

# CU Benefits Spring Open Enrollment Form Plan Year 2026-2027

## Surviving Spouse/Partner

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Open Enrollment elections can be made during the dates:

8:00 a.m. MDT, April 20, 2026 - 5:00 p.m. MDT, May 8, 2026

Open Enrollment (OE) Elections – **Effective July 1, 2026**

Complete this form and submit to Employee Services using the options listed on [page 5](#) during Open Enrollment by  
5:00 p.m. MDT, May 8, 2026.

If you **do not want** to make changes for the new plan year July 1, 2026 - June 30, 2027,

**you do not** need to fill out this form.

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### Instructions

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- 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.
    3. **Submit** the form.
  - Plan and current rate information are available on the [CU Open Enrollment website](http://www.cu.edu/oe) (www.cu.edu/oe).
  - 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.
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### Surviving Spouse/Partner Information

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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

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## Section 1: Medical and Dental Plan Options

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- Complete **one** option (A or B).
- 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.

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**Option A - Under age 65 – For 401(a) only.** Complete only if you and your dependents are **not** eligible for Medicare.

The medical CU Health Plan - Exclusive and the CU Health Plan - Kaiser are only available to Colorado residents.

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**CU Health Medical Plans:**

Exclusive  
High Deductible  
Kaiser  
Pathway  
waive (irrevocable election)  
no change

**Coverage Level for Medical:**

surviving spouse only  
surviving spouse + children

**CU Health Dental Plans:**

Essential Dental  
Choice Dental  
waive (irrevocable election)  
no change

**Coverage Level for Dental:**

surviving spouse only  
surviving spouse + children

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**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 Plan (plan year 1/1-12/31) (must be enrolled in Medicare Parts A and B) and the non-Medicare individual will be covered under the CU Health Plan – High Deductible (plan year 7/1-6/30).

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**CU Health Medical Plans:**

CU Health Plan Medicare/High Deductible  
Alternate Medicare Payment (AMP – surv.spouse must be Medicare, children not eligible for AMP)  
waive (irrevocable election)  
no change

**Coverage Level for Medical:**

surviving spouse only  
surviving spouse + children

**CU Health Dental Plans:**

Dental Premier  
waive (irrevocable election)  
no change

**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

U/X (unspecified or another gender identity)

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

U/X (unspecified or another gender identity)

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

U/X (unspecified or another gender identity)

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  
U/X (unspecified or another gender identity)

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  
U/X (unspecified or another gender identity)

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  
U/X (unspecified or another gender identity)

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

Name: \_\_\_\_\_ ID# \_\_\_\_\_

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## General Fraud Statement

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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.

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## Authorization and Signature – Read, Sign and Send in

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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](http://www.cu.edu/benefits) (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: \_\_\_\_\_

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## Complete Your Enrollment: How to Upload This Form

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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)