Print

**Open Enrollment Form**

2019-2020 Benefits Plan Year Faculty, Officers, and University Staff

***IMPORTANT - READ FIRST***


# You have until 5 p.m. MDT on May 10th to complete your OPEN ENROLLMENT via this form OR via your portal (my.cu.edu)

**Plan information, rates and all Open Enrollment information is available for review at** [**https://www.cu.edu/oe**](http://www.cu.edu/oe)

**Failure to make a specific benefit election on this form will be considered your election to accept the default enrollment.**

**Each section must be completed in its entirety and necessary documentation must be attached.**

**Incomplete and/or incorrect forms, or forms missing documentation (demonstrating dependent eligibility), will not be processed. Consequently, you could risk losing open enrollment eligibility.**

**You are not required to submit dependent eligibility documentation for dependents who have been previously verified.**

**ENROLLMENT TYPE**

**OPEN ENROLLMENT (OE) Elections - Effective July 1, 2019**

Open Enrollment ends at 5 p.m MDT on May 10, 2019

**EMPLOYEE INFORMATION - *YOU MUST COMPLETE ALL SECTIONS***

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

Personal Telephone Campus Telephone Email Address

[**https://www.cu.edu/oe**](http://www.cu.edu/oe)

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

**SECTION 1: MEDICAL/DENTAL/VISION - YOU MUST ELECT OR WAIVE -** 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:**

**CU Health Plan Dental Options:**

**Coverage Levels:**

**Pre-tax**

**Post-tax**

**Pre-tax**

Essential Dental

**Post-tax**

**Medical Dental Vision**

Employee Only

Exclusive

Choice Dental

Employee + Child(ren)

Extended

Waive dental coverage

Employee + Spouse\*

High Deductible

(HSA Compatible)

No Change

Family

Kaiser

**Vision Plan Options:**

No Change

Waive medical coverage\*\* **Pre-tax Post-tax**

No Change

CU Health Plan - Vision

Waive vision coverage No Change

**\*Spouse includes common-law, domestic partners, and civil union partners.**

**EMPLOYEE ENROLLMENT** Complete all boxes.

Name

Last, First MI

If enrolling in CU Health Plan - Exclusive you must elect a Primary Care

Date of Birth

Gender

Male Female

Physician (PCP) or on will be assigned to you. To find a doctor go to [www.anthem.com/cuhealthplan](http://www.anthem.com/cuhealthplan) and select the "Find a Doctor" Tab

Medicare-eligible  No  Yes, Medicare Claim Number

## DEPENDENT ENROLLMENT

PCP # Current patient?  Yes  No

 ***IMPORTANT:*** Dependent eligibility verification **REQUIRED** unless previously verified.

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

If Domestic/Civil Union Partner is not a tax dependent, employees will be subject to imputed income (taxable income). Information at [https://www.cu.edu/employee-services/imputed-income](http://www.cu.edu/employee-services/imputed-income)

Name

Last, First MI Gender  Male  Female

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

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

If YES (domestic/civil union partner IS a tax dependent), you MUST SUBMIT to Employee Services the Tax Certification of Dependency form located at: [https://www.cu.edu/doc/dptax-cert2018.pdf](http://www.cu.edu/doc/dptax-cert2018.pdf)

If NO (domestic/civil union partner is NOT a tax dependent), employees will be subject to imputed income (taxable income). Information at: [https://www.cu.edu/employee-services/imputed-income](http://www.cu.edu/employee-services/imputed-income)

Date of Birth SSN #

If enrolling in CU Health Plan - Exclusive you must elect a Primary Care Physician (PCP) at [https://www.anthem.com/cuhealthplan/](http://www.anthem.com/cuhealthplan/) findadoc.html or Anthem will assign you one.

Medicare-eligible No Yes, Medicare Claim Number

 Medical  Dental  Vision  Optional Life  Voluntary AD&D

PCP # Current patient? Yes  No

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

**Child(ren)** Complete all boxes. If not applicable, write "N/A". If you need to add more children, please make copies of this page.

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 #

If enrolling in CU Health Plan - Exclusive you must elect a Primary Care Physician (PCP) at [https://www.anthem.com/cuhealthplan/](http://www.anthem.com/cuhealthplan/) findadoc.html or Anthem will assign one.

Medicare-eligible No Yes, Medicare Claim Number

 Medical  Dental  Vision  Optional Life  Voluntary AD&D PCP # Current patient?  Yes  No

Name

Last, First MI Relationship to employee

Biological/adopted child Step-child Child for whom you have legal responsibility.

Gender  List relationship

Male Female

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 CU Health Plan - Exclusive you must elect a Primary Care Physician (PCP) at [https://www.anthem.com/cuhealthplan/](http://www.anthem.com/cuhealthplan/) findadoc.html or Anthem will assign one.

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 Savings Account (HCFSA) and Dependent Care Flexible Savings Account (DCFSA) elections are **irrevocable** for the Plan Year (July 1, 2019 to June 30, 2020). **YOU MUST ELECT 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 $2,700 in a calendar and plan year. Check one box only.

I elect to enroll for a **PLAN YEAR** (July 1, 2019 - June 30, 2020) amount of $ I understand my election will be

**divided by 12 months.** The plan election minimum is $10/month and the maximum $2,700/plan year, per employee.

 I waive enrollment.

**DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT (DCFSA) -** Covers eligible daycare expenses for your 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, 2019 - June 30, 2020) amount of $ I understand my election will  be **divided by 12 months.** The plan election minimum is $120/plan year, and the maximum $5,000/plan year, per

household.

I waive enrollment.

**HEALTH SAVINGS ACCOUNT (HSA) -** You **must be enrolled** in the **CU Health Plan - High Deductible** to enroll in the HSA**.**

Covers eligible health care expenses for you and your tax dependents. You may not exceed $3,500 for single coverage or $7,000 for family coverage in a calendar year (January-December). If you are age 55 or older, you can make additional "catch-up" contribution of $1,000. To enroll, submit the HSA Authorization Form to Employee Services ([**https://www.cu.edu/doc/hsa-**](http://www.cu.edu/doc/hsa-) **authorization-form-final-2018.pdf** to Employee Services

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

# SECTION 3: BASIC TERM LIFE/Accidental Death & Dismemberment (AD&D), OPTIONAL TERM LIFE/ AD&D, AND VOLUNTARY AD&D

## For Employee, Dependent 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**

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| **PRIMARY** |  |  |  | % |
| **PRIMARY** |  |  |  | % |
| **CONTINGENT** |  |  |  | % |
| **CONTINGENT** |  |  |  | % |

## OPTIONAL TERM LIFE/AD&D INSURANCE

**EMPLOYEE ENROLLMENT -** $1,000 increments up to $1,000,000. To enroll or increase your coverage, you must complete the Medical History Statement located on the Employee Services website ([**https://www.cu.edu/doc/med-historyfoep.pdf**](http://www.cu.edu/doc/med-historyfoep.pdf%29)), and be approved by The Standard. Medical History Statement MUST be sent to The Standard. The Standard will notify you if approved or denied.

 No change to current coverage level.  I waive enrollment.

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**

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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** unless previously verified.

**Spouse\* -** $1,000 increments up to $500,000. **Coverage cannot exceed employee's Optional Term Life/AD&D insurance coverage amount.**

To enroll or increase your coverage, you must complete the Medical History Statement located on the Employee Services website ([https://www.cu.edu/doc/med-historyfoep.pdf](http://www.cu.edu/doc/med-historyfoep.pdf%29)), and be approved by Standard. Medical History Statement MUST be sent to The Standard. The Standard will notify if approved or denied.

 No change to current coverage level.  I waive enrollment.

## Child(ren) - Coverage cannot exceed employee's Optional Term Life/AD&D insurance coverage amount. No Medical History need

 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 to current coverage level

 I waive enrollment.

## 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 $

 No change to current coverage level.

 I waive enrollment.

($10,000 increments)

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

**BENEFICIARY(IES) NAME(S): Last, First, MI Relationship**

## Date of Birth

**mm/dd/yyyy Percentage**

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| **PRIMARY** |  |  |  | % |
| **PRIMARY** |  |  |  | % |
| **CONTINGENT** |  |  |  | % |
| **CONTINGENT** |  |  |  | % |

## DEPENDENT ENROLLMENT

***IMPORTANT:*** Dependent eligibility verification **REQUIRED** unless previously verified.

**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 $  No change to current coverage level. ($10,000 increments)  I waive enrollment.

**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.

 No change to current coverage level.  I waive enrollment.

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

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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.  No change to current coverage.

 I waive enrollment.

#  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 Open Enrollment 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**.**](http://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 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 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

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| **HOW TO RETURN YOUR BENEFITS ENROLLMENT/CHANGE FORM** |
| **BY MAIL** | **BY FAX** (Secured) | **IN PERSON** |
| Make a copy for your records and send the | 303-860-4299 | Bring your completed original form and a |
| original to: | Keep a copy of the fax transmission | copy for your records to Employee Services. |
| Employee Services | report with your form for your | The receptionist will date stamp both your |
| University of Colorado | records. | original form and your copy. Employee |
| 1800 Grant Street, Suite 400 | **BY EMAIL** (Non-Secured) | Services will keep the original. |
| Denver, CO 80203 | Benefits@cu.edu |  |

To confirm your enrollment has been processed, log in to your Employee Portal. Click CU Resources >Benefits & Wellness>Benefits Tools>Benefits Summary. Contact Employee Services immediately at 303-860-4200, option 3, if your Benefits Summary is incorrect.