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

CU Benefit Enrollment/Change Form Plan Year 2021-2022

Retiree

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 a health, optional life and/or voluntary AD&D plan, 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

☐ **Newly Retired**– Benefits effective: _____
mm/dd/yyyy

☐ **Qualifying Life Change**:

Type of qualifying life change: _____

Date of qualifying life change: _____
mm/dd/yyyy

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

Retiree Information

Completion of all sections is required

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

Date of Retirement (mm/dd/yyyy) | Retirement Plan 401(a) or PERA

Personal Telephone | Email Address

Home Address | City | State | Zip Code

Is this a change of address? Yes ☐ No ☐

Name: _____ ID#: _____

Section 1: Medical and 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	☐ ☐ Retiree Only
☐ High Deductible (HSA Compatible)	☐ Waive dental coverage	☐ ☐ Retiree + Child(ren)
☐ Waive medical coverage	☐ No change	☐ ☐ Retiree + Spouse*
☐ No change		☐ ☐ Family (spouse*+child(ren)
*CU Health Plans Exclusive & Kaiser are only available to Colorado residents.		☐ ☐ No change

OR

OPTION B – MEDICARE-ELIGIBLE/UNDER AGE 65 – For 401(a) retirees ONLY. 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) – retiree must be Medicare eligible	☐ Waive dental coverage	☐ ☐ Retiree Only
☐ Waive (NO medical coverage/NO AMP)	☐ No change	☐ ☐ Retiree + Child(ren)
☐ No change		☐ ☐ Retiree + Spouse*
		☐ ☐ Family (spouse*+child(ren)
		☐ ☐ No change

OR

OPTION C – MEDICARE-ELIGIBLE – For 401(a) retirees ONLY. 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	☐ ☐ Retiree Only
☐ Waive (NO medical coverage/NO AMP)	☐ No change	☐ ☐ Retiree + Child(ren)
☐ No change		☐ ☐ Retiree + Spouse*
		☐ ☐ Family (spouse*+child(ren)
		☐ ☐ No change

*Includes: Spouse, Common Law, Domestic Partner and Civil Union Partner
**The Medicare individual will be covered under the CU Medicare (must be enrolled in 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#: _____

Dependent Enrollment

Important

Complete all information. If not applicable, write N/A. If you need to add more children please make copies of this page.

Retiree Enrollment

Last, First, MI _____

Gender: Male ☐ Female ☐ Date of Birth (mm/dd/yyyy): _____

Medicare-eligible? ☐ Yes ☐ No Medicare Claim Number:_____ (Documentation Required)

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

Last, First, MI _____

Gender: Male ☐ Female ☐ Date of Birth (mm/dd/yyyy): _____ SS Number _____

Relationship to retiree: Spouse ☐ Common Law Spouse ☐ Domestic Partner ☐ Civil Union Partner ☐

Domestic/Civil Union Partners: Is your Domestic/Civil Union Partner your qualified tax dependent for health coverage?
☐ Yes, submit 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:_____(Documentation required)

Child 1

Last, First, MI _____

Gender: Male ☐ Female ☐ Date of Birth (mm/dd/yyyy): _____ SS Number _____

Relationship to retiree: ☐ Biological/adopted Child ☐ Stepchild (child of spouse/partner)
☐ Child for whom you have legal responsibility

Domestic/Civil Union Partners: Is your Domestic/Civil Union Partner your qualified tax dependent for health coverage?
☐ Yes, submit 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:_____(Documentation required)

Child 2

Last, First, MI _____

Gender: Male ☐ Female ☐ Date of Birth (mm/dd/yyyy): _____ SS Number _____

Relationship to retiree: ☐ Biological/adopted Child ☐ Stepchild (child of spouse/partner)
☐ Child for whom you have legal responsibility

Domestic/Civil Union Partners: Is your Domestic/Civil Union Partner your qualified tax dependent for health coverage?
☐ Yes, submit 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:_____(Documentation required)

Name: _____ ID#: _____

Section 2: Basic Term Life and Optional Term Life

Contact The Standard 800-378-4668 for conversion and portability information.

Basic Term Life Insurance

Retiree Enrollment - $3,000 Basic Term Life Insurance. Premium is paid by the university for normal retiree. Prorated premium for early retiree. Enrollment only available at time of retirement.

- ☐ I elect to enroll in the Retiree Basic Term Life Insurance
- ☐ I waive enrollment
- ☐ No change

Optional Term Life Insurance

Retiree Enrollment- Benefits-eligible retirees may be eligible to enroll in Optional Term Life insurance up to 25% of current optional life insurance amount not to exceed $9,500. Enrollment only available at the time of retirement and if currently enrolled.

- ☐ I elect to enroll, or decrease my enrollment in Optional Term Life insurance in the amount of $_____
  (not to exceed $9,500)
  - ☐ Discount rate (no tobacco use in the last 12 months)
  - ☐ Standard rate (tobacco use in the last 12 months)
- ☐ I waive enrollment
- ☐ No change

List your Basic Term Life & Optional Term Life beneficiary(ies) below. If you name more than one primary or contingent beneficiary, please indicate the percentage assigned to each and make sure the total in this category equals 100 percent. Use whole numbers **only**, no decimals.

Beneficiary(ies) Name(s): Last, First, MI		**Relationship**	**Date of Birth**	**%**
Primary				%
Primary				%
Contingent				%
Contingent				%

- If you do not designate a beneficiary for your life insurance, benefits will be paid according to the provisions of the Group Policy.
- Beneficiary designations on this form revoke all prior designations.
- **PRIMARY BENEFICIARY(IES)** receive the benefit in the event of your death.
- **CONTINGENT BENEFICIARY(IES)** receive the benefit only if your primary beneficiary(ies) are deceased.
- If you name more than one primary or contingent beneficiary, please indicate the percentage assigned to each and make sure the total in this category equals 100 percent. Use whole numbers **only**, no decimals.

Name: _____ ID#: _____

General Fraud Statement

Any retiree, retiree'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 benefit 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.