Benefits Enrollment/Change Form

Faculty & Staff

IMPORTANT INFORMATION—READ FIRST

1. **Name, DU ID Number, And Signature—**You are required to list your DU ID number on this form. You can find your DU ID number on your ID Card or you can request it from your hiring manager. Please be sure to list your Social Security Number (SSN) on page 1 of this form and if you are enrolling your dependents, list their SSNs on page 2. Do not forget to sign your forms as your benefits elections cannot be processed without a signature.
2. **Benefits Materials—**Review your benefit choices online so you can make educated benefits elections: http://www.du.edu/human-resources/media/documents/2015_16_du_benefits_guide.pdf
3. **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 a qualifying event.
4. **Be Thorough—**This form will be returned to you if it is not filled in completely.
5. **Deadline—**Submit this form by the payroll deadline date and time within 30 days of your hire/qualifying event.
6. **Confirmation Of Benefits Enrollment—**Your Kaiser and EyeMed cards (with the exception of Delta Plans) will be mailed to you within 2 weeks of your enrollment. Be sure to check your paycheck stubs to make sure that your premiums are being paid as you have intended.

ENROLLMENT TYPE AND DEADLINES—CHECK ONE

☐ **Newly Hire/Newly Eligible** **Hire Date:**__________ (mm/dd/yyyy) **Benefits Effective:**__________ (mm/dd/yyyy)

*You have 30 days from the date you were hired into a benefited position to complete and return this form. Benefits effective date will be the 1st of the month following your date of hire. (Hire Date: 7/2/2015. Benefits Effective Date: 8/1/2015). 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: 7/1/2015. Benefits Effective: 7/1/2015 or 8/1/2015)

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

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

EMPLOYEE INFORMATION **DU ID Number—REQUIRED:**__________

Name (Last) (First) (Middle Initial) SSN

Date of Birth (mm/dd/yyyy) Hire Date (mm/dd/yyyy) I am paid: ☐ Monthly ☐ Bi-weekly

Home Telephone Campus Phone Email Address Gender

Home Address (Must be Denver/Boulder local) City State Zip Code

SECTION 1: MEDICAL

CHOOSE 1 OF PLAN OPTIONS:

- ☐ Kaiser HMO
- ☐ Kaiser HSA-Qualified CDHP
- ☐ Kaiser Triple Option POS Plan

- ☐ Kaiser PPO
- ☐ HSA-Qualified, Kaiser CDHP PPO

PPO Plans are not available to new enrollees after 06/30/2010

CHOOSE 1 OF THE COVERAGE LEVELS:

- ☐ Employee Only
- ☐ Employee + Spouse/Partner
- ☐ Employee + Child(ren)
- ☐ Employee + Family
- ☐ Decline Health Coverage—Reason:
  - ☐ I am covered by Medicare, non-group or veteran's program
  - ☐ I am covered under another plan as a spouse/dependent
  - ☐ I am covered under a second employer's plan
  - ☐ I do not wish to participate in health care coverage

SECTION 2: DENTAL

CHOOSE 1 OF PLAN OPTIONS:

- ☐ Delta Dental Base PPO Plan
- ☐ Delta Dental Enhanced PPO Plan
- ☐ Delta Dental Patient Direct Discount Program*

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 **Patient Direct Discount program**. Please choose a dentist from the provider directory:
http://patientdirect.deltadentalco.com/delta/ Dentist Name:____ADP#____________

SECTION 3: VISION

CHOOSE 1 OF PLAN OPTIONS:

- ☐ EyeMed Base Plan
- ☐ EyeMed Enhanced 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 a copy of a marriage license for spouse/partner and birth certificates for children. For more information about eligible dependents, refer to Section 6 of this form.

Circle One	Name: First, Middle Initial, Last	Date of Birth	Gender	SSN	Check Coverage
Add Remove	Spouse/Partner				☐ Medical ☐ Dental ☐ Vision
Add Remove	Child				☐ Medical ☐ Dental ☐ Vision
Add Remove	Child				☐ Medical ☐ Dental ☐ Vision
Add Remove	Child				☐ Medical ☐ Dental ☐ Vision
Add Remove	Child				☐ Medical ☐ Dental ☐ Vision

SECTION 5: FLEXIBLE SPENDING—You may elect one or both options under DU FSA

Health Care Flexible Spending Account—Covers eligible health care expenses for you, your spouse/partner, and federal tax dependents. If enrolling during the 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 in March, deductions taken for March – June (4 months)

☐ I elect to enroll for a **monthly amount** of $_______________ for a total **annual amount** of $________________________

(Max. $208.33/month) (Max. $2,500/year)

☐ I waive enrollment

Dependent Care Flexible Spending Account—Covers eligible dependent care expenses for your federal tax dependents. To be 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/household/month) (Max. $5,000/household/year)

☐ I waive enrollment

IMPORTANT NOTES:

- Dependents eligible to incur expenses reimbursable through an FSA must meet Federal/IRS dependent guidelines.
- Employees enrolling in the Kaiser HSA-Qualified CDHP have access to a limited-purpose FSA. Please refer to the Benefits Guide online for more information: http://www.du.edu/human-resources/media/documents/2015_16_du_benefits_guide.pdf

SECTION 6: DEFINITION OF QUALIFIED DEPENDENT

Eligible dependents are defined as:

- Your spouse, unless legally separated for medical plan purposes
- Common law or domestic partner, in so far as the law will allow; Affidavit must be on file with the Benefits Office
- Children (defined as natural, step or legally adopted children who are dependent for federal income tax purposes) up to a maximum age which depends on the specific benefit as summarized below:
  - Health, dental, life and AD&D plans: Up to the end of the month in which the child reach age 26, regardless or marital status or tax dependency, or any age if physically or mentally incapable of self-support
  - Dependent Care Flexible Spending Account: Age 13 or any age if disabled
  - Tuition Waiver: Through the term in which children reach 25

SECTION 7: SHORT TERM AND LONG TERM DISABILITY INSURANCE

All benefitted employees are automatically covered under our Short Term and Long Term Disability Plans with The Hartford as a CORE benefit. All premiums are paid 100% by the University of Denver. Please refer to the Benefits Guide online for more information: http://www.du.edu/human-resources/media/documents/2015_16_du_benefits_guide.pdf

SECTION 8: RETIREMENT PLANS

Employees may begin contributing to a TIAA-Cref retirement account at any time. After 1 year and 1,000 hours of service to the University of Denver, benefitted employees are eligible to have 4% of the retirement deferrals matched with 8% by the University. The 1 year and 1,000 hours may be waived if you completed this requirement at another qualified educational institution. Please visit our website for more information: www.du.edu/hr

SECTION 9: LIFE INSURANCE AND AD&D

All benefitted employees are automatically covered for 1x their annual salary, up to $50,000 with The Hartford as a CORE benefit. All premiums are paid 100% by the University of Denver. Please refer to the Benefits Guide online for more information: http://www.du.edu/human-resources/media/documents/2015_16_du_benefits_guide.pdf

Colorado Seminary (University of Denver)
Life Insurance and AD&D Enrollment Form

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.**

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

Employer - Paid Coverage

Colorado Seminary (University of Denver) provides, at no cost to you, the following coverage:

- **Basic Life Insurance** in an amount equal to 1 times your basic annual earnings, rounded to the next higher $1,000, to a maximum of $50,000. Benefit reductions begin at age 65. Please see your benefits administrator for further information.
- **Basic AD&D** in an amount of 10,000.

Supplemental Life Insurance - Employee

You have the opportunity to enroll in University of Denver's Supplemental Life Insurance plan. Your election may 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 $100,000 you will need to provide evidence of good health that is satisfactory to The Hartford before the excess can become effective. ***You must complete the Beneficiary Designation section below.***

Have you smoked a cigarette, cigar, used pipe or chewing tobacco, nicotine chewing gum or snuff during the 12 months prior to today's date? If YES, use The Tobacco User Rate below; if No, use the Tobacco Free Rate below:

☐ **Yes** ☐ **No**

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	75+
Tobacco User Rate	$0.0600	$0.0700	$0.0800	$0.1100	$0.1700	$0.2800	$0.4700	$0.7700	$0.9600	$1.6600	$2.7000	$4.1600
Tobacco Free 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 Supplemental Life plan at the Monthly cost below.*

__________ ÷ $1,000 = __________ x __________ = $ __________

Elected Benefit Amount — Rate Above — Your Monthly Cost*

☐ I elect to **decline** the Supplemental Life 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 benefits administrator for further information.

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Supplemental Life Insurance - Spouse

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

Has your Spouse smoked a cigarette, cigar, used pipe or chewing tobacco, nicotine chewing gum or snuff during the 12 months prior to today's date? If YES, use The Tobacco User Rate below; if No, use the Tobacco Free Rate below:

☐ **Yes** ☐ **No**

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	75+
Tobacco User Rate	$0.0600	$0.0700	$0.0800	$0.1100	$0.1700	$0.2800	$0.4700	$0.7700	$0.9600	$1.6600	$2.7000	$4.1600
Tobacco Free 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 in the Supplemental Life plan at the Monthly cost below.*

________________ ÷ $1,000 = ____________ x ____________ = $________________

Elected Benefit Amount — Rate Above — Your Monthly Cost*

☐ I elect to **decline** the Supplemental Life plan for my Spouse.

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

SPOUSE:

First Name	Last Name	Gender	Date of Marriage	Date of Birth

Supplemental Life Insurance - Child(ren)

If you elect the Supplemental Life plan for yourself, you may elect Supplemental Life coverage for your Dependent Child(ren) between the ages of live birth and 19 years (25 years if a full time student). You may elect coverage in increments of $2,500 to a maximum of $10,000.

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 Supplemental Life plan for $__________ per ________________________

\# of Children

☐ I elect to **decline** the Supplemental Life plan for my Dependent Child(ren).

CHILD:

First Name	Last Name	Gender	Date of Birth

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. You may choose to cover yourself only or yourself and your family. The chart below shows the benefit percents 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, Spouse & Child(ren)
Percent of Benefit Paid:	100%	100% for Employee 60% for Spouse	100% for Employee 25% for each Child	100% for Employee 50% for Spouse 10% for each Child

Coverage Options	**Monthly Rate**
Myself Only	$0.022
Myself and My Family	$0.033

☐ I elect to **enroll** ☐ **myself only** ☐ **myself and my family in the Voluntary AD&D plan for the coverage indicated below.**

______________________ ÷ $1,000 = ______________ x ______________ = $ ______________________
Elected Benefit Amount Rate Above Your Monthly Cost

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

Beneficiary Designation

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. **This beneficiary designation will be for ALL group life or accidental death insurance coverage issued by The Hartford for you, unless specifically named otherwise.** 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. Please 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.

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

The beneficiary for insurance on the lives of your Spouse 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 described in the Benefit Highlight Sheets and offered through University of Denver.

I understand and agree that if I decline coverage now, but later decide to enroll, I will be required to provide evidence of insurability that is satisfactory to The Hartford and be approved for such coverage before it becomes effective. I understand my request for coverage may be denied by The Hartford.

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 the policyholder (your employer) can fully describe the provisions, terms, conditions, limitations and exclusions of your 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 The Hartford, I understand and agree that my life insurance benefit is reduced at a specified age stated in the policy. If I have disability income coverage with The Hartford, I understand and agree that the maximum duration benefits are payable will be limited to a specified period starting at a specified age and that a claim for benefits may not be approved for a pre-existing condition.

I authorize my employer to make the appropriate payroll deductions from my earnings.

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 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 10: 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 11: 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 Denver benefits as outlined in the Benefits Guide, which is available online at http://www.du.edu/human-resources/media/documents/2015_16_du_benefits_guide.pdf

☐ As a Kaiser Permanente Plan enrollee, I agree to have all disputes and/or claims for damages, except for small claims court cases and benefit claims arising under Section 502(a)(1)(B) of the Employee Retirement Income Security Act (ERISA), submitted to binding arbitration. I agree to apply for Kaiser Permanente membership for myself and eligible family dependents listed on this form. I understand that by enrolling with Kaiser Permanente, my benefits will be in accordance with the master contract applicable to the type of plan for which I have enrolled.

☐ 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 Date

HOW TO SUBMIT YOUR BENEFITS ENROLLMENT/CHANGE FORM

By US Mail	**By Fax**	**In Person**
Make a copy for your records and send originals to: University of Denver 2199 S. University Blvd., Room 107A Denver, CO 80208-4840 **By Campus Mail** Benefits, Shared Services Mary Reed Building, Room 107A	Keep a copy of the fax transmission report with your form for your records. Attention: Benefits, Shared Services 303-871-3635 **By Email:** totalrewards@du.edu	Keep a copy for yourself and bring your completed original forms to Mary Reed Building, Room 107A