

# CU Retiree Benefits Change Form

## Qualifying Life Change (QLC)

2026-2027\*

\*Medicare plan (over) Year 01/01-12/31 and non-Medicare (under) plan year is 07/01-06/30

- This form cannot be completed in a web browser.
  1. **Download** (Save) the form to your computer desktop from the web browser.
  2. **Open** the form in Adobe or Adobe Reader before completing.
  3. **Submit** the form.
- You have 31 days from the date of your Qualifying Life Change to send in this enrollment/change form. Plan information and current rates are available on the [CU Benefits website](http://www.cu.edu/benefits) (www.cu.edu/benefits).
- If you are enrolling any dependents in medical and/or dental plans, who have not previously completed dependent eligibility verification (DEV), it requires the completion of 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](#) (www.cu.edu/docs/dependent-eligibility-verification). And complete additional required designation documentation for domestic partner/child(ren) - [Tax Certification of Dependency for Tax Treatment of Medical Benefits for a Domestic Partner/Child\(ren\) \(PDF\)](#) (www.cu.edu/docs/domestic-partner-tax-certification-dependency-tax-treatment-medical-benefits).
- 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

#### Qualifying Life Change:

Type of Qualifying Life Change: \_\_\_\_\_

Date of Qualifying Life Change: \_\_\_\_\_  
mm/dd/yyyy

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

### Retiree Information

*Completion of all sections is required.*

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

Date of Retirement                      Retirement Plan 401(a) or PERA

Preferred Telephone                      Preferred Email Address

Home Address                      City                      State                      Zip Code

Is this a change of address?                      Yes                      No

## Section 1: Medical and Dental Plan Options

- Complete **one** option (A, B, or C).
- If enrolling in the CU Health Plan – Medicare, individual must be enrolled in original Medicare Parts A and B. **Copy of Medicare Card Part A and B required.**
- **Enrolling dependents** in medical and/or dental who have **not** previously completed dependent eligibility verification requires DEV documentation in your [employee portal](https://my.cu.edu) (<https://my.cu.edu>) **in addition** to this form. For more information on DEV, visit the [CU DEV website](http://www.cu.edu/docs/dependent-eligibility-verification) ([www.cu.edu/docs/dependent-eligibility-verification](http://www.cu.edu/docs/dependent-eligibility-verification)).
- Spouse refers to: *legal spouse, common law, domestic partner and civil union partner.*

**Option A - Under age 65 – For 401(a) or PERA retirees.** Complete only if you and your dependents are not eligible for Medicare. The medical CU Health Plan - Exclusive and the CU Health Plan - Kaiser are only available to Colorado residents.

**CU Health Medical Plans:**

Exclusive  
 Kaiser  
 High Deductible  
 Pathway  
 waive

**Coverage Level for Medical:**

retiree only  
 retiree + spouse  
 retiree + children  
 family (spouse+child(ren))  
 waive

**CU Health Dental Plans:**

Essential Dental  
 Choice Dental  
 waive

**Coverage Level for Dental:**

retiree only  
 retiree + spouse  
 retiree + children  
 family (spouse+child(ren))  
 waive

**Option B – Medicare-eligible Over/Under age 65 –** For 401(a) retirees only. Complete this option if you need coverage for individuals who are Medicare eligible AND individuals who are not eligible for Medicare. The Medicare individual will be covered under the CU Medicare Plan (plan year 1/1 – 12/31) (must be enrolled in Medicare Parts A and B) and the non-Medicare individual will be covered under the CU Health Plan – High Deductible (plan year 7/1 – 6/30).

**CU Health Medical Plans:**

CU Health Plan Medicare/High Deductible  
 Alternate Medicare Payment (AMP – retiree must be Medicare eligible)  
 waive

**Coverage Level for Medical:**

retiree only  
 retiree + spouse  
 retiree + children  
 family (spouse + child(ren))  
 waive

**CU Health Dental Plans:**

Dental Premier (if retiree is Medicare-eligible, all must enroll in Dental Premier)  
 Essential Dental (only for non-Medicare retiree and all dependents)  
 Choice Dental (only for non-Medicare retiree and all dependents)  
 waive all dental coverage

**Coverage Level for Dental:**

retiree only  
 retiree + spouse  
 retiree + children  
 family (spouse + child(ren))  
 waive

Name: \_\_\_\_\_ ID# \_\_\_\_\_

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**Option C – Medicare-eligible – For 401(a) retirees only.** Complete this option if you and your dependents are eligible for Medicare. If enrolling in the CU Health Plan – Medicare, individual must be enrolled in original Medicare Parts A and B. Copy of Medicare Card Part A and B required.

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**CU Health Medical Plans:**

CU Health Plan Medicare  
Alternate Medicare Payment (AMP – retiree must be Medicare eligible)  
waive

**Coverage Level for Medical:**

retiree only  
retiree + spouse  
retiree + children  
family (spouse + child(ren))  
waive

**CU Health Dental Plans:**

Dental Premier  
waive

**Coverage Level for Dental:**

retiree only  
retiree + spouse  
retiree + children  
family (spouse + child(ren))  
waive

Name: \_\_\_\_\_ ID# \_\_\_\_\_

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

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### Retiree Enrollment

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Retiree Name (Last) \_\_\_\_\_ (First) \_\_\_\_\_ (Middle Initial) \_\_\_\_\_ Date of Birth \_\_\_\_\_

**Gender** (please check one – required for insurance enrollment)

male

female

U/X (unspecified or another gender identity)

Medicare-eligible? Yes No Medicare number: \_\_\_\_\_ (copy of Medicare Card Part A and B required)

### Spouse, Common Law, Domestic or Civil Union Partner Enrollment

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

Social Security Number \_\_\_\_\_

**Relationship to Retiree**

spouse

common law spouse

domestic partner

civil union partner

**Gender** (please check one – required for insurance enrollment)

male

female

U/X (unspecified or another gender identity)

Medicare-eligible? Yes No Medicare number: \_\_\_\_\_ (copy of Medicare Card Part A and B required)

### Child 1 Enrollment

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Child Name (Last) \_\_\_\_\_ (First) \_\_\_\_\_ (Middle Initial) \_\_\_\_\_ Date of Birth \_\_\_\_\_

Social Security Number \_\_\_\_\_

**Relationship to Retiree**

biological/adopted

stepchild

child for whom you have legal responsibility

**Gender** (please check one – required for insurance enrollment)

male

female

U/X (unspecified or another gender identity)

Medicare-eligible? Yes No Medicare number: \_\_\_\_\_ (copy of Medicare Card Part A and B required)

Name: \_\_\_\_\_ ID# \_\_\_\_\_

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

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### Child 2 Enrollment

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

\_\_\_\_\_  
Social Security Number

**Relationship to Retiree**

biological/adopted  
stepchild  
child for whom you have legal responsibility

**Gender** (please check one – required for insurance enrollment)

male  
female  
U/X (unspecified or another gender identity)

Medicare-eligible? Yes No Medicare number: \_\_\_\_\_ (copy of Medicare Card Part A and B required)

### Child 3 Enrollment

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

\_\_\_\_\_  
Social Security Number

**Relationship to Retiree**

biological/adopted  
stepchild  
child for whom you have legal responsibility

**Gender** (please check one – required for insurance enrollment)

male  
female  
U/X (unspecified or another gender identity)

Medicare-eligible? Yes No Medicare Number: \_\_\_\_\_ (copy of Medicare Card Part A and B required)

### Child 4 Enrollment

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

\_\_\_\_\_  
Social Security Number

**Relationship to Retiree**

biological/adopted  
stepchild  
child for whom you have legal responsibility

**Gender** (please check one – required for insurance enrollment)

male  
female  
U/X (unspecified or another gender identity)

Medicare-eligible? Yes No Medicare Number: \_\_\_\_\_ (copy of Medicare Card Part A and B required)

**Additional children?** If you need to add more children, please add them in the [Attachment A: Additional Children section](#) of this document.

## Section 2: Basic Term Life and Optional Life

### Basic Term Life

**Fill out this section only** if you are currently enrolled in the \$3,000 Basic Term Life Insurance.

I waive enrollment (irrevocable election).

No change.

### Optional Term Life Insurance

**Fill out this section only** if you are currently enrolled in the Optional Term Life Insurance.

I elect to decrease (irrevocable) my enrollment in Optional Term Life insurance to \$ \_\_\_\_\_.

I waive enrollment (irrevocable election).

No change.

### Beneficiary Information

- The Beneficiary designation will apply to both life policies; Basic & Optional Life Term Life Insurance
- 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.
- 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](http://www.cu.edu/employee-services/how-manage-life-insurance-beneficiaries) (www.cu.edu/employee-services/how-manage-life-insurance-beneficiaries).

*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 | % |

Name: \_\_\_\_\_ ID# \_\_\_\_\_

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## General Fraud Statement

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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.

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## Authorization and Signature – Read, Sign and Send in

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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](http://www.cu.edu/benefits) (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 agree to abide by the eligibility, enrollment and election procedures and payment of premiums for my University of Colorado benefits as outlined in this form and on the Employee Services website.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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## Complete Your Enrollment: How to Upload This Form

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

1. **Complete** and **sign** (page 7).
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](#). If you need assistance with access to your employee portal please contact UIS at 303-860-4357.

### 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 process in your [employee portal](#) within 31 days of the Qualifying Life Change. And complete additional required designation documentation for domestic partner/child(ren) - [Tax Certification of Dependency for Tax Treatment of Medical Benefits for a Domestic Partner/Child\(ren\) \(PDF\)](#) ([www.cu.edu/docs/domestic-partner-tax-certification-dependency-tax-treatment-medical-benefits](http://www.cu.edu/docs/domestic-partner-tax-certification-dependency-tax-treatment-medical-benefits)).

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### Alternate Ways to Complete Enrollment

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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](#) ([www.cu.edu/docs/dependent-eligibility-verification](http://www.cu.edu/docs/dependent-eligibility-verification)). 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.

Name: \_\_\_\_\_ ID# \_\_\_\_\_

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## Attachment A: Additional Children

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### Child 5 Enrollment

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

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Social Security Number

**Relationship to Retiree**

biological/adopted  
stepchild  
child for whom you have legal responsibility

**Gender** (please check one – required for insurance enrollment)

male  
female  
U/X (unspecified or another gender identity)

Medicare-eligible? Yes No Medicare Number: \_\_\_\_\_ (copy of Medicare Card Part A and B required)

### Child 6 Enrollment

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

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Social Security Number

**Relationship to Retiree**

biological/adopted  
stepchild  
child for whom you have legal responsibility

**Gender** (please check one – required for insurance enrollment)

male  
female  
U/X (unspecified or another gender identity)

Medicare-eligible? Yes No Medicare Number: \_\_\_\_\_ (copy of Medicare Card Part A and B required)