

# CU Benefits Open Enrollment Form Plan Year 2021-2022

## GME Medical Residents, Interns and subspecialty Fellows

### 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](http://my.cu.edu). Only use this form if you are unable to access your portal. [Plan information](#) and current [rate](#) 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 and/or vision 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

**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*

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

## Medical, Dental and Vision Plan Options



### Important

- Make one selection in each category.

## Medical Plan

### Choose your plan

*Select one box only*

Exclusive\* – before tax

Exclusive\* – after tax

Waive – You will be required to provide proof of other coverage if you choose to waive. Please contact the [GME Benefits Office](#).

\*CU Health Plan Exclusive is 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 Plan

### Choose your plan

*Select one box only*

Essential – before tax

Essential – 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.**



**Important**

- **Health Plan Participants: 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	Male
Remove	Female
No change	

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	Male
Remove	Female
No change	

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

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

Relationship to employee:  
spouse  
common law  
domestic partner  
civil union

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**

- **Health Plan Participants: 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**

Add	Male
Remove	Female
No change	

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**

Add	Male
Remove	Female
No change	

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



### FSAs

You do not need to be enrolled in a CU 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 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

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 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: \_\_\_\_\_

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.