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

CU Benefit Enrollment/Change Form Plan Year 2020-2021

Faculty, Officers, University Staff

Instructions

- If you are a new employee/newly eligible, please enroll in your employee portal at my.cu.edu.
- You have 31 days from your date of benefits eligibility or qualifying life change to complete and submit this enrollment/change form. Plan information and current rate information are available at 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 been verified, you must provide dependent eligibility verification documentation electronically or attach all required documentation to this form (see Attachment A).
- 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.

Type of Enrollment

Check one box only

☐ **New Hire/Newly Eligible** - Date of hire or new eligibility: _____
mm/dd/yyyy

☐ **Qualifying Life Change** (choose from the list below): _____

- Birth or adoption
- Change from Classified Staff to Univeristy/Faculty Staff
- Change in dependent care needs
- Change of residence out of health plan's network
- Death of a spouse or partner
- Death of a child
- Dependent gaining eligibility
- Dependent losing eligibility
- Divorce or legal separation
- Employee gaining eligibility
- Employee losing eligibility
- Marriage or Partnership
- Medical child support order
- Other - Please contact a benefits professional @ 303-860-4200, Option 3

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

☐ **Beneficiary(ies) Update** – Effective the date of employee's signature on this form. Complete information below, section 2 and signature.

Employee Information

Completion of all sections is required

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

Personal Telephone Campus Telephone Email Address

Name: _____ ID #:_____

Section 1: Medical/Dental and Vision Plan Options

Medical Plans

Important

Make one selection in each category.

Choose your plan

Select one box only

- ☐ 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

Choose your coverage level

Select one box only

- ☐ Employee only
- ☐ Employee + spouse*
- ☐ Employee + child(ren)
- ☐ Family (employee+spouse+child(ren)
- ☐ No change

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

Dental Plans

Choose your plan

Select one box only

- ☐ Essential – before tax
- ☐ Essential – after tax
- ☐ Choice – before tax
- ☐ Choice – after tax
- ☐ Waive dental coverage
- ☐ No change

Choose your coverage level

Select one box only

- ☐ Employee only
- ☐ Employee + spouse*
- ☐ Employee + child(ren)
- ☐ Family (employee+spouse+child(ren)
- ☐ No change

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

Vision Plan

Choose your plan

Select one box only

- ☐ Vision – before tax
- ☐ Vision – after tax
- ☐ Waive vision coverage
- ☐ No change

Choose your coverage level

Select one box only

- ☐ Employee only
- ☐ Employee + spouse*
- ☐ Employee + child(ren)
- ☐ Family (employee+spouse+child(ren)
- ☐ No change

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

Name: _____ ID #:_____

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

Health Plan Participants

Important

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

Enrolling dependents in medical, dental, vision, optional life, and/or voluntary AD&D plans, who have NOT previously been verified, requires dependent eligibility verification documentation electronically or attach all required documentation to this form. For further information, see Attachment A.

Employee ☐ Add ☐ Remove ☐ No change ☐ Male ☐ Female

Name (First, Last, MI): _____

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

If enrolling in Exclusive*: PCP ID # _____ Current patient? ☐ Yes ☐ No

Medicare Eligible: ☐ Yes ☐ No

Medicare Claim Number: _____

Spouse, Common Law, Domestic Partner, Civil Union Partner ☐ Add ☐ Remove ☐ No change ☐ Male ☐ Female

Name (First, Last, MI): _____

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

Relationship to employee:

☐ spouse
☐ common law
☐ domestic partner
☐ civil union

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

☐ Yes, submit 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.

If enrolling in Exclusive*: PCP ID # _____ Current patient? ☐ Yes ☐ No

Medicare-eligible? ☐ Yes ☐ No

Medicare Claim Number: _____

***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

Name: _____ ID #:_____

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

Health Plan Participants

Important

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

Enrolling dependents in medical, dental, vision, optional life, and/or voluntary AD&D plans, who have NOT previously been verified, requires dependent eligibility verification documentation electronically or attach all required documentation to this form. For further information, see Attachment A.

Additional Children?

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

Child ☐ Add ☐ Remove ☐ No change ☐ Male ☐ Female

Name (First, Last, MI): _____

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

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, submit 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.

If enrolling in Exclusive*: PCP ID # _____ Current patient? ☐ Yes ☐ No

Medicare-eligible? ☐ Yes ☐ No

Medicare Claim Number: _____

Child ☐ Add ☐ Remove ☐ No change ☐ Male ☐ Female

Name (First, Last, MI): _____

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

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, submit 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.

If enrolling in Exclusive*: PCP ID # _____ Current patient? ☐ Yes ☐ No

Medicare-eligible? ☐ Yes ☐ No

Medicare Claim Number: _____

***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

Name: _____ ID #:_____

Section 2: Pretax Savings

FSAs

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

Dependent Care Flexible Spending Account

Health Care Flexible Spending Account (HCFSA)

Covers eligible health care expenses for you and your tax dependents. You may not exceed $2,750 in a calendar and plan year. Check one box only.

☐ I elect to enroll for Plan Year (July 1-June 30) the amount of $_____. I understand my election will be divided by the remaining months in the plan year. The plan election minimum is $120/year, and the maximum is $2,750 per employee in a calendar and plan year.

☐ I waive enrollment

☐ No change

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. Check one box only.

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

☐ I waive enrollment

☐ No change

HSA

For more information visit

Health Savings Account

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 $3,550 for single coverage or $7,100 for family coverage in the calendar year (January-December 2020). If you are age 55 or older, you can make an additional contribution of $1,000.

To increase, decrease or stop your HSA contributions please complete attachment B, or call Employee Services at 303-860-4200, Option 3.

Name: _____ ID #:_____

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

Basic Term Life with AD&D – Enrollment for the $57,000 policy is automatic and premiums are paid by CU. Designate or change your primary and contingent beneficiaries 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 Life - Employee Enrollment – You can elect $1,000 increments up to $1,000,000. If you are a new hire or newly eligible, you can elect 3x your salary without a medical history. To enroll after your new hire or increase your coverage, you must complete the Medical History Statement and be approved by *The Standard*.

☐ I elect to enroll in Optional Term Life/AD&D in the amount of $_____ ($1,000 increments only)

- ☐ Standard Rate (tobacco use in the last 12 months)
- ☐ Discount Rate (no tobacco use in the last 12 months)

☐ 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

Optional Life - Dependent Enrollment – Dependent eligibility documents are required unless your dependent has been previously verified. The university employee is automatically the sole beneficiary for all dependent life insurance plans.

Spouse or Partner – You can elect in $1,000 increments up to $500,000. If spouse/partner newly eligible you may elect up to $50,000 without medical history. Coverage cannot exceed the employee's Optional Term Life coverage amount. To enroll or increase your coverage, your spouse/partner must complete the Medical History Statement, send to The Standard and be approved by The Standard. The Standard will notify your spouse/partner and CU if enrollment or increase is approved or denied.

- ☐ I elect to enroll my spouse/partner in Optional Life in the amount of $_____($1,000 increments). Initial eligibility – max amount is $50,000. Qualifying Life Change – max amount of increase is $10,000, not to exceed $50,000.
  - ☐ Standard Rate (tobacco use in the last 12 months)
  - ☐ Discount Rate (no tobacco use in the last 12 months)
- ☐ 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.

- ☐ 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 & Dismemberment – Employee Enrollment– You can elect in $10,000 increments up to 10x your annual salary or $250,000, whichever is less.

- ☐ 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

Voluntary Accidental Death & Dismemberment – Dependent Enrollment–Dependent eligibility documents are required unless your dependent has been previously verified.

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

- ☐ 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)

- ☐ 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 Term and Long Term Disability

Short Term Disability

- ☐ I elect to enroll in Short Term Disability
- ☐ No change
- ☐ I waive enrollment

Long Term Disability

As a Faculty and University Staff employee, you will be automatically enrolled (opt out is unavailable) the first of the month following your one-year anniversary date, and CU pays the premium.

Section 5: Retirement Plans

For information on CU mandatory retirement plan eligibility and placement please Click Here.

For information on how to enroll in CU voluntary retirement plans please Click Here.

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

Authorization and Signature – Read, Sign and Submit

- 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 submitting 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: _____

How to Return your Benefits Enrollment Change Form and all applicable attachments

ELECTRONICALLY

If you are ready to submit your form, scroll to the bottom of this document and hit the submit button.

BY MAIL

Make a copy for your records and send the original to:

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

BY FAX (secured)

303-860-4299

Keep a copy of the fax transmission

BY EMAIL (non-secured)

benefits@cu.edu

IN PERSON

Bring your completed original form and a copy for your records to Employee Services. The receptionist will date stamp both your original and your copy. Employee Services will keep the original.

Name: _____ ID #:_____

Additional benefit document if applicable

Attachment A: Dependent Eligibility Verification

DEPENDENT ELIGIBILITY VERIFICATION (DEV) and REQUIRED DOCUMENTS

INSTRUCTIONS

1. Review the required documents below for verifying the eligibility of your dependents and review the definitions.
2. Use the check boxes below to indicate the dependent you are verifying and the corresponding required documents you are submitting.
3. Attach the required documents to this Benefit Enrollment/Change form and submit. Alternatively, you may upload your documents via your employee portal.

EMPLOYEE INFORMATION

Employee ID#: _____

Last Name: _____ First Name: _____ Middle Initial: _____

DEPENDENT TYPE

	Spouse	Most recent Federal Tax return form showing a married filing status. You must include the signed signature page or Certificate of Electronic filing.	or	Marriage Certificate and one Secondary Verification Document
	Common Law Spouse	CU Affidavit of Common Law	and	One Secondary Verification Document
	Civil Union Partner	Civil Union Certificate	and	One Secondary Verification Document
	Domestic Partner	CU Affidavit of Domestic Partnership	and	Two Secondary Verification Documents
	Child under the age of 27	Birth or Adoption Certificate	or	Court documents signed by a judge for parental responsibility or QMCSO
	Disabled Child over the age of 27	Birth or Adoption Certificate	and	A medical certificate of disability or Notice of Determination from the Social Security Administration

Continue to next page

Name: _____ ID #:_____

Additional benefit document if applicable

Attachment A: Dependent Eligibility Verification Cont.

SECONDARY VERIFICATION DOCUMENTS: (must be dated within the last 60 days)

- Joint ownership of residence or other real estate
- Lease agreement on home or another property listing both names
- Joint ownership of a motor vehicle
- Designation of dependent as primary beneficiary of the employee's life insurance or retirement benefits
- Utility bill listing the employee and dependent on the bill or two separate utility bills, one listing the employee and one listing the dependent at the same address

DEPENDENT DEFINITIONS

Spouse	A current spouse of a legal marriage. A legally separated or ex-spouse is not an eligible dependent.
Common Law Spouse	A current spouse of a common law. A legally separated or ex-spouse is not an eligible dependent.
Civil Union Partner	A current partner of a civil union. A legally separated or ex-partner in a Civil Union is not an eligible dependent.
Domestic Partner	A current domestic partner in a committed domestic partnership. The domestic partner must share a residence with the employee and have done so for at least twelve (12) consecutive months. A domestic ex-partner is not an eligible dependent.
Child under the age of 27	• Biological child • Child for whom there are parental responsibility documents issued by a court • Legally adopted child • Child of a current same-gender domestic partner or current civil union partner • Child legally place for adoption or foster care • Child for whom there is a Qualified Medical Child Support Order (QMCSO) • Stepchild as long as the employee and parent are married
Disabled Child over the age of 27	Unmarried; not covered by other government programs; covered under the University plan prior to turning age 27; and wholly dependent upon the employee for support and maintenance.

Individuals who are NOT eligible for university benefits include, but are not limited to, the employee's or spouse/civil union partner/domestic partner's: parent, grandparents, great-grandparents, siblings, nieces and nephews, aunts and uncles, cousins, grandchildren, great-grandchildren, ex-spouses, civil union ex-partners, domestic ex-partners, renters, boarders, tenants, employees, and any other individual not listed in the eligible dependents definitions.

Resources to Obtain Documents:
CU Website to obtain affidavits: https://www.cu.edu/benefits
Birth Certificates & Marriage Licenses: http://www.cdphe.state.co.us/certs/
Birth Certificates & Marriage Licenses nationwide: http://www.vitalchek.com
Children born outside of the United States: http://www.state.gov

Wisconsin law (Statute 69.24) strictly prohibits the copying of any vital records; therefore, if your vital record documentations from the state of Wisconsin you must obtain and submit a true certified copy. DO NOT send originals or uncertified copies, as they will not be accepted.

Name: _____ ID #:_____

Additional benefit document if applicable

Attachment B: 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 limits: http://www.cu.edu/node/153425
3. Complete this form if you want to enroll, change or stop deductions for your HSA.
4. Review, sign and date the second page of this form.
5. Submit this form to Employee Services (ES) by the 10th of the month in which the change is to be effective to ensure that your election is entered for that monthly pay cycle.
6. 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.

Employee Information

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

Middle Initial: _____ Phone Number: _____ Email: _____

Enrollment Type (select one): Effective Date: _____

- ☐ New enrollment
- ☐ Change in enrollment
- ☐ Stop contributions

Deduction – For current calendar year limits, refer to our HSA webpage: http://www.cu.edu/node/153425

Select one box only and fill out the deduction amount(s):

☐ 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.

☐ I elect a one-time lump sum amount of $ _____
I understand that the lump sum will replace my regular monthly deduction amount for the month in which it is taken.

My Annual pledge will be $ _____ after the lump sum is taken.
I understand my Annual pledge mount includes any deductions already taken in the current calendar year plus any pending deductions, including this lump sum.

Continue to next page

Name: _____ ID #:_____

Additional benefit document if applicable

Attachment B: Health Savings Account (HSA) Authorization Cont.

Read and Sign Below

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: _____

Hit submit to electronically submit your form

If you are submitting dependent verification documents, please attach them to the email after you hit submit.

SUBMIT