CU Benefits Enrollment/Change Form   2023-2024
GME Medical Residents, Interns and Subspecialty Fellows

- This form cannot be completed in a web browser.
    1. **Download** form to your desktop from the web browser.
    2. **Open** it in Adobe or Adobe Reader before completing.
- If you are a new employee/newly eligible, please enroll in your employee portal (https://my.cu.edu/).
- You have 31 days from your date of benefits eligibility or Qualifying Life Change to complete and send in this enrollment/change form.
- Plan information and current rate information are available on the CU Benefits website (www.cu.edu/benefits).
- If you are enrolling any dependents in medical, dental, vision, optional life and/or voluntary AD&D plans, who have **not** previously completed dependent eligibility verification (DEV), you must complete 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 (https://www.cu.edu/node/116040).
- The words underlined in blue are hyperlinks. To select the link, please press Ctrl + click the link to view the corresponding webpage or document.
- 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

Check one box only.

New hire/newly eligible   Qualifying Life Change (QLC)
Date of hire or new eligibility: _____   Date of QLC: _____
        mm/dd/yyyy   mm/dd/yyyy

If applicable, select your QLC from the list below:

Birth or adoption	Death of a spouse or partner	Employee losing eligibility
Change in dependent care needs (DCFSA)	Death of a child	Marriage or Partnership
Employee gaining eligibility	Dependent losing eligibility	Medical child support order
Dependent gaining eligibility	Divorce or legal separation	Other - Please contact a benefits professional @ 303-860-4200, Option 3

Allowable changes to benefit elections are limited based on the Qualifying Life Change. To learn what changes are permissible visit the CU Qualifying Life Changes website (https://www.cu.edu/employee-services/benefits-wellness/gme-medical-residents/gme-life-changes).

Employee Information

Completion of all sections is required.

_____

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

_____

Preferred Telephone   Preferred Email Address

Name: _____ ID# _____

Section 1: Medical, Dental and Vision Plan Options

! **Reminder:** Select your health plans according to your tax preference: *before tax or after tax*. For more information, visit the [CU Before or After Tax webpage](https://www.cu.edu/docs/before-or-after-tax) (https://www.cu.edu/docs/before-or-after-tax). This designation may only be changed during Open Enrollment after the initial election has been made for the plan year.

CU Medical Plan Options

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 plan

no change

Choose your coverage level - *must select one box*

employee only

employee + spouse**

employee + child(ren)

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

waive medical coverage

no change

CU Dental Plan Options

Choose your plan - *must select one box*

Essential – before tax

Essential – after tax

Choice – before tax

Choice – after tax

waive dental plan

no change

Choose your coverage level - *must select one box*

employee only

employee + spouse**

employee + child(ren)

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

waive dental coverage

no change

CU Vision Plan Options

Choose your plan - *must select one box*

Vision – before tax

Vision – after tax

waive vision plan

no change

Choose your coverage level - *must select one box*

employee only

employee + spouse**

employee + child(ren)

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

waive vision 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.

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

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

!

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

Enrolling dependents in medical, dental, vision, who have not previously completed dependent eligibility verification requires the completion of the [DEV form](#) in the employee portal in addition to this form. For more information on DEV, or for alternate submission instructions, visit the [CU DEV website](#) (https://www.cu.edu/node/116040).

CU Health Plan – Exclusive enrollments require the selection of a Primary Care Physician (PCP), or one will be assigned. To find a PCP and their ID# go to [Anthem's website](#). If known, please include your PCP number below.

Employee

_____
Employee Name (Last)   (First)   (Middle Initial)   Date of Birth

_____
PCP# (if applicable)

Action
add
remove
no change

Gender (please check one – required for insurance enrollment)
male
female

Spouse, Common Law, Domestic or Civil Union Partner

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

_____
Social Security Number - **required**   Employee ID of CU Spouse/Partner (if applicable)   PCP# (if applicable)

Relationship to Employee: spouse   common law spouse   domestic partner   civil union partner

Action
add
remove
no change

Gender (please check one – required for insurance enrollment)
male
female

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

Yes, complete the [Tax Certification of Dependency Form](#) (https://www.cu.edu/node/164116) with your enrollment.

No, you will be subject to imputed income (taxable income). For more information, go to the [CU Imputed Tax website](#) (http://www.cu.edu/node/56944).

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

Child 1

_____

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

_____

Social Security Number   PCP# (if applicable)

Relationship to Employee: biological/adopted   stepchild   child for whom you have legal responsibility
relationship: _____

Action	**Gender** (please check one – required for insurance enrollment)
add	male
remove	female
no change	

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

Yes, complete the Tax Certification of Dependency Form (https://www.cu.edu/node/164116) with your enrollment.

No, you will be subject to imputed income (taxable income). For more information, go to the CU Imputed Tax website (http://www.cu.edu/node/56944).

Child 2

_____

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

_____

Social Security Number   PCP# (if applicable)

Relationship to Employee: biological/adopted   stepchild   child for whom you have legal responsibility
relationship: _____

Action	**Gender** (please check one – required for insurance enrollment)
add	male
remove	female
no change	

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

Yes, complete the Tax Certification of Dependency Form (https://www.cu.edu/node/164116) with your enrollment.

No, you will be subject to imputed income (taxable income). For more information, go to the CU Imputed Tax website (http://www.cu.edu/node/56944).

Name: _____   ID# _____

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

Child 3

_____
Child's Name (Last)   (First)   (Middle Initial)   Date of Birth

_____
Social Security Number   PCP# (if applicable)

Relationship to Employee: biological/adopted   stepchild   child for whom you have legal responsibility
relationship: _____

Action   **Gender** (please check one – required for insurance enrollment)
add   male
remove   female
no change

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

Yes, complete the Tax Certification of Dependency Form (https://www.cu.edu/node/164116) with your enrollment.

No, you will be subject to imputed income (taxable income). For more information, go to the CU Imputed Tax website (http://www.cu.edu/node/56944).

Child 4

_____
Child's Name (Last)   (First)   (Middle Initial)   Date of Birth

_____
Social Security Number   PCP# (if applicable)

Relationship to Employee: biological/adopted   stepchild   child for whom you have legal responsibility
relationship: _____

Action   **Gender** (please check one – required for insurance enrollment)
add   male
remove   female
no change

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

Yes, complete the Tax Certification of Dependency Form (https://www.cu.edu/node/164116) with your enrollment.

No, you will be subject to imputed income (taxable income). For more information, go to the CU Imputed Tax website (http://www.cu.edu/node/56944).

Additional children? If you need to add more children, please make copies of this page.

Section 2: Pretax Savings

! **Flexible Spending Accounts (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).
- Dependent Care Flexible Spending Account (https://www.cu.edu/node/153400).

Health Care Flexible Spending Account (HCFSA)

You may not exceed $3,050 in a calendar 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 $3,050 per employee in a calendar and/or plan year.

I waive enrollment.

Dependent Care Flexible Spending Account (DCFSA)

You may not exceed $5,000 per household in a calendar 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)

HSA contributions can be updated at any time during the Plan Year. For more information see the Health Savings Account Fact Sheet (PDF) (https://www.cu.edu/node/153374).

- You must be enrolled in the CU Health Plan-High Deductible to enroll in the HSA.

- Your contributions may not exceed $3,850 for single coverage or $7,750 for family coverage in the calendar year (January-December 2023).

- 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 call Employee Services at 303-860-4200, option 3 or complete the HSA Authorization Form (https://www.cu.edu/node/115949).

- 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# _____

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, go to page 9.

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 call Employee Services at 303-860-4200, option 3 or complete the HSA Authorization Form (https://www.cu.edu/node/115949).

- You must be enrolled in the CU Health Plan-High Deductible as a primary member to enroll in the HSA.
- Visit the CU HSA website (www.cu.edu/node/153425) for current calendar year (Jan.- Dec. 2023) **contribution limits**.
- 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.
- Changes will be **effective July 1, 2023**. 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 (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.

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: _____

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 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**.

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 form 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, go to the DEV website (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.