Print

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

Benefits Enrollment/Change Form

2019-2020 Benefit Plan Year
Retirees

IMPORTANT - READ FIRST

- **You have 31 days from your date of retirement or qualifying life change to complete and submit this enrollment/change form. Plan information and rates are available at https://www.cu.edu/benefits**
- **If enrolling any dependents in a medical and/or dental plan who have not previously been verified, you *must* attach the required documents as listed on the Employee Services website to demonstrate dependent eligibility. Your dependents will not be enrolled in benefits if the correct documents are not attached.**
- **The form must be legible, each section must be completed in its entirety, and all necessary documentation must be attached.**
- **Incomplete and/or incorrect forms will not be processed. Consequently, your benefits could be delayed or you could risk losing enrollment eligibility for certain benefits.**

ENROLLMENT TYPE—*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

☐ **BENEFICIARY(IES) UPDATE** Effective the date of retiree's signature on this form.

RETIREE INFORMATION —*YOU ARE REQUIRED TO COMPLETE ALL SECTIONS*

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

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

SECTION 1: MEDICAL/DENTAL

Complete one option (A, B, or C) below. Be sure to check one box under CU Health Plan Options, one box under Dental Plan Options, and elect your Coverage Levels.

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

CU Health Plan Options:

- ☐ Exclusive
- ☐ Kaiser
- ☐ High Deductible (HSA Compatible)
- ☐ Waive medical coverage
- ☐ No change

CU Health Plan Dental Options:

- ☐ Essential Dental
- ☐ Choice Dental
- ☐ Waive dental coverage
- ☐ No change

Coverage Levels:

Medical	Dental
☐	☐ Retiree Only
☐	☐ Retiree + Child(ren)
☐	☐ Retiree + Spouse*
☐	☐ Family (spouse + child)
☐	☐ 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 **NOT** Medicare eligible **AND** individuals who **ARE** eligible for Medicare.

Choose 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

CU Health Plan Dental Options:

- ☐ Dental Premier
- ☐ Waive dental coverage
- ☐ No change

Coverage Levels:

Medical	Dental
☐	☐ Retiree Only
☐	☐ Retiree + Child(ren)
☐	☐ Retiree + Spouse*
☐	☐ Family (spouse + child)
☐	☐ No change

OR

OPTION C—MEDICARE-ELIGIBLE - For 401(a) retirees ONLY. Complete this option if you and your dependents **ARE** eligible for Medicare.

Choose 1 of the Following Options:

- ☐ CU Health Plan—Medicare**
- ☐ Alternate Medicare Payment (AMP)
- ☐ Waive medical coverage
- ☐ No change

CU Health Plan Dental Options:

- ☐ Dental Premier
- ☐ Waive dental coverage
- ☐ No change

Coverage Levels:

Medical	Dental
☐	☐ Retiree Only
☐	☐ Retiree + Child(ren)
☐	☐ Retiree + Spouse*
☐	☐ Family
☐	☐ No change

*Spouse includes Common Law, Domestic Partner, and Civil Union Partner

**If enrolling in the CU Health Plan—Medicare, individual must be enrolled in Medicare Parts A and B.

RETIREE ENROLLMENT

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

Last, First, MI _____ Gender ☐ Male ☐ Female

Date of Birth _____ SS Number _____

If enrolling in CU Health Plan - Exclusive you must elect a Primary Care Physician (PCP) or one will be assigned to you. To find your doctor's ID# or to find a doctor go to https://www.anthem.com/cuhealthplan and select the 'find a doctor' tab. PCP # _____ Current patient? ☐ Yes ☐ No

Medicare-eligible ☐ No ☐ Yes, Medicare Claim Number _____

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

DEPENDENT ENROLLMENT

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

SPOUSE, COMMON-LAW SPOUSE, DOMESTIC PARTNER OR CIVIL UNION PARTNER

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

Last, First, MI _____ Gender ☐ Male ☐ Female

Date of Birth _____ SS Number _____

Relationship to employee ☐ Spouse ☐ Common-law spouse ☐ Domestic partner ☐ Civil Union

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 (www.cu.edu/node/164116) with your enrollment

If NO, you will be subject to imputed income (taxable income) www.cu.edu/employee-services/imputed-income

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Medicare-eligible ☐ No ☐ Yes, Medicare Claim Number _____

CHILD(REN)

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

Important: 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 employee ☐ Biological/adopted child ☐ Stepchild (Of spouse/partner) ☐ Child for whom you have legal responsibility. List relationship _____

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 (www.cu.edu/node/164116) with your enrollment

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Medicare-eligible ☐ No ☐ Yes, Medicare Claim Number _____

Last, First, MI _____ Gender ☐ Male ☐ Female

Date of Birth _____ SS Number _____

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Medicare-eligible ☐ No ☐ Yes, Medicare Claim Number _____

Last, First, MI _____ Gender ☐ Male ☐ Female

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

SECTION 2: BASIC TERM LIFE AND OPTIONAL TERM LIFE

BASIC TERM LIFE INSURANCE

RETIREE ENROLLMENT—$3,000 Basic Term Life Insurance. Premium is paid by the University for benefits-eligible retirees receiving a 100 percent CU contribution.

- ☐ I elect to continue my enrollment in 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 to not to exceed $9,500.

- ☐ I elect to enroll continue 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:

BENEFICIARY(IES) NAME(S): Last, First, MI	Relationship	Date of Birth mm/dd/yyyy	Percentage
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.

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

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

BY MAIL	**BY FAX (secured)**	**IN PERSON**
Make a copy for your records and send the original to: Employee Services University of Colorado 1800 Grant Street, Suite 400 Denver, Colorado 80203	303-860-4299 Keep a copy of the fax transmission report with your form for your records. **BY EMAIL (non-secured)** benefits@cu.edu	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.