

CU Benefits Enrollment/Change Form Plan Year 2022-2023

Surviving Spouse/Partner

Instructions

- This form cannot be completed in a web browser, please **download** it to your desktop and **open** it in Adobe or Adobe Reader before completing.
- You have **31 days** from your date of your Qualifying Life Change to complete and submit this enrollment/change form. [Plan Information](#) and current [rate \(PDF\)](#) information are available at <https://www.cu.edu/employee-services/benefits-wellness/surviving-spouse>
- Coverage for dependent children is available only if dependent children were covered at the time of employee's death.
- 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

Newly Eligible Surviving Spouse – Benefits effective: _____
mm/dd/yyyy

Qualifying Life Change:

Type of Qualifying Life Change: _____

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

Allowable changes to benefit elections are limited based on the Qualifying Life Change. [Click Here](#) to learn what changes are permissible or visit: www.cu.edu/employee-services/benefits-wellness/current-employee/life-changes

Surviving Spouse/Partner Information

Completion of all sections is required

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

Completion of all sections is required Active Retiree – Current CU Contribution _____

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

Date of Employment _____ Years of Service with CU _____

Name: _____ ID #: _____

Section 1: Medical and Dental

Complete one option (A, B or C) below. **Check** one box under CU Health Plan, one box under Dental Plan Options, and one box under Coverage Levels.

| | | |
|---|---|--|
| OPTION A – UNDER AGE 65 – For surviving spouses/children of 401(a) employee/retirees. Complete this option only if you and your dependents are NOT eligible for Medicare. | | |
| CU Health Medical Plans: Exclusive* Kaiser* High Deductible (HSA Compatible) Waive medical coverage (irrevocable) No change *CU Health Plan Exclusive is only available to Colorado residents & CU Health Plan Kaiser is available in specific geographic regions in Colorado. | CU Health Dental Plans: Essential Dental Choice Dental Waive dental coverage (irrevocable) No change | Coverage Level: Medical Dental Surv Spouse Only Surv Spouse + Child(ren) Waive coverage No change |
| OR | | |
| OPTION B – MEDICARE-ELIGIBLE/UNDER AGE 65 – For surviving spouses/children of 401(a) employee/retirees ONLY**. Complete this option if you need coverage for individuals who ARE Medicare eligible AND individuals who ARE NOT eligible for Medicare. *** (Over/Under Plan) | | |
| CU Health Medical Plans: Choose only 1 of the following options: CU Health Plan – Medicare**/High Deductible (HSA Compatible) Alternate Medicare Payment (AMP) – Surv Spouse must be Medicare eligible Waive medical coverage (NO medical/NO AMP. Irrevocable election) No change | CU Health Dental Plans: Dental Premier Waive dental coverage (irrevocable) No change | Coverage Level: Medical Dental Surv Spouse Only Surv Spouse + Child(ren) Waive coverage No change |
| OR | | |
| OPTION C – MEDICARE-ELIGIBLE – For 401(a) retirees ONLY. Complete this option if you and your dependents ARE eligible for Medicare. | | |
| CU Health Medical Plans: Choose only 1 of the following options: CU Health Plan – Medicare** Alternate Medicare Payment (AMP) Waive medical coverage (NO medical/NO AMP. Irrevocable election) No change | CU Health Dental Plans: Dental Premier Waive dental coverage (irrevocable) No change | Coverage Level: Medical Dental Surv Spouse Only Surv Spouse + Child(ren) Waive coverage No change |

*The Medicare individual will be covered under the CU Medicare (must be enrolled in original Medicare Parts A and B) and the non-Medicare individual will be covered under the CU Health Plan – High Deductible plan.

**If enrolling in the CU Health Plan – Medicare, individual must be enrolled in original Medicare Parts A and B. Documentation required.

Name: _____ ID#: _____

Dependent Enrollment**Important**

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

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

Surviving Spouse Enrollment

Last, First, MI _____

Gender: Male Female Date of Birth (mm/dd/yyyy): _____ SS Number _____
(please check one – required for insurance enrollment)

Medicare-eligible? Yes No Medicare Claim Number: _____ (Documentation required)

Child 1

Last, First, MI _____

Gender: Male Female Date of Birth (mm/dd/yyyy): _____ SS Number _____
(please check one – required for insurance enrollment)

Relationship to Surv Spouse: Biological/adopted Child Stepchild (child of spouse/partner)
Child for whom you have legal responsibility

Medicare-eligible? Yes No Medicare Claim Number: _____ (Documentation required)

Child 2

Last, First, MI _____

Gender: Male Female Date of Birth (mm/dd/yyyy): _____ SS Number _____
(please check one – required for insurance enrollment)

Relationship to Surv Spouse: Biological/adopted Child Stepchild (child of spouse/partner)
Child for whom you have legal responsibility

Medicare-eligible? Yes No Medicare Claim Number: _____ (Documentation required)

Child 3

Last, First, MI _____

Gender: Male Female Date of Birth (mm/dd/yyyy): _____ SS Number _____
(please check one – required for insurance enrollment)

Relationship to Surv Spouse: Biological/adopted Child Stepchild (child of spouse/partner)
Child for whom you have legal responsibility

Medicare-eligible? Yes No Medicare Claim Number: _____ (Documentation required)

Name: _____ ID#: _____

General Fraud Statement

Any surviving spouse, surviving spouse'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: _____

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 4)
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](#).

If you do not have an employee ID, please use one of the alternate submission options.

Dependent eligibility verification (DEV)

If you are enrolling a NEW dependent that has not completed [dependent eligibility verification \(DEV\)](#) 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.