

Name: _____ ID# _____

CU Benefits Medicare Open Enrollment Form 2027 Plan Year

401(a) Retiree Surviving Spouse/Partner

Open Enrollment elections can be made during these dates:

8:00 a.m. MST, October 12, 2026 – 5:00 p.m. MST, October 23, 2026.

Open Enrollment (OE) Elections – **Effective January 1, 2027**

Complete this form and submit to Employee Services using the options listed on [page 5](#) during Open Enrollment by 5:00 p.m. MST, October 23, 2026.

If you **do not want** to make changes for the new benefit year January 1, 2027 – December 31, 2027, **you do not** need to complete this form.

Instructions

- This form cannot be completed in a web browser.
 1. **Download** (Save) the form to your computer desktop from the web browser. Change download to save
 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 Medicare Open Enrollment website](http://www.cu.edu/medicare) (www.cu.edu/medicare).
- 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.

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

Section 1: Medical and Dental Plan Options

- 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.

Medicare-eligible 401(a): Select a plan and designate the coverage level for the new plan year.

CU Health Medical Plans:

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

Coverage Level for Medical:

- ☐ surviving spouse only
- ☐ surviving spouse + children
- ☐ waive

CU Health Dental Plans:

- ☐ CU Health Plan – Premier Dental
- ☐ waive (irrevocable election)
- ☐ no change

Coverage Level for Dental:

- ☐ surviving spouse only
- ☐ surviving spouse + children
- ☐ waive

*The Medicare-eligible member(s) will be enrolled in the CU Health Plan – Medicare plan (1/1 - 12/31) and the non-Medicare member(s) will be enrolled in the CU Health Plan – High Deductible plan. The CU Health Plan – High Deductible plan will have a different plan year (7/1 - 6/30) and the rates are subject to change 7/1 when the plan rates are underwritten for the new plan year.

Name: _____ ID# _____

Surviving Spouse/Partner and Dependent Enrollment

Continued coverage is available only if surviving spouse and children were enrolled at the time of employee/retiree/s death.

Surviving Spouse Enrollment

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)

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# _____

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](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: _____

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)