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

Name: _____ ID# _____

CU Benefits Medicare Open Enrollment Form 2025

401(a) Retiree Surviving Spouse/Partner

Open Enrollment elections can be made during these dates:

8:00 a.m. MST, October 7, 2024 – 5:00 p.m. MST, October 18, 2024.

Open Enrollment (OE) Elections – **Effective January 1, 2025**

Complete this form and submit to Employee Services using the options listed on page 5 during Open Enrollment by 5:00 p.m. MST, October 18, 2024.

If you **do not want** to make changes for the new benefit year January 1, 2025 – December 30, 2025, **you do not** need to complete this form.

Instructions

- This form cannot be completed in a web browser.
  1. **Download** (Save) the form to your computer desktop from the web browser. Change download to save
  2. **Open** the form in Adobe or Adobe Reader before completing.
- Plan and current rate information are available on the CU Medicare Open Enrollment website (https://www.cu.edu/node/39058).
- 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. All sections of this form must be completed.

Surviving Spouse/Partner Information

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

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

_____
Preferred Telephone Preferred Email Address

_____
Home Address City State Zip Code

Is this a change of address? ☐ Yes ☐ No

Name: _____ ID# _____

Section 1: Medical and Dental Plan Options

- Complete **one** option (A or B).
- If enrolling in the CU Health Plan – Medicare, individual must be enrolled in original Medicare Parts A and B. **Copy of Medicare Card Part A and B required.**
- Spouse refers to: spouse, common law, domestic partner and civil union partner.

OPTION A- Medicare-eligible Over/Under age 65 – **For 401(a) only**. Complete this option if you need coverage for who **are** Medicare eligible AND individuals who **are not** eligible for Medicare. The Medicare individual will be covered under the CU Medicare Plan (Plan Year 1/1 – 12/31) (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 Year 7/1 – 6/30).

CU Health Medical Plans:

- ☐ CU Health Plan Medicare/High Deductible
- ☐ Alternate Medicare Payment (AMP – surviving spouse must be eligible for Medicare, children not eligible for AMP)
- ☐ waive (irrevocable election)
- ☐ no change

Coverage Level for Medical:

- ☐ surviving spouse only
- ☐ surviving spouse + children
- ☐ waive

CU Health Dental Plans:

- ☐ Dental Premier
- ☐ waive (irrevocable election)
- ☐ no change

Coverage Level for Dental:

- ☐ surviving spouse only
- ☐ surviving spouse + children
- ☐ waive

OPTION B – Medicare-eligible – For 401(a) only. Complete this option if you and your dependents **are** eligible for Medicare. If enrolling in the CU Health Plan – Medicare, individual must be enrolled in original Medicare Parts A and B. Copy of Medicare Card Part A and B required.

CU Health Medical Plans:

- ☐ CU Health Plan Medicare
- ☐ Alternate Medicare Payment (AMP – surviving spouse must be eligible for Medicare, children not eligible for AMP)
- ☐ waive (irrevocable election)
- ☐ no change

Coverage Level for Medical:

- ☐ surviving spouse only
- ☐ surviving spouse + children
- ☐ waive

CU Health Dental Plans:

- ☐ Dental Premier
- ☐ waive (irrevocable election)
- ☐ no change

Coverage Level for Dental:

- ☐ surviving spouse only
- ☐ surviving spouse + children
- ☐ waive

Name: _____ ID# _____

Surviving Spouse/Partner and Dependent Enrollment

Continued coverage is available only if surviving spouse and children were enrolled at the time of employee/retiree/s death.

Surviving Spouse Enrollment

_____

Surviving Spouse Name (Last) (First) (Middle Initial) Date of Birth

_____

Social Security Number

Gender (please check one – required for insurance enrollment)
- ☐ male
- ☐ female

Medicare-eligible? Yes ☐ No ☐ Medicare Number: _____ (copy of Medicare Card Part A and B required)

Child 1

_____

Child Name (Last) (First) (Middle Initial) Date of Birth

_____

Social Security Number

Relationship to Surv.Spouse
- ☐ biological/adopted
- ☐ stepchild
- ☐ child for whom you have legal responsibility

Gender (please check one – required for insurance enrollment)
- ☐ male
- ☐ female

Medicare-eligible? Yes ☐ No ☐ Medicare Number: _____ (copy of Medicare Card Part A and B required)

Child 2

_____

Child Name (Last) (First) (Middle Initial) Date of Birth

_____

Social Security Number

Relationship to Surv. Spouse
- ☐ biological/adopted
- ☐ stepchild
- ☐ child for whom you have legal responsibility

Gender (please check one – required for insurance enrollment)
- ☐ male
- ☐ female

Medicare-eligible? Yes ☐ No ☐ Medicare Number: _____ (copy of Medicare Card Part A and B required)

Name: _____ ID# _____

Child 3

_____
Child Name (Last) (First) (Middle Initial) Date of Birth

_____
Social Security Number

Relationship to Surv.Spouse
- ☐ biological/adopted
- ☐ stepchild
- ☐ child for whom you have legal responsibility

Gender (please check one – required for insurance enrollment)
- ☐ male
- ☐ female

Medicare-eligible? Yes ☐ No ☐ Medicare Number: _____ (copy of Medicare Card Part A and B required)

Child 4

_____
Child Name (Last) (First) (Middle Initial) Date of Birth

_____
Social Security Number

Relationship to Surv.Spouse
- ☐ biological/adopted
- ☐ stepchild
- ☐ child for whom you have legal responsibility

Gender (please check one – required for insurance enrollment)
- ☐ male
- ☐ female

Medicare-eligible? Yes ☐ No ☐ Medicare Number: _____ (copy of Medicare Card Part A and B required)

Child 5

_____
Child Name (Last) (First) (Middle Initial) Date of Birth

_____
Social Security Number

Relationship to Surv.Spouse
- ☐ biological/adopted
- ☐ stepchild
- ☐ child for whom you have legal responsibility

Gender (please check one – required for insurance enrollment)
- ☐ male
- ☐ female

Medicare-eligible? Yes ☐ No ☐ Medicare Number: _____ (copy of Medicare Card Part A and B 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 (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 agree to abide by the eligibility, enrollment and election procedures and payment of premiums for my University of Colorado benefits as outlined in this form and on the Employee Services website.

Signature: _____ Date: _____

Complete Your Enrollment

Documents with personal information should never be emailed for security reasons. Please mail or fax your enrollment form. Retain a copy for your records. If you need additional assistance, contact Employee Services at 303-860-4200, option 3.

Mail:

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

Fax:

Attention: Employee Services
303-860-4299 (retain a copy of the fax transmission)