

CU Benefit Enrollment/Change Form Plan Year 2020-2021

Surviving Spouse/Partner

Instructions

- If you are filling this form out in a web browser, please download it to your desktop before completing.
- You have 31 days from your date of your qualifying life change to complete and submit this enrollment/change form. [Plan information](#) and current [rate](#) information are available at www.cu.edu/benefits.
- Coverage for dependent children is available only if dependent children were covered at the time of employee's death.
- 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

Newly Eligible— Benefits effective: _____
mm/dd/yyyy

Qualifying Life Change (from the list below): _____

- Change of residence out of health plans network
- Death of a child
- Dependent or Surv Spouse gaining other eligibility
- Gaining Medicare eligibility
- 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 permissible or visit: www.cu.edu/employee-services/benefits-wellness/current-employee/life-changes

Deceased Employee/Retiree Information

Completion of all sections is required

Active

Retiree – Current CU Contribution _____

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

Date of Employment Years of Service with CU

Surviving Spouse/Partner Information

Completion of all sections is required

Surviving Spouse/Partner Name (Last) (First) (Middle Initial)

Social Security Number – **REQUIRED** CU ID # (assigned by CU after initial enrollment)

Personal Telephone Email Address

Home Address City State Zip Code

Is this a change of address? Yes No

Name: _____ ID #: _____

SECTION 1: MEDICAL/DENTAL Complete one option (A,B or C) below. **Check** one box under CU Health Plan, one box under Dental Plan Options, and one box under Coverage Levels.

OPTION A – UNDER AGE 65 – For 401(a) or PERA retirees. Complete this option only if you and your dependents are NOT eligible for Medicare.

CU Health Medical Plans:	CU Health Dental Plans:	Coverage Level:
Exclusive	Essential Dental	Medical Dental
Kaiser	Choice Dental	Surv.Spouse Only
High Deductible (HSA Compatible)	Waive dental coverage (irrevocable)	Surv.Spouse + Child(ren)
Waive medical coverage (no medical coverage. Irrevocable election)	No change (Only for Qualifying Life Change)	Waive coverage
No change (Only for Qualifying Life Change)		No Change (Only for Qualifying Life Change)

OR

OPTION B – MEDICARE-ELIGIBLE/UNDER AGE 65 –Complete this option if you need coverage for individuals who ARE Medicare eligible AND individuals who ARE NOT eligible for Medicare. (Over/Under Plan) *

CU Health Medical Plans: Choose only 1 of the following options:	CU Health Dental Plans:	Coverage Level:
CU Health Plan – Medicare**/High Deductible (HSA Compatible)	Dental Premier	Medical Dental
Alternate Medicare Payment (AMP) – Surv. Spouse must be Medicare eligible	Waive dental coverage (irrevocable)	Surv.Spouse Only
Waive medical coverage (no medical coverage/no AMP. Irrevocable election)	No change (Only for Qualifying Life Change)	Surv.Spouse + Child(ren)
No change (Only for Qualifying Life Change)		Waive coverage
		No change (Only for Qualifying Life Change)

OR

OPTION C – MEDICARE-ELIGIBLE – Complete this option if you and your dependents ARE eligible for Medicare.

CU Health Medical Plans: Choose only 1 of the following options:	CU Health Dental Plans:	Coverage Level:
CU Health Plan – Medicare**	Dental Premier	Medical Dental
Alternate Medicare Payment (AMP)	Waive dental coverage (irrevocable)	Surv.Spouse Only
Waive medical coverage (no medical coverage/no AMP. Irrevocable election)	No change (Only for Qualifying Life Change)	Surv.Spouse + Child(ren)
No change (Only for Qualifying Life Change)		Waive coverage
		No change (Only for Qualifying Life Change)

*The Medicare individual will be covered under the CU Medicare (must be enrolled in original Medicare Parts A and B) and the non-Medicare individual will be covered under the CU Health Plan – High Deductible plan.

**If enrolling in the CU Health Plan – Medicare, individual must be enrolled in original Medicare Parts A and B. Documentation required.

Name: _____ ID #: _____

**Important**

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

Enrolling Dependents

Coverage is available only if dependents were covered at the time of employee/retiree's death.

Additional Children?

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

Surviving Spouse Enrollment

Last, First, MI _____

Gender: Male Female

Date of Birth _____ SS Number _____

Medicare-eligible? Yes No

Medicare claim number: _____ (Documentation Required)

Child 1

Last, First, MI _____

Gender: Male Female

Date of Birth _____ SS Number _____

Relationship to Surv Spouse:

Biological/adopted Child Stepchild (child of spouse/partner)

Child for whom you have legal responsibility

Medicare-eligible? Yes No

Medicare claim number: _____ (Documentation Required)

Child 2

Last, First, MI _____

Gender: Male Female

Date of Birth _____ SS Number _____

Relationship to Surv Spouse:

Biological/adopted Child Stepchild (child of spouse/partner)

Child for whom you have legal responsibility

Medicare-eligible? Yes No

Medicare claim number: _____ (Documentation Required)

Child 3

Last, First, MI _____

Gender: Male Female

Date of Birth _____ SS Number _____

Relationship to Surv Spouse:

Biological/adopted Child Stepchild (child of spouse/partner)

Child for whom you have legal responsibility

Medicare-eligible? Yes No

Medicare claim number: _____ (Documentation 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 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 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 or drop off your 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.

Alternative 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.