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

CU Benefit Enrollment/Change Form Plan Year 2020-2021

Retiree

Instructions

- You have 31 days from your date of your retirement or qualifying life change to complete and submit 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 medical and/or dental plan 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

Check one box only

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

☐ **Qualifying Life Change** (choose from the list below): _____

- Change of residence out of health plan's network
- Death of a spouse or partner
- Death of a child
- Dependent gaining eligibility
- Dependent losing eligibility
- Divorce or legal separation
- Retiree gaining eligibility
- Retiree losing eligibility
- Marriage or Partnership
- 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 .

☐ **Beneficiary(ies) Update** – Effective the date of retiree's signature on this form. Complete Retiree information below, section 2 and signature.

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/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:

- ☐ Exclusive
- ☐ Kaiser
- ☐ High Deductible (HSA Compatible)
- ☐ Waive medical coverage
- ☐ No change (Only for Qualifying Life Change)

CU Health Dental Plans:

- ☐ Essential Dental
- ☐ Choice Dental
- ☐ Waive dental coverage
- ☐ No change (Only for Qualifying Life Change)

Coverage Level:

Medical	Dental	
☐	☐	Retiree Only
☐	☐	Retiree + Child(ren)
☐	☐	Retiree + Spouse*
☐	☐	Family (spouse + child(ren)
☐	☐	No change (Only for Qualifying Life 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 Plan – Medicare**/High Deductible (HSA Compatible)
- ☐ Alternate Medicare Payment (AMP) – retiree must be Medicare eligible
- ☐ Waive medical coverage
- ☐ No change (Only for Qualifying Life Change)

CU Health Dental Plans:

- ☐ Dental Premier
- ☐ Waive dental coverage
- ☐ No change (Only for Qualifying Life Change)

Coverage Level:

Medical	Dental	
☐	☐	Retiree Only
☐	☐	Retiree + Child(ren)
☐	☐	Retiree + Spouse*
☐	☐	Family (spouse + child(ren)
☐	☐	No change (Only for Qualifying Life 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 Plan – Medicare***
- ☐ Alternate Medicare Payment (AMP)
- ☐ Waive (no medical coverage/no AMP)
- ☐ No change (Only for Qualifying Life Change)

CU Health Dental Plans:

- ☐ Dental Premier
- ☐ Waive dental coverage
- ☐ No change (Only for Qualifying Life Change)

Coverage Level:

Medical	Dental	
☐	☐	Retiree Only
☐	☐	Retiree + Child(ren)
☐	☐	Retiree + Spouse*
☐	☐	Family (spouse + child(ren)
☐	☐	No change (Only for Qualifying Life 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#: _____

Retiree Enrollment

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

Last, First, MI _____ Gender: ☐ Male ☐ Female

Date of Birth _____

Medicare-eligible? ☐ Yes ☐ No Medicare claim number: _____ (Documentation required)

Dependent Enrollment

Important: Dependent eligibility documents are required unless your dependent has been previously verified.

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

Complete all information. If not applicable, write N/A. Dependent eligibility documents are required unless your dependent has been previously verified.

Last, First, MI _____ Gender: ☐ Male ☐ Female

Date of Birth _____ SS Number _____

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

Domestic/Civil Union Partners: Is your Domestic/Civil Union Partner a qualified tax dependent for health coverage? ☐ Yes ☐ No

If Yes, submit the Tax Certification of Dependency Form found at www.cu.edu/node/164116 with your enrollment.
If 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

Complete all information. If not applicable, write N/A. Dependent eligibility documents are required unless your dependent has been previously verified.
If you need to add more children please make copies of this page.

Last, First, MI _____ Gender: ☐ Male ☐ Female

Date of Birth _____ 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 child a qualified tax dependent for health coverage? ☐ Yes ☐ No

If Yes, submit the Tax Certification of Dependency Form found at www.cu.edu/node/164116 with your enrollment.
If 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 _____ 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 a qualified tax dependent for health coverage? ☐ Yes ☐ No

If Yes, submit the Tax Certification of Dependency Form found at www.cu.edu/node/164116 with your enrollment.
If 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: Basics 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 . Pro-rated 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.

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 benefits plans, or as provided in regulations, statutes, and applicable written directives.

Name: _____ ID#: _____

Authorization and Signature – Read, Sign and Date

- 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 submitting 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 to conduct related administrative operations.
- I hereby authorize the University of Colorado to bill me directly.

Signature Date

How to Return Your Benefits Enrollment/Change Form

ELECTONICALLY
If you are ready to submit your form, scroll to the last page and hit submit.

If you need to add dependent verification, complete the applicable attachments and hit submit on the last page.

BY MAIL
Make a copy for your records and send the original to:

Employee Services
University of Colorado
1800 Grant Street, Suite 400
Denver, CO 80203

BY FAX (secured)
303-860-4299
Keep a copy of the fax transmission report with your form for your records.

BY EMAIL (non-secured)
benefits@cu.edu

IN PERSON
Bring your completed original form and a copy for your records to Employee Services. The receptionist will date stamp both your original form and your copy. Employee Services will keep the original.

Name: _____ ID#: _____

Attachment A: Dependent Eligibility Verification (If applicable)

DEPENDENT ELIGIBILITY VERIFICATION (DEV) and REQUIRED DOCUMENTS

INSTRUCTIONS

- Review the required documents below for verifying the eligibility of Your dependents and review the definitions.
- Use the check boxes below to indicate the dependent you are verifying and the corresponding required documents you are submitting.
- Attach the required documents to this Benefit Enrollment/Change form and submit. Alternatively, you may upload your documents via your employee portal.

EMPLOYEE INFORMATION

Employee ID#: _____

Last Name: _____ First Name: _____ Middle Initial: _____

DEPENDENT TYPE

	Spouse	Most recent Federal Tax return form showing a married filing status. You must include the signed signature page or Certificate of Electronic filing.	or	Marriage Certificate and one Secondary Verification Document
	Common Law Spouse	CU Affidavit of Common Law	and	One Secondary Verification Document
	Civil Union Partner	Civil Union Certificate	and	One Secondary Verification Document
	Domestic Partner	CU Affidavit of Domestic Partnership	and	Two Secondary Verification Documents
	Child under the age of 27	Birth or Adoption Certificate	or	Court documents signed by a judge for parental responsibility or QMCSO
	Disabled Child over the age of 27	Birth or Adoption Certificate	and	A medical certificate of disability or Notice of Determination from the Social Security Administration

Continue to next page

Name: _____ ID#: _____

SECONDARY VERIFICATION DOCUMENTS: (must be dated within the last 60 days)

- Joint ownership of residence or other real estate
- Lease agreement on home or another property listing both names
- Joint ownership of a motor vehicle
- Designation of dependent as primary beneficiary of the employee's life insurance or retirement benefits
- Utility bill listing the employee and dependent on the bill or two separate utility bills, one listing the employee and one listing the dependent at the same address

DEPENDENT DEFINITIONS

Spouse	A current spouse of a legal marriage. A legally separated or ex-spouse is not an eligible dependent.
Common Law Spouse	A current spouse of a common law. A legally separated or ex-spouse is not an eligible dependent.
Civil Union Partner	A current partner of a civil union. A legally separated or ex-partner in a Civil Union is not an eligible dependent.
Domestic Partner	A current domestic partner in a committed domestic partnership. The domestic partner must share a residence with the employee and have done so for at least twelve (12) consecutive months. A domestic ex-partner is not an eligible dependent.
Child under the age of 27	• Biological child • Child for whom there are parental responsibility documents issued by a court • Legally adopted child • Child of a current same-gender domestic partner or current civil union partner • Child legally place for adoption or foster care • Child for whom there is a Qualified Medical Child Support Order (QMCSO) • Stepchild as long as the employee and parent are married
Disabled Child over the age of 27	Unmarried; not covered by other government programs; covered under the University plan prior to turning age 27; and wholly dependent upon the employee for support and maintenance.

Individuals who are NOT eligible for university benefits include, but are not limited to, the employee's or spouse/civil union partner/domestic partner's: parent, grandparents, great-grandparents, siblings, nieces and nephews, aunts and uncles, cousins, grandchildren, great-grandchildren, ex-spouses, civil union ex-partners, domestic ex-partners, renters, boarders, tenants, employees, and any other individual not listed in the eligible dependents definitions.

Resources to Obtain Documents:
CU Website to obtain affidavits: https://www.cu.edu/benefits
Birth Certificates & Marriage Licenses: http://www.cdphe.state.co.us/certs/
Birth Certificates & Marriage Licenses nationwide: http://www.vitalchek.com
Children born outside of the United States: http://www.state.gov

Wisconsin law (Statute 69.24) strictly prohibits the copying of any vital records; therefore, if your vital record documentations from the state of Wisconsin you must obtain and submit a true certified copy. DO NOT send originals or uncertified copies, as they will not be accepted.

Form Submission Instructions

If you are submitting dependent verification documents, please attach them to the email after you hit submit.

SUBMIT