

Name: _____ ID#: _____

Section 1: Medical, Dental and Vision Plan Options



Important

- Reminder: Your health plans can be selected **before tax or after tax**. For more information, please visit <https://www.cu.edu/docs/before-or-after-tax>.
- CU Health Plan – Exclusive enrollments require the selection of a Primary Care Physician (PCP) for each plan participant, or one will be assigned. To find a PCP and their ID# [Click Here](#) or go to <https://www.anthem.com/cuhealthplan/find-a-doctor/>

Medical Plans

Choose your plan

Must select one box

Exclusive* – before tax

Exclusive* – after tax

Extended – before tax

Extended – after tax

High Deductible – before tax

High Deductible – after tax

Kaiser* – before tax

Kaiser* – after tax

Waive medical coverage

No change

*CU Health Plan Exclusive is only available to Colorado residents & CU Health Plan Kaiser is available in specific geographic regions in Colorado.

Choose your coverage level

Must select one box

Employee only

Employee + spouse*

Employee + child(ren)

Family (employee+spouse*+child(ren))

Waive

No change

*spouse, common-law spouse, domestic partner or civil union partner

Dental Plans

Choose your plan

Must select one box

Essential – before tax

Essential – after tax

Choice – before tax

Choice – after tax

Waive dental coverage

No change

Choose your coverage level

Must select one box

Employee only

Employee + spouse*

Employee + child(ren)

Family (employee+spouse*+child(ren))

Waive

No change

*spouse, common-law spouse, domestic partner or civil union partner

Vision Plans

Choose your plan

Must select one box

Vision - before tax

Vision - after tax

Waive vision coverage

No change

Choose your coverage level

Must select one box

Employee only

Employee + spouse*

Employee + child(ren)

Family (employee+spouse*+child(ren))

Waive

No change

*spouse, common-law spouse, domestic partner or civil union partner

Name: _____ ID#: _____

Section 1: Medical, Dental and Vision Plan Options Cont.**Important**

- **Complete** all information. If not applicable, write N/A.
- **Enrolling Dependents** in medical, dental, vision, who have NOT previously completed dependent eligibility verification, requires [DEV documentation](#) in your [employee portal](#) in addition to completing and sending your benefit elections.
- CU Health Plan – Exclusive enrollments require the selection of a Primary Care Physician (PCP) for each plan participant, or one will be assigned. To find a PCP and their ID# [Click Here](#) or go to <https://www.anthem.com/cuhealthplan/find-a-doctor/>.

Employee

Add	Male
Remove	Female
No change	(please check one – required for insurance enrollment)

Name (First, Last, MI): _____

Date of Birth (mm/dd/yyyy): _____

Spouse, Common Law, Domestic or Civil Union Partner

Add	Male
Remove	Female
No change	(please check one – required for insurance enrollment)

Name (First, Last, MI): _____

Date of Birth (mm/dd/yyyy): _____ SS Number: _____

Relationship to Employee: Spouse Common Law Spouse Domestic Partner Civil Union Partner

Is your domestic/civil union partner your qualified tax dependent for health coverage?

Yes, complete the Tax Certification of Dependency Form found at www.cu.edu/node/164116 with your enrollment.No, you will be subject to imputed income (taxable income). For more information, go to www.cu.edu/node/56944.

Name: _____ ID#: _____

Section 1: Medical, Dental and Vision Plan Options Cont.



Important

- **Complete** all information. If not applicable, write N/A.
- **Enrolling Dependents** in medical, dental, vision, who have NOT previously completed [dependent eligibility verification \(DEV\)](#), you must provide DEV documentation in your [employee portal](#) in addition to completing and sending your benefit elections.
- **Additional Children?** If you need to add more children, please make copies of this page.

Child 1

Add	Male
Remove	Female
No change	(please check one – required for insurance enrollment)

Name (First, Last, MI): _____

Date of Birth (mm/dd/yyyy): _____ SS Number: _____

Relationship to Employee:
 biological/adopted child
 step-child
 child for whom you have legal responsibility - Relationship: _____

Is the child of your domestic/civil union partner your qualified tax dependent for health coverage?
 Yes, complete the Tax Certification of Dependency Form found at www.cu.edu/node/164116 with your enrollment.
 No, you will be subject to imputed income (taxable income). For more information, go to www.cu.edu/node/56944.

Child 2

Add	Male
Remove	Female
No change	(please check one – required for insurance enrollment)

Name (First, Last, MI): _____

Date of Birth (mm/dd/yyyy): _____ SS Number: _____

Relationship to Employee:
 biological/adopted child
 step-child
 child for whom you have legal responsibility - Relationship: _____

Is the child of your domestic/civil union partner your qualified tax dependent for health coverage?
 Yes, complete the Tax Certification of Dependency Form found at www.cu.edu/node/164116 with your enrollment.
 No, you will be subject to imputed income (taxable income). For more information, go to www.cu.edu/node/56944.

Name: _____ ID#: _____

Child 3

Add	Male
Remove	Female
No change	(please check one – required for insurance enrollment)

Name (First, Last, MI): _____

Date of Birth (mm/dd/yyyy): _____ SS Number: _____

Relationship to employee:

biological/adopted child

step-child

child for whom you have legal responsibility - Relationship: _____

Is the child of your domestic/civil union partner your qualified tax dependent for health coverage?

Yes, complete the Tax Certification of Dependency Form found at www.cu.edu/node/164116 with your enrollment.No, you will be subject to imputed income (taxable income). For more information, go to www.cu.edu/node/56944.**Child 4**

Add	Male
Remove	Female
No change	(please check one – required for insurance enrollment)

Name (First, Last, MI): _____

Date of Birth (mm/dd/yyyy): _____ SS Number: _____

Relationship to employee:

biological/adopted child

step-child

child for whom you have legal responsibility - Relationship: _____

Is the child of your domestic/civil union partner your qualified tax dependent for health coverage?

Yes, complete the Tax Certification of Dependency Form found at www.cu.edu/node/164116 with your enrollment.No, you will be subject to imputed income (taxable income). For more information, go to www.cu.edu/node/56944.**Additional Children?** If you need to add more children, please make copies of this page.

Name: _____ ID#: _____

Section 2: Pretax Savings



Important

FSA

You must make a new FSA election for each Plan Year. You do not need to be enrolled in a medical plan to elect the HCFSA. Flexible Spending Account elections are irrevocable for the Plan Year. FSA elections can only be made as a new hire/newly eligible, during Open Enrollment or due to a Qualifying Life Change.

For more information visit

[Heath Care Flexible Spending Account](https://www.cu.edu/node/153399) or go to <https://www.cu.edu/node/153399>.
[Dependent Care Flexible Spending Account](https://www.cu.edu/node/153400) or go to <https://www.cu.edu/node/153400>.

HSA (can be changed at any time during the Plan Year).

For more information see the [Health Savings Account Fact Sheet \(PDF\)](#) or go to <https://www.cu.edu/node/153374>.

Health Care Flexible Spending Account (HCFSA)

Covers eligible health care expenses for you and your tax dependents. You may not exceed \$2,850 in a calendar and/or plan year.

Must select one box.

I elect \$ _____ to enroll for plan year (July 1-June 30). I understand my election will be divided by 12 months. The plan election minimum is \$120/year, and the maximum is \$2,850 per employee in a calendar and/or plan year.

I waive enrollment

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.

Must select one box.

I elect \$ _____ to enroll for plan year (July 1-June 30). I understand my election will be divided by 12 months. The plan election minimum is \$120/year, and the maximum is \$5,000 per Household in a calendar and/or plan year.

I waive enrollment

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 \$3,650 for single coverage or \$7,300 for family coverage in the calendar year (January-December 2022). If you are age 55 or older, you can make an additional contribution of \$1,000.

If you are a current CU Health Plan High Deductible plan participant and want to enroll in the HSA or are a current HSA participant and want to update your HSA, please complete the [HSA Authorization Form](#), or call Employee Services at 303-860-4200, option 3.

If you are **enrolling** in the CU Health Plan High Deductible **for the first time** and want to enroll in the Health Savings Account, please continue and complete Attachment A.

Name: _____ ID#: _____

Section 3: Basic Term Life with AD&D, Optional Life and Voluntary AD&D

If needed, you can access the Medical History Statement by clicking [here](#) or visit <https://www.cu.edu/node/115428>.

Basic Term Life with AD&D

Enrollment for the \$57,000 policy is automatic and premiums are paid by CU.

If you wish to change or designate your primary and contingent beneficiaries do it here:

- 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 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	%
Primary				%
Primary				%
Contingent				%
Contingent				%

Optional Term Life with AD&D – Employee Enrollment

To enroll or increase your coverage, you must complete and send the [Medical History Statement](#) to The Standard Insurance Company anytime during the year. You can elect in \$1,000 increments up to \$1,000,000. The Standard Insurance Company will notify you and CU if enrollment or increase is approved or denied.

The Medical History Statement can be found at <https://www.cu.edu/node/115428>.

Must select one box.

No change in current coverage level

I waive enrollment

Beneficiary(ies)	Name(s): Last, First, MI	Relationship	Date of Birth	%
Primary				%
Primary				%
Contingent				%
Contingent				%

Name: _____ ID#: _____

Section 3: Basic Term Life with AD&D, Optional Life and Voluntary AD&D Cont.

Optional Term Life with AD&D – Dependent Enrollment

Optional Life - Dependent Enrollment – [Dependent eligibility documents](#) are required unless your dependent has previously completed dependent eligibility verification. The university employee is automatically the sole beneficiary for all dependent life insurance plans.

Spouse or Partner – To enroll or increase your coverage, your spouse/partner must complete and send a [Medical History Statement](#) to The Standard Insurance Company anytime during the year. You can elect in \$1,000 increments up to \$500,000. Coverage cannot exceed the employee's Optional Term Life coverage amount. The Standard Insurance Company will notify your spouse/partner and CU if enrollment or increase is approved or denied.

The Medical History Statement can be found at <https://www.cu.edu/node/115428>.

Must select one box.

No change in current coverage level

I waive enrollment

Children – You can elect flat amounts of \$5,000 or \$10,000. No medical history statement needed. Coverage cannot exceed employee's Optional Life coverage amount.

Must select one box.

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 in current coverage level

I waive enrollment

Voluntary Accidental Death and Dismemberment – Employee Enrollment

You can elect in \$10,000 increments up to 10x your annual salary or \$250,000, whichever is less.

Must select one box.

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

No change in current coverage level

I waive enrollment

Beneficiary(ies) Name(s): Last, First, MI	Relationship	Date of Birth	%
Primary			%
Primary			%
Contingent			%
Contingent			%

Name: _____ ID#: _____

Section 3: Basic Term Life with AD&D, Optional Life and Voluntary AD&D Cont.

Voluntary Accidental Death and Dismemberment – Dependent Enrollment

Dependent Enrollment– [Dependent eligibility documents](#) are required unless your dependent has previously completed dependent eligibility verification.

Spouse/Partner – You can elect in \$10,000 increments. Coverage cannot exceed employee’s Voluntary AD&D coverage amount.

Must select one box.

I elect to enroll my spouse/partner in Voluntary AD&D in the amount of \$ _____ (\$10,000 increments)

No change in current coverage level

I waive enrollment

Child(ren)

Must select one box.

I elect to enroll my child in Voluntary AD&D in the flat amount of \$5,000

No change in current coverage level

I waive enrollment

Section 4: Short and Long Term Disability

Short Term Disability

Must select one box.

I elect to enroll in Short Term Disability

No change

I waive enrollment

Long Term Disability

Faculty and University Staff employees are automatically enrolled (opt out is unavailable) the first of the month following their anniversary date, and CU pays the premium.

Section 5: Retirement Plans

For information on CU Mandatory Retirement Plan eligibility and placement please [Click Here](#) or visit <http://www.cu.edu/node/153123>.

For information on how to enroll in CU Voluntary Retirement Plans please [Click Here](#) or visit <http://www.cu.edu/node/153431>.

Name: _____ ID#: _____

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

Authorization and Signature – Read, Sign and Send in

- 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 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 hereby authorize the University of Colorado to deduct the necessary premiums, if any, from my paycheck or bill me directly.

Signature: _____ Date: _____

Action Required

- If you are **enrolling** in the CU Health Plan High Deductible for the **first time** and want to enroll in the Health Savings Account, please continue and complete Attachment A.

OR

- If you are ready to complete your enrollment, [Click Here](#) or go to page 13.

Name: _____ ID#: _____

Attachment A: Health Savings Account (HSA) Authorization

Only complete if enrolling in the CU Health Plan High Deductible for the **first time**.

If you are a current CU Health Plan High Deductible plan participant and want to enroll in the HSA or are a current HSA participant and want to update your HSA, please complete the [HSA Authorization Form](#), or call Employee Services at 303-860-4200, option 3.

Health Savings Account (HSA) Authorization

Health Savings Account (HSA) Authorization Form

1. You must be enrolled in the CU Health Plan High Deductible as a primary member to enroll in a Health Savings Account.
2. Refer to our [HSA webpage](#) for current calendar year (Jan.- Dec. 2022) limits or go to www.cu.edu/node/153425.
3. Complete this form if you want to enroll in the HSA.
4. Review, sign and date the second page of this form.
5. Once your account is opened, you will receive a welcome packet from Optum Bank in the mail with information about using your HSA, creating an online account and the agreements governing your account.
6. Changes will be effective July 1, 2022. The contribution election made will be divided by 6 months (July – December).

Employee Information

Employee ID# _____ First Name: _____ Last Name: _____

Middle Initial: _____ Phone Number: _____ Email: _____

Enrollment Type – New Enrollment

Deduction – For current calendar year limits, refer to our [HSA webpage](#) or go to www.cu.edu/node/153425.

I elect to enroll in an annual pledge of \$ _____

I understand that my annual pledge amount entered above includes any deductions already taken in the current calendar year plus any pending deductions.

Name: _____ ID#: _____

Attachment A: Health Savings Account (HSA) Authorization Continued

Health Savings Account (HSA) Authorization

Acknowledgment: I understand and agree to the following:

1. I would like to open an Optum Bank HSA, and I am eligible to contribute to an HSA.
2. I authorize the University of Colorado to act as my agent to open an Optum Bank HSA for me and to send my name, residential address, date of birth, Social Security Number/Individual Taxpayer Identification Number, phone number, email address, country of citizenship and residency status to Optum Bank. As an agent on my behalf, the University of Colorado will receive a notice from Optum Bank, which explains that Optum Bank will obtain, verify and record information to identify me before it opens my HSA. Optum Bank does this to help the United States government fight money laundering activities and terrorism funding.
3. I agree that the University of Colorado will be my agent until the first of three events occurs:
 - I receive my HSA welcome packet from Optum Bank.
 - I give the University of Colorado my written notice that I do not want the University of Colorado to act as my agent, and the University of Colorado has enough time to act on my notice.
 - I receive a notice from Optum Bank that my application for an HSA has been declined.
4. I also authorize Optum Bank to make any inquiries it considers appropriate to determine if it should open and maintain my HSA. This may include obtaining information from a credit reporting agency for identity verification and fraud protection.

Once your account is opened, you'll receive a welcome packet in the mail with information about using your HSA, creating an online account and the agreements governing your account. If you no longer want an HSA, you'll have seven business days after receiving your welcome packet to cancel the account.

If you have other questions or would like to review the agreements, visit <https://www.optumbank.com/> or call 1-844-326-7967.

Authorization and Signature

By my signature below, I agree that for amounts paid after the date this agreement is effective, my salary will be reduced by the dollar amount elected herein. I am eligible to enroll in an HSA, and I have reviewed, understand and agree to the provisions listed under the Acknowledgement section of this agreement.

Employee Signature: _____ Date: _____

Name: _____ ID#: _____

Complete Your Enrollment Through Secure Upload

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

1. **COMPLETE** and **SIGN** (page 10)
2. **SAVE** this form to your device
3. **CLICK** to **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 [HERE](#).

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 your hire date or Qualifying Life Change.

Alternate Ways to Complete Enrollment

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, [Click Here](#) or go to <https://www.cu.edu/node/116040>. 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.