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

Benefits Enrollment/Change Form

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

IMPORTANT-READFIRST

- **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**
- **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

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

☐ **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

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 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 (sp + child(ren)
☐	☐	☐ No change

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

Employee Enrollment

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

Last, First MI _____ Gender ☐ Male ☐ Female

Date of Birth _____ SSNumber _____

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 and select the 'find a doctor' tab. PCP# _____ Current patient? ☐ Yes ☐ No

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

Dependent Enrollment

Important: Dependent eligibility document 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 _____ Gender ☐ Male ☐ Female

Date of Birth _____ SSNumber _____

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 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.

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

Last, First, MI _____ Gender ☐ Male ☐ Female

Date of Birth _____ SSNumber _____

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

Domestic/Civil Union Partners: Is your Domestic/Civil Union Partner a qualified tax dependent for health coverage? ☐ Yes ☐ No

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

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 and select the 'find a doctor' tab. PCP# _____ Current patient? ☐ Yes ☐ No

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

Last, First, MI _____ Gender ☐ Male ☐ Female

Date of Birth _____ SS Number _____

Relationship to employee ☐ Biological/adopted child ☐ Step-child ☐ Child for whom you have legal responsibility 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 and select the 'find a doctor' tab. PCP# _____ Current patient? ☐ Yes ☐ No

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

Last, First, MI _____ Gender ☐ Male ☐ Female

Date of Birth _____ SS Number _____

Relationship to employee ☐ Biological/adopted child ☐ Step-child ☐ Child for whom you have legal responsibility 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 and select the 'find a doctor' tab. PCP# _____ Current patient? ☐ Yes ☐ No

Medicare-eligible ☐ No ☐ Yes, 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

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

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.

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

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 amout allowed.

☐ No change in current coverage level.

☐ I waive enrollment.

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

Beneficiar(ies) Name(s) Last, First, MI		Relationship	Date of Birth mm/dd/yyyy	Percentage
PRIMARY				%
PRIMARY				%
CONTINGENT				%
CONTINGENT				%

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
- ☐ 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 & 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 $ _____ ($10,000 increments)
- ☐ I waive enrollment.
- ☐ No change.

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

Beneficiar(ies) Name(s) Last, First, MI		Relationship	Date of Birth mm/dd/yyyy	Percentage
PRIMARY				%
PRIMARY				%
CONTINGENT				%
CONTINGENT				%

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 $ _____ ($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

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 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 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 dependentt 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 f or 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	**BY FAX (secured)**	**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. **BYEMAIL (non-secured)** benefits@cu.edu	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.