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

CU Benefits Enrollment/Change 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.
- 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 send in 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 and/or vision who have NOT previously been verified, you must provide dependent eligibility verification documentation in your employee portal in addition to completing and sending this Benefit 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

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 in dependent care needs
Death of a spouse or partner
Death of a child
Dependent gaining eligibility
Dependent losing eligibilty
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

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#:_____

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
☐ 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
☐ 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 with your enrollment.
☐ No, you will be subject to imputed income (taxable income). For more information, go to www.cu.edu/node/56944.

Medicare-eligible? Yes ☐ No ☐ Medicare Claim Number: _____

***CU Health Plan – Exclusive**, that all GME employees are covered under, 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.

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
☐ 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 with your enrollment.
☐ No, you will be subject to imputed income (taxable income). For more information, go to www.cu.edu/node/56944.

Medicare-eligible? Yes ☐ No ☐ Medicare Claim Number: _____

Child

☐ 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 with your enrollment.
☐ No, you will be subject to imputed income (taxable income). For more information, go to www.cu.edu/node/56944.

Medicare-eligible? Yes ☐ No ☐ Medicare Claim Number: _____

***CU Health Plan – Exclusive**, that all GME employees are covered under, 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

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.

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 the date the dependent was added to benefits.

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.