

◯ **Pre-tax** ◯ **Post-tax**

- ☐ Exclusive
- ☐ Extended
- ☐ High Deductible (HSA Compatible)
- ☐ Kaiser
- ☐ Waive medical coverage**
- ☐ No change

CU Health Plan Dental Options:

◯ **Pre-tax** ◯ **Post-tax**

- ☐ Essential Dental
- ☐ Choice Dental
- ☐ Waive dental coverage
- ☐ No change

Vision Plan Options:

◯ **Pre-tax** ◯ **Post-tax**

- ☐ CU Health Plan - Vision
- ☐ Waive vision coverage
- ☐ No change

Coverage Levels:

Medical	Dental	Vision
☐	☐	☐ Employee Only
☐	☐	☐ Employee + Child(ren)
☐	☐	☐ Employee + Spouse*
☐	☐	☐ Family
☐	☐	☐ No change

**If you waived medical coverage, why did you waive? Mark all that apply:

- ☐ Spouse's employer benefits provide better coverage.
- ☐ Spouse's employer benefits cost less.
- ☐ I purchased better individual coverage.
- ☐ I purchased individual coverage that costs less.
- ☐ I cannot afford the cost of university benefits.
- ☐ I can afford the university benefits, but I choose not to carry coverage.
- ☐ I know I have the option to enroll each year at open enrollment, and I am choosing to go without coverage this year.
- ☐ Other, please explain _____

EMPLOYEE ENROLLMENT Complete all boxes.

Name Last, First MI _____ Date of Birth _____ Gender ☐ Male ☐ Female

If enrolling in Exclusive you must elect a primary care physician (PCP). PCP # _____ Current patient? ☐ Yes ☐ No

Medicare-eligible ☐ No ☐ Yes, Medicare Claim Number _____

DEPENDENT ENROLLMENT

IMPORTANT: Dependent eligibility verification **REQUIRED**.

***Spouse includes common-law, domestic partner, and civil union** Complete all boxes.

Name Last, First MI _____ Gender ☐ Male ☐ Female

Relationship to employee ☐ Spouse ☐ Common-law spouse ☐ Domestic Partner ☐ Civil Union

Domestic partners and Civil Unions only: Qualified tax dependent for health coverage? ☐ Yes ☐ No

Date of Birth _____ SSN # _____ ☐ Medical ☐ Dental ☐ Vision ☐ Optional Life ☐ Voluntary AD&D

If enrolling in Exclusive you must elect a primary care physician (PCP). PCP # _____ Current patient? ☐ Yes ☐ No

Medicare-eligible ☐ No ☐ Yes, Medicare Claim Number _____

Employee ID Number— **REQUIRED** Name (Last) (First) (Middle Initial)

Child(ren) Complete all boxes. If not applicable, write "N/A".

Name
Last, First MI _____ Gender ☐ Male ☐ Female

Relationship to employee ☐ Biological/adopted child ☐ Step-child ☐ Child for whom you have legal responsibility List relationship _____

Domestic partners and Civil Unions children only: Qualified tax dependent? ☐ Yes ☐ No

Date of Birth _____ SSN # _____ ☐ Medical ☐ Dental ☐ Vision ☐ Optional Life ☐ Voluntary AD&D

If enrolling in Exclusive you must elect a primary care physician (PCP). PCP # _____ Current patient? ☐ Yes ☐ No

Medicare-eligible ☐ No ☐ Yes, Medicare Claim Number _____

Name
Last, First MI _____ Gender ☐ Male ☐ Female

Relationship to employee ☐ Biological/adopted child ☐ Step-child ☐ Child for whom you have legal responsibility List relationship _____

Domestic partners and Civil Unions children only: Qualified tax dependent? ☐ Yes ☐ No

Date of Birth _____ SSN # _____ ☐ Medical ☐ Dental ☐ Vision ☐ Optional Life ☐ Voluntary AD&D

If enrolling in Exclusive you must elect a primary care physician (PCP). PCP # _____ Current patient? ☐ Yes ☐ No

Medicare-eligible ☐ No ☐ Yes, Medicare Claim Number _____

SECTION 2: CAFETERIA PLANS

Check one box only for each plan. Heath Care Flexible Spending Account (HCFSA) and Dependent Care Flexible Spending Account (DCFSA) elections are **irrevocable** for the plan year. **YOU MUST ELECT OR WAIVE EVERY PLAN YEAR - YOU CANNOT BE ENROLLED IN A HCFSA AND HSA**

HEALTH CARE FLEXIBLE SPENDING ACCOUNT (HCFSA) - Covers eligible health care expenses for you and your federal tax dependents. You may not exceed $2,650 in a calendar year (January-December). If you are making a mid-year increase or decrease due to a qualifying life event contact Benefits Administration. Check one box only.

☐ I elect to enroll for a **PLAN YEAR** (July 1 - June 30) amount of $ _____ I understand my election will be **divided by the remaining months in the plan year.** The plan election minimum is $10/month, and the maximum $2,650/plan year.

☐ I waive enrollment.

☐ No change.

DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT (DCFSA) - Covers eligible daycare expenses for you and your federal tax dependents. You may not exceed $5,000 per household in a calendar year (January-December). Check one box only.

☐ I elect to enroll for a **PLAN YEAR** (July 1 - June 30) amount of $ _____ I understand my election will be **divided by the remaining months in the plan year.** The plan election minimum is $10/month, and the maximum $5,000/plan year.

☐ I waive enrollment.

☐ No change.

HEALTH SAVINGS ACCOUNT (HSA) - You **must be enrolled** in the **CU Health Plan - High Deductible** to enroll in the HSA through CU. Covers eligible health care expenses for you and your federal tax dependents. You may not exceed $3,450 for single coverage or $6,850 for family coverage in a calendar year (January-December). To enroll, you must call the CU Benefits Office at 303-860-4200, option 3.

Employee ID Number— REQUIRED Name (Last) (First) (Middle Initial)

SECTION 3: BASIC TERM LIFE/AD&D, OPTIONAL TERM LIFE/AD&D, AND VOLUNTARY AD&D

For Employee, Spouse*, and Dependent Children.

BASIC TERM LIFE/AD&D INSURANCE

EMPLOYEE ENROLLMENT - Automatic university-paid $57,000 Basic Term Life/AD&D Insurance

Designate your primary and contingent beneficiaries in this section

- 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 university 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.

BENEFICIARY(IES) NAME(S): Last, First, MI		Relationship	Date of Birth mm/dd/yyyy	Percentage
PRIMARY				%
PRIMARY				%
CONTINGENT				%
CONTINGENT				%

OPTIONAL TERM LIFE/AD&D INSURANCE

EMPLOYEE ENROLLMENT - $1,000 increments. If electing more than the maximum allowed, you MUST complete a **Medical History Statement** (**http://www.cu.edu/sites/default/files/policies/docs/Med-History_FOEP.pdf**) and be approved by Standard Insurance Company.

☐ I elect to enroll in Optional Term Life/AD&D insurance in the amount of $ _____ ($1,000 increments)

Initial eligibility—maximum amount is three times your annual salary.
Qualifying Life Event—maximum amount of increase is $10,000, not to exceed three times your annual salary.

- ☐ Standard rate.
- ☐ Discount rate (no tobacco use in the last 12 months).
- ☐ I submitted my Medical History Statement to Standard Insurance Company for approval to enroll in more than the maximum amount allowed.

☐ I waive enrollment.

☐ No change.

List your Optional Term Life/AD&D beneficiary(ies) below.

BENEFICIARY(IES) NAME(S): Last, First, MI		Relationship	Date of Birth mm/dd/yyyy	Percentage
PRIMARY				%
PRIMARY				%
CONTINGENT				%
CONTINGENT				%

*Spouse includes Common Law, Domestic Partners, and Civil Union Partner

Employee ID Number— **REQUIRED** Name (Last) (First) (Middle Initial)

DEPENDENT ENROLLMENT - The University employee is automatically the sole beneficiary for all dependent life insurance plans.

IMPORTANT: Dependent eligibility verification **REQUIRED.**

Spouse* - $1,000 increments. **Coverage cannot exceed employee's Optional Term Life/AD&D insurance coverage amount.** If electing more than the maximum allowed, you MUST complete a **Medical History Statement (http://www.cu.edu/sites/default/files/policies/docs/Med-History_FOEP.pdf)** and be approved by Standard Insurance Company.

☐ I elect to enroll my spouse* in Optional Term Life/AD&D insurance in the amount of $ _____ ($1,000 increments)

Initial eligibility—maximum amount is $50,000.

Qualifying Life Event—maximum amount of increase is $10,000, not to exceed $50,000.

☐ Standard rate

☐ Discount rate (no tobacco use in the last 12 months)

☐ I submitted my spouse's* Medical History Statement to Standard Insurance Company for approval to enroll in more than the maximum amount allowed.

☐ I waive enrollment.

☐ No change.

Child(ren) - Coverage cannot exceed employee's Optional Term Life/AD&D insurance coverage amount.

☐ I elect to enroll my child(ren) for $5,000 per child.

☐ I elect to enroll my child(ren) for $10,000 per child.

☐ I waive enrollment.

☐ No change.

VOLUNTARY ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) INSURANCE

EMPLOYEE ENROLLMENT - $10,000 increments up to ten times your annual salary or $250,000 whichever is less.

☐ I elect to enroll in Voluntary AD&D insurance in the amount of $_____ ($10,000 increments)

☐ I waive enrollment.

☐ No change.

List your Voluntary AD&D beneficiary(ies) below.

BENEFICIARY(IES) NAME(S): Last, First, MI		Relationship	Date of Birth mm/dd/yyyy	Percentage
PRIMARY				%
PRIMARY				%
CONTINGENT				%
CONTINGENT				%

DEPENDENT ENROLLMENT

IMPORTANT: Dependent eligibility verification **REQUIRED.**

Spouse* - $10,000 increments. **Coverage cannot exceed employee's Voluntary AD&D insurance coverage amount.** Maximum amount is same as employee's.

☐ I elect to enroll my spouse* in Voluntary AD&D insurance in the amount of $ _____ ($10,000 increments)

☐ I waive enrollment.

☐ No change.

Child(ren) - Coverage cannot exceed employee's Voluntary AD&D insurance coverage amount.

☐ I elect to enroll my child(ren) in Voluntary AD&D insurance in the amount of $5,000.

☐ I waive enrollment.

☐ No change.

*Spouse includes Common Law, Domestic Partners, and Civil Union Partner

Employee ID Number— **REQUIRED** Name (Last) (First) (Middle Initial)

SECTION 4: SHORT-TERM DISABILITY INSURANCE

I elect to enroll in

- ☐ Short-Term Disability-60 percent of your weekly pre-disability earnings up to a maximum weekly benefit of $1,500.
- ☐ I waive enrollment.
- ☐ No change.

SECTION 5: RETIREMENT PLANS

If you are in a retirement-eligible position, 401(a) Optional Retirement Plan (ORP), or Public Employees' Retirement Association (PERA), refer to the Employee Services website at https://www.cu.edu/employee-services/retirement-plans for enrollment information.

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 of the university's benefits plans, or as provided in regulations, statutes, and applicable written directives.

AUTHORIZATION AND SIGNATURE - READ, SIGN, AND DATE

- 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 at www.cu.edu/benefits.
- By signing this form, I attest that I have reviewed the dependent eligibility definitions and that the information I am submitting 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 event.
- 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 to 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

HOW TO RETURN YOUR BENEFITS ENROLLMENT/CHANGE FORM

BY MAIL	BY FAX	IN PERSON
Make a copy for your records and send the original to: Employee Services University of Colorado 1800 Grant Street, Suite 400 Denver, Colorado 80203	303-860-4299 Keep a copy of the fax transmission report with your form for your records.	Bring your completed original form and a copy for your records to Employee Services. The receptionist will date stamp both your original form and your copy. Employee Services will keep the original.

Employee Services typically enters your enrollment/change information within 48 hours of receipt, if not sooner. Please check your employee portal to verify that your enrollment is reflected accurately. If you do not see your information in your employee portal or it is incorrect, contact Employee Services immediately at 303.860.4200, option 3.