

# CU Benefits Open Enrollment Form

## Classified Staff

## Plan Year 2021-2022

### Instructions

- If you are filling this form out in a web browser, please download it to your desktop and open it in Adobe or Adobe Reader before completing.
- You have until 5 p.m. MDT on May 7th to complete your Open Enrollment via this form or via your portal at my.cu.edu. [Plan information](#) and current [rate \(PDF\)](#) information are available at [www.cu.edu/benefits](http://www.cu.edu/benefits).
- Failure to make a specific benefit election on this form, the default enrollment for that specific coverage will be considered your election.
- 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 in your [employee portal](#) in addition to completing and sending this Benefits Enrollment/Change Form.
- 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

#### OPEN ENROLLMENT (OE) Elections – Effective July 1, 2021

Open Enrollment ends May 7, 2021, at 5:00 p.m. Mountain Daylight Time.

### Employee Information

*Completion of all sections is required*

Employee ID Number – <b>REQUIRED</b>	Name (Last)	(First)	(Middle Initial)
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Personal Telephone	Campus Telephone	Email Address
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## Section 1: Medical, Dental and Vision Plan Options



### Important

- Make one selection in each category.

### Medical Plans

#### 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

\*CU Health Plans Exclusive & Kaiser are only available to Colorado residents.

#### 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 Plans

#### 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.****Important**

- **Complete** all information. If not applicable, write N/A.
- **Enrolling Dependents** in medical, dental, vision, who have NOT previously been verified, requires dependent eligibility verification documentation in your [employee portal](#) in addition to completing and sending your benefit elections.

**Employee**

Add  
Remove  
No change

Male  
Female

Name (First, Last, MI): \_\_\_\_\_

Date of Birth (mm/dd/yyyy): \_\_\_\_\_ SS Number: \_\_\_\_\_

Medicare-eligible? Yes      No      Medicare Claim Number: \_\_\_\_\_

**Spouse, Common Law, Domestic or Civil Union Partner**

Add  
Remove  
No change

Male  
Female

Name (First, Last, MI): \_\_\_\_\_

Date of Birth (mm/dd/yyyy): \_\_\_\_\_ SS Number: \_\_\_\_\_

Relationship to Employee:    Spouse    Common Law Spouse    Domestic Partner    Civil Union Partner

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

Yes, complete the Tax Certification of Dependency Form found at [www.cu.edu/node/164116](http://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](http://www.cu.edu/node/56944).

Medicare-eligible? Yes      No      Medicare Claim Number: \_\_\_\_\_

**\*CU Health Plan – Exclusive:** Enrollment in this medical option requires 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.****Important**

- **Complete** all information. If not applicable, write N/A.
- **Enrolling Dependents** in medical, dental, vision, who have NOT previously been verified, requires dependent eligibility verification documentation in your [employee portal](#) in addition to completing and sending your benefit elections.
- **Additional Children?** If you need to add more children, please make copies of this page.

**Child 1**

Add  
Remove  
No change

Male  
Female

Name (First, Last, MI): \_\_\_\_\_

Date of Birth (mm/dd/yyyy): \_\_\_\_\_ SS Number: \_\_\_\_\_

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, complete the Tax Certification of Dependency Form found at [www.cu.edu/node/164116](http://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](http://www.cu.edu/node/56944).

Medicare-eligible? Yes No Medicare Claim Number: \_\_\_\_\_

**Child 2**

Add  
Remove  
No change

Male  
Female

Name (First, Last, MI): \_\_\_\_\_

Date of Birth (mm/dd/yyyy): \_\_\_\_\_ SS Number: \_\_\_\_\_

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, complete the Tax Certification of Dependency Form found at [www.cu.edu/node/164116](http://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](http://www.cu.edu/node/56944).

Medicare-eligible? Yes No Medicare Claim Number: \_\_\_\_\_

**\*CU Health Plan – Exclusive:** Enrollment in this medical option requires 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



### Important

#### FSA's

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**

[Health Care Flexible Spending Account](#)

[Dependent Care Flexible Spending Account](#)

**HSA** (can be changed at any time during the Plan Year).

**For more information see the** [Health Savings Account Fact Sheet \(PDF\)](#)

## 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 12 months. The plan election minimum is \$120/year, and the maximum is \$2,750 per employee in a calendar and plan year.

I waive enrollment

## 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 12 months. The plan election minimum is \$120/year, and the maximum is \$5,000 per Household in a calendar and plan year.

I waive enrollment

## 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 \$3,600 for single coverage or \$7200 for family coverage in the calendar year (January-December 2021). 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 A, 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 \$50,000 policy is automatic and premiums are paid by CU.

If you wish to change or designate your primary and contingent beneficiaries do it 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.

<b>Beneficiary(ies)</b>	<b>Name(s): Last, First, MI</b>	<b>Relationship</b>	<b>Date of Birth</b>	<b>%</b>
Primary				%
Primary				%
Contingent				%
Contingent				%

**Optional Term Life with AD&D – Employee Enrollment**

To enroll or increase your coverage, you must complete and send the [Medical History Statement](#) to The Standard Insurance Company anytime during the year. You can elect in \$1,000 increments up to \$1,000,000. The Standard Insurance Company will notify you and CU if enrollment or increase is approved or denied.

No change in current coverage level

I waive enrollment

<b>Beneficiary(ies)</b>	<b>Name(s): Last, First, MI</b>	<b>Relationship</b>	<b>Date of Birth</b>	<b>%</b>
Primary				%
Primary				%
Contingent				%
Contingent				%

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

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

**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** – To enroll or increase your coverage, your spouse/partner must complete and send a [Medical History Statement](#) to The Standard Insurance Company anytime during the year. You can elect in \$1,000 increments up to \$500,000. Coverage cannot exceed the employee's Optional Term Life coverage amount. The Standard Insurance Company will notify your spouse/partner and CU if enrollment or increase is approved or denied.

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 and 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 Cont.

#### Voluntary Accidental Death and Dismemberment – Dependent Enrollment

**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 and Long Term Disability and Retirement

**Short Term Disability** – Classified employees are automatically enrolled in Short Term Disability. CU pays the premium.

**Long Term Disability** – You can apply at any time. To apply for coverage, you must complete the [Medical History Statement](#) and sent it to The Standard Insurance Company for approval. You must work a minimum of 30 hours/week.

I waive enrollment

No change

You must contact Employee Services if you become vested with PERA. Upon notification, you will be enrolled in the vested rate on the next available pay period.

### 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 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](http://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: \_\_\_\_\_

### Action Required

- If you are completing the Health Savings Account (HSA) enrollment, please continue and complete Attachment A.
- OR
- If you are ready to complete your enrollment, [Click Here](#).

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

## Attachment A: Health Savings Account (HSA) Authorization

*Additional benefit document: Only complete if enrolling(ed) in CU Health Plan – High Deductible.*

### 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: [www.cu.edu/node/153425](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. Send this form to Employee Services (ES) by the 10<sup>th</sup> 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: www.cu.edu/node/153425](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 amount includes any deductions already taken in the current calendar year plus any pending deductions, including this lump sum.

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

## Attachment A: Health Savings Account (HSA) Authorization Continued

### Health Savings Account (HSA) Authorization

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: \_\_\_\_\_

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 10)
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](#).

### Dependent eligibility verification (DEV)

If you are enrolling a NEW dependent that has not been verified 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, you can utilize the [DEV paper form](#). 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.