UNIVERSITY OF DENVER

Benefits Enrollment / Change Form

Faculty & Staff

For Maximum Functionality
Download this form and complete on your computer

Important Information

- When to Use This Form – Use this form to make initial benefit elections during your 30-day new hire period OR changes to your voluntary benefits within 30 days of an IRS qualifying event.
- Name, DU ID Number, and Signature – You are required to list your DU ID number on this form. Your DU ID number is on your ID card or can be requested from your hiring manager.
- Dependent Verification Documentation – If you enroll dependents for any benefit, you must upload dependent documentation via MyDU (Employee Resources > Benefits Information > My Benefits > Upload Dependent Documentation).
- Benefits Materials – Review your benefits choices online to ensure you make educated benefit elections.
- Premiums for Bi-weekly Paid Employees – Monthly medical premium is divided between the 1st and 2nd paycheck of every month; all other premiums are taken from the 1st paycheck.
- DEADLINE – Submit this form within 30 days of your hire date or qualifying event. Do not forget to sign this form because it cannot be processed without a signature.
- Confirmation of Benefits Enrollment – you will receive an email when the enrollment is completed. Please review your paycheck stubs to ensure your benefit premiums are deducted.

Employee Information

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

DU ID Number (Required): _____ Date of Birth: _____ Gender: ☐ Male ☐ Female

Hire Date: _____ I am paid: ☐ Monthly ☐ Bi-weekly

Home Address: _____

City: _____ State: _____ Zip Code: _____

Home Telephone: _____ Campus Telephone: _____

Email Address: _____

Enrollment Reason

☐ New Hire/Newly Eligible Hire Date: _____ (mm/dd/yyyy) Benefits Effective Date: _____ (mm/dd/yyyy)

Benefits effective date will be the 1st of the month following your date of hire. (Hire Date: 6/2/2022. Benefits Effective Date: 7/1/2022). Employees hired on the 1st of a month may choose to have their benefits start on their hire date or the 1st of the month following. (Hire Date: 6/1/2022. Benefits Effective: 6/1/2022 or 7/1/2022).

☐ IRS Qualifying Event Date of Event: _____ (mm/dd/yyyy) Benefits Effective Date: _____ (mm/dd/yyyy)

You have 30 days from the date of the qualifying event to complete and return this form. Benefits effective date will be the 1st of the month following the event except in cases of childbirth, the benefits will be effective on the child's date of birth.

Type of Event:

- ☐ Marriage / Divorce
- ☐ Birth / Adoption of Child
- ☐ Custody Change
- ☐ Other: _____
- ☐ Ineligible Dependent
- ☐ Death of Spouse / Partner / Child
- ☐ Loss of Coverage through Employer / Spouse

Section 1: Medical Plans

Choose 1 of the Plan Options:

- ☐ Cigna Copay Plan
- ☐ Cigna HDHP Plan*
- ☐ Kaiser HMO Plan
- ☐ Kaiser HDHP Plan*

Choose 1 of the Coverage Levels:

- ☐ Employee Only
- ☐ Employee + Spouse / Partner
- ☐ Employee + Child(ren)
- ☐ Employee + Family
- ☐ Decline Health Coverage – I am covered under:
  - ☐ Medicare, non-group or veteran's program
  - ☐ Another plan as a spouse / dependent
  - ☐ A second employer's plan
  - ☐ None

*See section 5 for Health Savings Account (HSA) details.

Section 2: Dental Plans

Choose 1 of the Plan Options:

- ☐ Delta Dental Base PPO Plan
- ☐ Delta Dental Enhanced PPO Plan
- ☐ Beta Health Alpha Dental Plan*

Choose 1 of the Coverage Levels:

- ☐ Employee Only
- ☐ Employee + Spouse / Partner
- ☐ Employee + Child(ren)
- ☐ Employee + Family
- ☐ Decline Dental Coverage

* You must be assigned to a participating dentist in the Beta Health Alpha Dental Discount Plan. Please choose a dentist from the provider directory: https://www.betaplans.com/alpha19/.

Dentist Name: _____ ADP#: _____

Section 3: Vision Plans

Choose 1 of the Plan Options:

- ☐ EyeMed Base Vision Plan
- ☐ EyeMed Enhanced Vision Plan

Choose 1 of the Coverage Levels:

- ☐ Employee Only
- ☐ Employee + Spouse / Partner
- ☐ Employee + Child(ren)
- ☐ Employee + Family
- ☐ Decline Vision Coverage

Section 4: Dependent Coverage Information

If adding dependents, please provide dependent verification documentation for spouse/partner (i.e. marriage license, common law affidavit, domestic partner affidavit, etc.) and children (birth certificates).

Check One	Coverage	Name: First, M.I., Last	DOB	Gender	SSN
☐ Add ☐ Remove	☐ Medical ☐ Dental ☐ Vision	Spouse / Partner		☐ M ☐ F	
☐ Add ☐ Remove	☐ Medical ☐ Dental ☐ Vision	Child		☐ M ☐ F	
☐ Add ☐ Remove	☐ Medical ☐ Dental ☐ Vision	Child		☐ M ☐ F	
☐ Add ☐ Remove	☐ Medical ☐ Dental ☐ Vision	Child		☐ M ☐ F	
☐ Add ☐ Remove	☐ Medical ☐ Dental ☐ Vision	Child		☐ M ☐ F	

Section 5: Health Savings Account (HSA)
Skip this section if you are NOT enrolling on the Cigna HDHP

Rocky Mountain Reserve (RMR), who partners with UMB Bank, administers the Health Savings Account (HSA). You can open and contribute to an HSA if you:

1. Are covered by a HSA-qualified health plan (HDHP);
2. Are NOT covered by other health insurance (with some exceptions);
3. Are NOT enrolled in Medicare;
4. Are NOT enrolled in Tricare;
5. Are NOT eligible to be claimed as a dependent on another person's tax return;
6. Have NOT received health benefits from the Veterans Administration with the exception of services for a "service related disability" or an Indian Health Services facility within the last three months; and
7. Are NOT covered by your own or your spouse's Healthcare FSA.

Authorization and Certification

☐ I certify that I am eligible to make HSA contributions. I understand my Employer will rely on this certification in making the contributions to my HSA and for appropriate tax withholding and reporting. I understand that with this signed authorization, a UMB Bank HSA will be opened for me as part of my enrollment.

☐ I decline to have a HSA, therefore declining any Employer contributions.

Initial: _____ Date: _____

Section 6: Flexible Spending Account (FSA)

Health Care Flexible Spending Account - Covers eligible health care expenses for you, your spouse/partner, and eligible dependents. If enrolling during the benefit plan year (July-June), your annual election will be divided by the number of remaining pay periods in the plan year. Example: Form received in February, plan begins March and deductions are taken for March through June (4 months).

☐ I elect to enroll for a monthly amount of $_____ for a total annual amount of $_____
(Max. $254.16/month) (Max. $3,050/year)

☐ I decline enrollment

Dependent Care Flexible Spending Account - Covers eligible dependent care expenses for your eligible dependents. Eligible expenses must be necessary to enable you or your spouse to be gainfully employed or in search of gainful employment or to attend school on a full-time basis and must be for the care of a child under 13 years of age or a disabled dependent adult.

☐ I elect to enroll for a monthly amount of $_____ for a total annual amount of $_____
(Max. $416.66/month) (Max. $5,000/year)

☐ I decline enrollment

IMPORTANT NOTES:

- Employees enrolling in the Cigna HDHP Plan will have access to a Limited Purpose FSA that only reimburses you for eligible dental and vision expenses.
- Health and Dependent Care FSA needs to be re-elected during open enrollment in May for a July 1 effective date.

Section 7: Retirement Savings Plan

Employees can contribute to a 403(b) retirement plan through TIAA at any time. Appointed employees are eligible to enroll in the employer match feature after completing one year of service with the University. Employees may waive this service requirement with prior service at another qualified educational institution by completing the Retirement Plan Participation Waiver of Service form. Please visit the benefits website for more information: https://www.du.edu/human-resources/benefits/index.html.

Please contact TIAA at 800-842-2252 to enroll in the retirement savings plan.

Section 8: Life and Accidental Death & Dismemberment (AD&D) Insurance

Benefited employees receive a basic life insurance of 1x their annual salary up to a maximum of $100,000 and AD&D insurance up to a $100,000 coverage as a core benefit. Premiums are paid 100% by the University. Please refer to the benefits website for more information.

Voluntary Life, AD&D, Critical Illness, and Accidental Injury Insurance Enrollment Form
Offered by Life Insurance Company of North America, a Cigna company

Your Information

Name:	**Social Security Number / Employee ID Number:**
Date of Birth:	**Date of Hire:**

Instructions

Please enter all required information clearly so that there will be no question as to your meaning.

Step 1: Please **enter or check** your coverage elections and details. You may only elect—and will be covered for—levels of coverage included *in your employer's contract.*

Step 2: Please **sign, date and return.**

Important: You must complete the Beneficiary Designation section below.

The following costs should be calculated based on your age as of the effective date.

Voluntary Life Insurance – Employee

You have the opportunity to enroll in University of Denver's Voluntary Life Insurance plan. Your election can be made in increments of $10,000, not to exceed the lesser of 5 times your salary or $500,000. If you elect an amount that exceeds the guaranteed issue amount of $200,000 you will need to provide evidence of good health before the excess can become effective.

Use the rate chart and calculation line below to determine your monthly cost for this coverage.*

Age	Under 25	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	70+
Rate	$0.0500	$0.0600	$0.0800	$0.0900	$0.1000	$0.1500	$0.2300	$0.4300	$0.6600	$1.2700	$2.0600	$2.0600

☐ I elect to **enroll** in the Voluntary Life Insurance plan at the monthly cost below.*

_____ ÷ $1,000 = _____ x _____ = $_____
Life Benefit Amount Rate Monthly Cost

☐ I elect to **decline** the Voluntary Life Insurance plan.

*Your cost may change if your age category changes within the benefits plan year.

*Note: Benefit reductions begin at age 65. Please see your benefit administrator for further information.

Voluntary Life Insurance – Spouse/Partner

If you elect the Voluntary Life Insurance plan for yourself, you may elect Voluntary Life Insurance coverage for your spouse/partner. Your election may be made in increments of $5,000 to a maximum of $250,000 but may not exceed 100% of your approved election. If you elect an amount that exceeds the guaranteed issue amount of $50,000, your spouse/partner will need to provide evidence of good health before the excess can become effective. **Voluntary spouse/partner rates and premiums are based on the age of the spouse/partner, not the employee's age.**

Spouse/Partner

First Name	Last Name	Gender	Date of Marriage	Date of Birth

Age	Under 25	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	70+
Rate	$0.0500	$0.0600	$0.0800	$0.0900	$0.1000	$0.1500	$0.2300	$0.4300	$0.6600	$1.2700	$2.0600	$2.0600

☐ I elect to **enroll** my spouse/partner in the Voluntary Life Insurance plan at the monthly cost below.*

_____ ÷ $1,000 = _____ x _____ = $_____
Life Benefit Amount Rate Monthly Cost

☐ I elect to **decline** the Voluntary Life Insurance plan for my spouse/partner.

*The cost may change if your spouse/partner's age category changes within the benefits plan year.

Voluntary Life Insurance – Child(ren)

If you elect the Voluntary Life Insurance plan for yourself, you may elect Voluntary Life Insurance coverage for your dependent child(ren) between the ages of birth and 26 years (coverage terminates at age 26; full-time student is not required). You may elect coverage in increments of $2,500 to a maximum of $10,000.

First Name	Last Name	Gender	Date of Birth

Child Life Amount	$2,500	$5,000	$7,500	$10,000
Cost	$0.50	$1.00	$1.50	$2.00

☐ I elect to **enroll** my dependent child(ren) in the Voluntary Life Insurance plan for the following amount:

$_____ per _____
Life Benefit Amount # of Children

☐ I elect to **decline** the Voluntary Life Insurance plan for my dependent child(ren).

Voluntary Accidental Death & Dismemberment Insurance

You have the opportunity to enroll in University of Denver's Voluntary Accidental Death & Dismemberment (AD&D) Insurance plan. You may elect in increments of $10,000 not to exceed 10 times your annual earnings, rounded to the next lower $10,000 to a maximum of $500,000. The maximum benefits for your spouse/partner is $300,000 and $50,000 for your child(ren). You may choose to cover yourself only or yourself and your family.

The chart below shows the benefit percent of your principal sum payable for each option. Use the rate chart and calculation line below to determine your monthly cost for this coverage.

Family Member(s) Covered:	Employee Only	Employee & Spouse Only	Employee & Child(ren) Only	Employee and Family
Percent of Benefit Paid:	100%	100% for Employee 60% for Spouse	100% for Employee 15% for each Child	100% for Employee 50% for Spouse 10% for each Child

Coverage Options	**Monthly Rate**
Employee Only	$0.022
Employee and Family	$0.033

☐ I elect to **enroll:** ☐ myself only ☐ myself and my family

_____ ÷ $1,000 = _____ x _____ = $_____
Elected Benefit Amount | Rate | Monthly Cost

☐ I elect to **decline** the Voluntary AD&D plan.

Voluntary Accidental Injury Insurance

Accidental Injury insurance can provide you and your family with the additional financial protection you may need for expenses associated with an unexpected covered accident. The plan pays benefits directly to you. What you do with the money is up to you.

This benefit will pay a lump sum in the event of a covered accident. Examples include fractures, dislocation, surgery, ambulance transport, coma, burns, laceration, X-ray, and more.

Coverage Options	**Monthly Rate**
Employee Only	$9.92
Employee and Spouse	$17.96
Employee and Child(ren)	$22.90
Employee and Family	$30.95

☐ I elect to **enroll:** ☐ myself only ☐ myself and spouse ☐ myself and child(ren) ☐ myself and family

☐ I elect to **decline** the Voluntary Accidental Injury Insurance plan.

Voluntary Critical Illness Insurance

Critical Illness insurance eases the financial impact of a major illness. If you or a covered family member is diagnosed due to an illness and meets the group policy and certificate requirements, you will receive a payment to use as you see fit. It can be used to help cover your health insurance deductibles, copays, incidental hospital charges (e.g. TV, phone, etc.) or for any purpose you choose. Critical Illness provides payments for illnesses such as organ/kidney failure, cancer, arteriosclerosis, heart attack, carcinoma in situ, stroke, and benign brain tumor.

Family Member(s) Covered:	Employee	Spouse	Child(ren)
Benefit Amount:	$10,000, $20,000, or $30,000 Guarantee issue: $30,000	50% of Employee benefit amount; Guarantee issue: 100%	50% of Employee benefit amount

If you complete a health screening, this plan will pay you a health screening benefit of $50 per year. These health screenings include annual physicals, biometrics, preventive cancer screenings, etc.

Monthly Rates per $10,000 coverage based on age	**Employee**	**Employee and Spouse**	**Employee and Child(ren)**	**Employee and Family**
0-29	$2.49	$3.98	$3.71	$5.22
30-39	$4.42	$6.94	$5.65	$8.07
40-49	$8.16	$12.75	$9.39	$13.98
50-59	$16.19	$25.77	$17.42	$27.01
60-69	$25.85	$41.31	$27.08	$42.53
70-79	$45.53	$70.56	$46.76	$71.78
80+	$72.33	$109.99	$73.57	$111.23

☐ I elect to **enroll:** ☐ myself only ☐ myself and spouse ☐ myself and child(ren) ☐ myself and family

_____ ÷ $10,000 = _____ x _____ = $_____
Elected Benefit Amount Rate Monthly Cost

☐ I elect to **decline** the Voluntary Critical Illness Insurance plan.

Beneficiary Designation - REQUIRED

You must select your beneficiary – the person (or more than one person) or legal entity (or more than one entity) who receives a benefit payment if you die while covered by the plans.

A primary beneficiary is the beneficiary or beneficiaries that you name to receive the benefits if they are living at the time of your death. The primary beneficiaries are the first in line to receive death benefits. Please make sure that you also name a contingent beneficiary – who would receive your benefit if your primary beneficiary dies first.

Please make sure your beneficiary designation is clear so that there will be no question as to your meaning. If you name more than one primary or contingent beneficiary, show the percentage of your benefit to be paid to each beneficiary. Provide all of the information requested below. If your beneficiary is not related either by blood or by marriage, insert the words, "Not Related" as their stated relationship. If you need assistance, contact your benefits administrator or your own legal advisor.

This beneficiary designation will be for ALL group life or accidental death insurance coverage issued by Life Insurance Company of North America.

	Full Name	Address	Social Security #	Relationship	Date of Birth	Percentage
Primary Beneficiary						
Contingent Beneficiary						

The beneficiary for insurance on the lives of your Spouse/Partner and Dependent Children will automatically be you, if surviving. Otherwise, the beneficiary will be the estate of the Spouse and Dependent Children, subject to policy provisions. A beneficiary for employee life Insurance may be changed upon written request.

Employee Confirmation

I acknowledge that I have been given the opportunity to enroll in the insurance coverage offered by my employer. I understand and agree that if I decline coverage now, but later decide to enroll, I may be required to provide evidence of insurability that is satisfactory to Life Insurance Company of North America and be approved for such coverage before it becomes effective. I understand my request for coverage may be denied by Life Insurance Company of North America.

I understand and agree that insurance will go into effect and remain in effect only in accordance with the provisions, terms and conditions of the insurance policy. I understand and agree that only the insurance policy issued to my employer can fully describe the provisions, terms, conditions, limitations and exclusions of my insurance coverage. In the event of any difference between the enrollment form and the insurance policy, I agree to be bound by the insurance policy.

If I have life insurance coverage with Life Insurance Company of North America, I understand and agree that my life insurance benefit(s) reduce at a specified age(s) stated in the policy.

I authorize payroll deductions from my wages to cover my cost of coverage when applicable. I understand rates and benefits may be changed by the insurer.

I understand that no insurance will be valid or in force if I am not eligible in accordance with the terms of the group policy as issued to my employer. I acknowledge and agree that if group participation requirements are required by Life Insurance Company of North America or by law and are not met, this policy will not be implemented and the coverage I have elected will not be in force.

Signed_____ Date_____

See next page for authorization, signature and instructions on how to submit your form.

Section 9: General Fraud Statement

Any employee, employee'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.

Section 10: 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 the University of Denver benefits as outlined in the Benefits Guide, which is available at https://www.du.edu/human-resources/benefits/index.html.

☐ I am enrolling in a medical plan.

As a Cigna Plan enrollee, I agree, for myself and my covered dependents, that in the event any health services provided are the primary responsibility of any other party by way of other group health coverage or by the act or omission of another person, I will fully inform the health plan and will execute such assignments, liens or other documents which may be necessary to enable the health plan to recover the value of the services provided. I further agree that in the event I or any of my covered dependents collect benefits or damages from any other party who has primary responsibility for services provided by the health plan, I will immediately reimburse the health plan to the extent permitted by state law.

Any person who, knowingly and with intent to defraud any insurance company or other person: (1) files an application for insurance or statement of claim containing any materially false information; or (2) conceals for the purpose of misleading, information concerning any material fact thereto, commits a fraudulent insurance act.

☐ I hereby authorize the University of Denver to deduct the necessary premiums, if any, from my paycheck. I understand that my contributions for premiums and/or Flexible Spending Account shall be taken from my salary prior to the calculation of taxes, thus reducing my gross taxable salary. I understand that there will be no withholding of Federal Income Tax or State Income Tax amounts reported as income to me on my W-2 statement.
By taking advantage of these tax savings, I understand that I am not eligible for the tax credits and/or deductions offered for such benefits on IRS Form 1040 and these elections are irrevocable during the plan year except for qualified changes in status as defined by the IRS.

Signature *(If using electronic signature, please return this form using your @du.edu email address)* Date

How to Submit Your Benefits Enrollment Form

Email	In Person
• Email your completed form to: Benefits@du.edu • Please encrypt the email and use the following format for the subject header: DU CONFIDENTIAL: Benefits Enrollment Form	Keep a copy for your record and bring your completed original form to: Mary Reed Building 4th Floor 2199 S University Blvd Denver, CO 80208

Internal Use Only

Date	Action	Initials
	PDADEDN Entered	
	PDABENE Update	
	PDABCOV Linked	
	DOO in BCOV	
	Required Certification Add/Replace & Notes Added	

Notes/Instructions