CU Benefit Enrollment/Change Form Plan Year 2020-2021

Surviving Spouse/Partner

Instructions

- 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** (choose from the list below):_____

- Change of residence out of health plan's network
- Dependent or Surv Spouse gaining other eligibility
- Other - Please contact a benefits professional @ 303-860-4200, Option 3
- Death of a child
- Gaining Medicare eligibility

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

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 #:_____

Surviving Spouse Enrollment

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

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

Date of Birth _____ SS Number _____

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

Dependent Enrollment

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

Child 1

Complete all information. If not applicable, write N/A. 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 Surv Spouse: ☐ Biological/adopted child ☐ Stepchild (child of deceased) ☐ Child for whom you had legal responsibility

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

Child 2

Complete all information. If not applicable, write N/A. 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 Surv Spouse: ☐ Biological/adopted child ☐ Stepchild (child of employee) ☐ Child for whom you had legal responsibility

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

Child 3

Complete all information. If not applicable, write N/A. 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 Surv Spouse: ☐ Biological/adopted child ☐ Stepchild (child of deceased) ☐ Child for whom you had legal responsibility

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

Child 4

Complete all information. If not applicable, write N/A. 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 Surv Spouse: ☐ Biological/adopted child ☐ Stepchild (child of employee) ☐ Child for whom you had 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 of the university's benefits plans, or as provided in regulations, statutes, and applicable written directives.

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, click on the submit button below.

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.

SUBMIT