You have 31 days from your date of benefits eligibility or qualifying life change to complete and submit this enrollment/change form. Plan information and rates are available at [https://www.cu.edu/benefits](https://www.cu.edu/benefits)

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 _______________ or date of new eligibility _______________
- [ ] QUALIFYING CHANGE Type of qualifying life change __________________ Date of qualifying life change _______________ mm/dd/yyyy
- [ ] BENEFICIARY(IES) UPDATE Effective the date of employee's signature on this form.

**Employee Information – Completion of All Sections is Required**

<table>
<thead>
<tr>
<th>Employee ID Number</th>
<th>REQUIRED</th>
<th>Name (Last)</th>
<th>(First)</th>
<th>(Middle Initial)</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Personal Telephone</th>
<th>Campus Telephone</th>
<th>Email Address</th>
</tr>
</thead>
</table>

[www.cu.edu/benefits](http://www.cu.edu/benefits)
**SECTION 1: Medical/Dental/Vision**

One box under CU Health Plan Options, one box under Dental Plan Options, one box under Vision Plan Options, and elect your Coverage Levels.

<table>
<thead>
<tr>
<th>CU Health Plan Options:</th>
<th>CU Health Plan Dental Options:</th>
<th>Coverage Levels:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Medical</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Dental</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Vision</td>
</tr>
<tr>
<td>Pre-tax</td>
<td>Pre-tax</td>
<td>Employee Only</td>
</tr>
<tr>
<td>Post-tax</td>
<td>Post-tax</td>
<td>Employee + Child(ren)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Employee + Spouse*</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Family (sp + child(ren))</td>
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<tr>
<td></td>
<td></td>
<td>No change</td>
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</tbody>
</table>

**Vision Plan Options:**

<table>
<thead>
<tr>
<th>Pre-tax</th>
<th>Post-tax</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

---

**Employee Enrollment**

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

- **Last, First MI**
- **Date of Birth**
- **SSNumber**
- **Gender**
  - Male
  - Female
- **Medicare-eligible**
  - No
  - Yes, Medicare Claim Number

**Dependent Enrollment**

Important: Dependent eligibility documents are required unless your dependent has been previously verified.

**Spouse, Common Law, Domestic Partner, Civil Union**

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

- **Last, First MI**
- **Date of Birth**
- **SSNumber**
- **Gender**
  - Male
  - Female
- **Relationship to employee**
  - Spouse
  - Common-law spouse
  - Domestic partners
  - Civil Union
- **Domestic/Civil Union Partners**: Is your Domestic/Civil Union Partner a qualified tax dependent for health coverage?
  - Yes
  - No
- **If YES, submit the Tax Certification of Dependency Form** with your enrollment
- **If NO**, you will be subject to imputed income (taxable income)
- **If enrolling in CU Health Plan - Exclusive**, you must elect a Primary Care Physician (PCP) or one will be assigned to you. To find your doctor's ID# or to find a doctor, go to [https://www.anthem.com/cuhealthplan](https://www.anthem.com/cuhealthplan) and select the 'find a doctor' tab.
- **PCP#**
- **Current patient?**
  - Yes
  - No
- **Medicare-eligible**
  - No
  - Yes, Medicare Claim Number

**Child(ren)**

Complete all information: If not applicable, write N/A. If you need to add more children please make copies of this page.

- **List relationship**
- **Domestic/Civil Union Partners**: Is your Domestic/Civil Union Partner a qualified tax dependent for health coverage?
  - Yes
  - No
If YES, submit the **Tax Certification of Dependency Form** with your enrollment.
If NO, you will be subject to **imputed income** (taxable income).

If enrolling in CU Health Plan - Exclusive you must elect a Primary Care Physician (PCP) or one will be assigned to you. To find your doctor's ID# or to find a doctor, go to [https://www.anthem.com/cuhealthplan](https://www.anthem.com/cuhealthplan) and select the 'find a doctor' tab.

Medicare-eligible: Yes No

Medicare Claim Number

---

**SECTION 2: Cafeteria Plans**

Check one box only for each plan. Health Care Flexible Saving Account (HCFSA) and Dependent Care Flexible Account (DCFSA) elections are irrevocable for the Plan Year (July 1, 2019 to June 30, 2020). You must make a new election each plan year. You cannot enroll on HCFSA and HSA.

**Health Care Flexible Spending Account (HCFSA)** - Covers eligible health care expenses for you and your tax dependents. You may not exceed $2,700 in a calendar and plan year. 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 $120/year, and the maximum $2,700/plan year, per employee.
- 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 and plan year. 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 $120 per year, 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. Your contributions 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 an additional contribution of $1,000. To enroll, submit the [HSA Authorization Form](#) to Employee Services.
SECTION 3:
Basic Term Life, Optional Life and Voluntary AD&D
Basic Term Life with AD&D

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.

<table>
<thead>
<tr>
<th>BENEFICIARY(IES) NAME(S): Last, First, MI</th>
<th>Relationship</th>
<th>Date of Birth mm/dd/yyyy</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>PRIMARY</td>
<td></td>
<td></td>
<td>%</td>
</tr>
<tr>
<td>PRIMARY</td>
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<td>%</td>
</tr>
<tr>
<td>CONTINGENT</td>
<td></td>
<td></td>
<td>%</td>
</tr>
<tr>
<td>CONTINGENT</td>
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<td></td>
<td>%</td>
</tr>
</tbody>
</table>

Optional Term Life with AD&D

Employee Enrollment
You can elect $1,000 increments up to $1,000,000. To enroll or increase your coverage, you must complete the Medical History Statement and be approved by The Standard. The Medical History Statement MUST be sent to The Standard. The Standard will notify you and CU if increase is approved or denied.

☐ I elect to enroll in Optional Term Life/AD&D Insurance in the amount of $ _______________ ($1,000 increments)
  Initial eligibility – max amount is 3x your annual salary.
  Qualifying Life Change – max amount of increase is $10,000, not to exceed 3x your annual salary.
  ☐ Standard Rate (tobacco use in the last 12 months).
  ☐ Discount Rate (no tobacco use in the last 12 months).
  ☐ I submitted by Medical History Statement to The Standard Insurance Company for approval to enroll in more that the maximum amount allowed.

☐ No change in current coverage level.
☐ I waive enrollment.

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

<table>
<thead>
<tr>
<th>Beneficiary(ies) Name(s) Last, First, MI</th>
<th>Relationship</th>
<th>Date of Birth mm/dd/yyyy</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>PRIMARY</td>
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<td></td>
<td>%</td>
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<tr>
<td>PRIMARY</td>
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<tr>
<td>CONTINGENT</td>
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</tr>
<tr>
<td>CONTINGENT</td>
<td></td>
<td></td>
<td>%</td>
</tr>
</tbody>
</table>
Employee ID Number— REQUIRED
Name (Last) (First) (Middle Initial)

**Dependent Enrollment**

*IMPORTANT:* Dependent eligibility documents are required unless your dependent has been previously verified.

The university employee is automatically the sole beneficiary for all dependent life insurance plans.

**Spouse/Partner**

You can elect $1,000 increments up to $500,000.

Coverage cannot exceed employee’s Optional Term Life coverage amount.

To enroll or increase your coverage, your spouse/partner must complete the Medical History Statement, and be approved by The Standard. The Medical History Statement MUST be sent to The Standard. The Standard will notify your spouse/partner and CU if increase is approved or denied.

- I elect to enroll my spouse* in Optional Term Life/AD&D in the amount of $__________ ($1,000 Increments)
  - Initial eligibility - max amount is $50,000
  - Qualifying Life Change – max amount of increase is $10,000, not to exceed $50,000.
  - Standard Rate (tobacco use in the last 12 months)
  - Discount Rate (no tobacco use in the last 12 months)
  - I submitted my spouse’s* Medical History Statement to The Standard Insurance Company for approval to enroll in more than the maximum amount allowed.

- I waive enrollment

**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 & Dismemberment**

**Employee Enrollment**

You can elect in $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 $__________
- I waive enrollment.
- No change.

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

<table>
<thead>
<tr>
<th>Beneficiary Name(s) Last, First, MI</th>
<th>Relationship</th>
<th>Date of Birth</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>PRIMARY</td>
<td></td>
<td>mm/dd/yyyy</td>
<td>%</td>
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<tr>
<td>PRIMARY</td>
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<td>CONTINGENT</td>
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<tr>
<td>CONTINGENT</td>
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<td>%</td>
</tr>
</tbody>
</table>

**Dependent Enrollment**

*IMPORTANT:* Dependent eligibility documents are required unless your dependent has been previously verified.

**Spouse/Partner**

You can elect $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 $__________
- 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
SECTION 4: Short-Term Disability

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 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 here 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 Submit

• 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 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

How to Return your Benefits Change Form

BY MAIL
Make a copy for your records and send the original to:
Employee Services
University of Colorado
1800 Grant Street, Suite 400
Denver, Colorado 80203

BY FAX (secured)
303-860-4299
Keep a copy of the fax transmission report with your form for your records.
BYEMAIL (non-secured)
benefits@cu.edu

IN PERSON
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.