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

# CU Benefits Enrollment/Change Form — Plan Year 2023-2024

## Surviving Spouse/Partner

- This form cannot be completed in a web browser.
  1. **Download** the form to your computer desktop from the web browser.
  2. **Open** the form in Adobe or Adobe Reader before completing.
- You and your dependent children have **60 days** from the date of the active/retiree's death or **31 days** from a Qualifying Life Change to complete and send in this enrollment/change form. Plan and current rate (PDF) information are available on the CU Surviving Spouse Benefits website (https://www.cu.edu/employee-services/benefits-wellness/surviving-spouse).
- Coverage for spouse and dependent children is available only if spouse and dependent children were covered at the time of employee or retiree's death. Children may enroll only if the surviving spouse is enrolling.
- 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

**Newly eligible** - benefits effective: _____
mm/dd/yyyy

**Qualifying Life Change:**

Type of Qualifying Life Change: _____

Date of Qualifying Life Change: _____
mm/dd/yyyy

For more information regarding qualifying life changes, please contact a benefits professional at 303-860-4200, option 3.

## Surviving Spouse/Partner Information

_____
Surviving Spouse/Partner Name (Last) (First) (Middle Initial)

_____
Social Security Number – **required** CU ID# (assigned by CU after initial enrollment)

_____
Preferred Telephone Preferred Email Address

_____
Home Address City State Zip Code

Is this a change of address? ☐ Yes ☐ No

## Deceased Employee/Retiree Information – Initial Enrollment Only

☐ Active ☐ Retiree – Current CU contribution _____

_____
Employee ID Number - **required** (Last) (First) (Middle Initial)

_____
Date of Employment Years of Service with CU

Name: _____ ID# _____

## 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.**
- Spouse refers to: spouse, common law, domestic partner and civil union partner.

**Option A - Under age 65 – For 401(a) only.** Complete only if you and your dependents are **not** eligible for Medicare. CU Health Plan - Exclusive is only available to Colorado residents & CU Health Plan - Kaiser is available in specific geographic regions in Colorado.

**CU Health Medical Plans:**

- ☐ Exclusive
- ☐ Kaiser
- ☐ High Deductible (HSA compatible)
- ☐ waive (irrevocable election)
- ☐ no change (only for QLC)

**Coverage Level for Medical:**

- ☐ surviving spouse only
- ☐ surviving spouse + children

**CU Health Dental Plans:**

- ☐ Essential Dental
- ☐ Choice Dental
- ☐ waive (irrevocable election)
- ☐ no change (only for QLC)

**Coverage Level for Dental:**

- ☐ surviving spouse only
- ☐ surviving spouse + children

Name: _____ ID# _____

**OPTION B - Medicare-eligible/Under age 65** – For 401(a) **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 (must be enrolled in Medicare Parts A and B) and the non-Medicare individual will be covered under the CU Health Plan – High Deductible.

**CU Health Medical Plans:**

- ☐ CU Health Plan Medicare/High Deductible (HSA compatible)
- ☐ Alternate Medicare Payment (AMP – surviving spouse must be Medicare eligible)
- ☐ waive (irrevocable election)
- ☐ no change (only for QLC)

**Coverage Level for Medical:**

- ☐ surviving spouse only
- ☐ surviving spouse + children

**CU Health Dental Plans:**

- ☐ Dental Premier
- ☐ waive (irrevocable election)
- ☐ no change (only for QLC)

**Coverage Level for Dental:**

- ☐ surviving spouse only
- ☐ surviving spouse + children

**OPTION C – Medicare-eligible** – **For 401(a) 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.

**CU Health Medical Plans:**

- ☐ CU Health Plan Medicare
- ☐ Alternate Medicare Payment (AMP – surv spouse must be Medicare eligible)
- ☐ waive (irrevocable election)
- ☐ no change (only for QLC)

**Coverage Level for Medical:**

- ☐ surviving spouse only
- ☐ surviving spouse + children

**CU Health Dental Plans:**

- ☐ Dental Premier
- ☐ waive
- ☐ no change (only for QLC)

**Coverage Level for Dental:**

- ☐ surviving spouse only
- ☐ surviving spouse + children

Name: _____ ID# _____

## Surviving Spouse Enrollment

Coverage is available only if surviving spouse was covered at the time of employee's death.

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

_____
Social Security Number

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

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

## Dependent Enrollment

Coverage is available only if children were covered at the time of employee/retiree's death, and provided surviving spouse is enrolling.

## Child 1

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

_____
Social Security Number

**Relationship to Surv Spouse**
☐ biological/adopted
☐ stepchild
☐ child for whom you have legal responsibility

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

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

## Child 2

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

_____
Social Security Number

**Relationship to Surv Spouse**
☐ biological/adopted
☐ stepchild
☐ child for whom you have legal responsibility

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

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

Name: _____ ID# _____

## Child 3

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

_____
Social Security Number

**Relationship to Surv Spouse**
- ☐ biological/adopted
- ☐ stepchild
- ☐ child for whom you have legal responsibility

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

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

## Child 4

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

_____
Social Security Number

**Relationship to Surv Spouse**
- ☐ biological/adopted
- ☐ stepchild
- ☐ child for whom you have legal responsibility

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

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

## Child 5

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

_____
Social Security Number

**Relationship to Surv Spouse**
- ☐ biological/adopted
- ☐ stepchild
- ☐ child for whom you have legal responsibility

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

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

Name: _____ ID# _____

## General Fraud Statement

Any surviving spouse, 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 (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: _____

Name: _____ ID# _____

## Complete Your Enrollment

Documents with personal information should never be emailed for security reasons. Please mail or fax your enrollment form. Retain a copy for your records. If you need additional assistance, contact Employee Services at 303-860-4200, option 3.

**Mail:**

Employee Services
University of Colorado
1800 Grant Street, Suite 400
Denver, CO 80203

**Fax:**

Attention: Employee Services
303-860-4299 (retain a copy of the fax transmission)