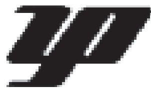

University Physicians, Inc.
13611 E. Colfax Avenue
Aurora, CO 80045-5701

Benefits Enrollment/Change Form

2009–10 Plan Year

IMPORTANT INFORMATION—*READ FIRST*

1. **NAME AND SIGNATURE**—Be sure to include your signature. Your elections cannot be processed without it.
2. **SOCIAL SECURITY NUMBER(S)**—You **MUST** list the Social Security number for each of your dependents.
3. **BENEFITS MATERIALS**—Review the Benefits Guide on the UPI website at **www.upicolo.org/benefits** for information that will assist you in making educated benefits elections.
4. **WHEN TO USE THIS FORM**—Use this form for open enrollment elections, or when you are newly hired/newly eligible, requesting a change due to a qualifying life event, or changing your beneficiary(ies).
5. **BE THOROUGH**—Be sure to fill in this form correctly.
6. **DEADLINE**—Be sure you submit this form by the deadline date (31 days from your date of hire or qualifying life event).
7. **CONFIRMATION OF BENEFITS ENROLLMENT**—HR will mail a statement confirming your enrollment/changes within two weeks after receiving this form. Contact HR immediately if your statement is incorrect or you do not receive your statement within two weeks.

ENROLLMENT TYPE AND DEADLINES—*CHECK ONE*

☐ **OPEN ENROLLMENT** Effective July 1, 2009. Open Enrollment ends May 22, 2009, at 4:00 p.m. Mountain Daylight Time.

☐ **NEWLY HIRED/NEWLY ELIGIBLE** Benefits effective ____________________.
(mm/dd/yyyy)

You have 31 days from your date of hire to complete and return this form to HR.

☐ **QUALIFYING LIFE EVENT**

Type of qualifying life event ________________________________ Date of qualifying life event ____________________
(mm/dd/yyyy)

You have 31 days after a qualifying life event to complete and return this form with the proper supporting documentation attached.

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

EMPLOYEE INFORMATION

Name (Last) ____________ (First) ____________ (Middle Initial) ____________

Date of Birth (mm/dd/yyyy) ____________ Date of Employment (mm/dd/yyyy) ____________

Home Telephone ____________ Campus Telephone ____________ Address ____________

Name (Last) (First) (Middle Initial)

SECTION 1: MEDICAL

CHOOSE 1 OF THE FOLLOWING PLAN OPTIONS:

- ☐ HMO Colorado
- ☐ UA Net HMO
- ☐ Kaiser Permanente HMO
- ☐ Lumenos
- ☐ BluePreferred PPO
- ☐ Waive medical coverage

CHOOSE 1 OF THE FOLLOWING COVERAGE LEVELS:

- ☐ Employee only
- ☐ Employee + Child(ren)
- ☐ Employee + Spouse/SGDP
- ☐ Family

SECTION 2: DENTAL

If electing medical coverage, you MUST elect at least employee-only dental coverage. If waiving medical coverage, you may either elect or waive dental coverage.

CHOOSE 1 OF THE FOLLOWING PLAN OPTIONS:

- ☐ Exclusive Panel Option (EPO)
- ☐ Delta Dental PPO
- ☐ Waive dental coverage

CHOOSE 1 OF THE FOLLOWING COVERAGE LEVELS:

- ☐ Employee only
- ☐ Employee + Child(ren)
- ☐ Employee + Spouse/SGDP
- ☐ Family

SECTION 3: EMPLOYEE AND DEPENDENT COVERAGE INFORMATION

If enrolling in HMO Colorado, UA Net HMO, or Kaiser Permanente in the Colorado Springs/Pueblo area, you MUST select a primary care physician (PCP) and write in the PCP number. Go to the UPI website at **www.upicolo.org/benefits** to find out more about PCP numbers. If you and/or your spouse/dependents are current patient(s) of the PCP you elected, check the "existing patient" box.

You MUST also indicate whether each child or relative is a federal tax dependent as defined in Section 7. To list additional children or relatives, attach a sheet with the information requested below.

Add/ Change	Remove	Name: Last, First, MI	Date of Birth mm/dd/yyyy	Gender M/F	Check all that apply	Medical Primary Care Physician
☐	☐	Self			☐ Medical ☐ Dental ☐ Optional Term Life/AD&D ☐ Voluntary AD&D	PCP# ☐ Existing Patient
☐	☐	Spouse/SGDP SSN **REQUIRED** ___-__-____			☐ Medical ☐ Dental ☐ Optional Term Life/AD&D ☐ Voluntary AD&D ☐ Federal Tax Dependent*	PCP# ☐ Existing Patient
☐	☐	Child/Relative SSN **REQUIRED** ___-__-____			☐ Medical ☐ Dental ☐ Optional Term Life/AD&D ☐ Voluntary AD&D ☐ Federal Tax Dependent*	PCP# ☐ Existing Patient
☐	☐	Child/Relative SSN **REQUIRED** ___-__-____			☐ Medical ☐ Dental ☐ Optional Term Life/AD&D ☐ Voluntary AD&D ☐ Federal Tax Dependent*	PCP# ☐ Existing Patient
☐	☐	Child/Relative SSN **REQUIRED** ___-__-____			☐ Medical ☐ Dental ☐ Optional Term Life/AD&D ☐ Voluntary AD&D ☐ Federal Tax Dependent*	PCP# ☐ Existing Patient

*See Section 7.

Name (Last) (First) (Middle Initial)

SECTION 4: UPI FLEX—You may elect one or all options under UPI Flex. Elections are **irrevocable** for the plan year.

PREMIUM ONLY PLAN—Deducts your medical and dental premiums before taxes are calculated.

☐ I elect to enroll. ☐ I waive enrollment.

HEALTH CARE FLEXIBLE SPENDING ACCOUNT (HCFSA)—Covers eligible healthcare expenses for you and your federal tax dependents. Effective the first of the month FOLLOWING receipt of this form by HR. 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.* If you are making a mid-year increase or decrease due to a qualifying life event, contact HR.

☐ I elect to enroll for an **annual** amount of $______________ (minimum $10/month, maximum $6,000/plan year). The monthly contribution will be the annual election divided by the remaining months in the plan year.

☐ I waive enrollment.

*Example: Form received in February, plan begins in March, deductions taken for March—June (4 months).

DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT (DCFSA)—Covers eligible day care expenses for your federal tax dependents. Effective the first of the month FOLLOWING receipt of this form by HR. 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.* If you are making a mid-year increase or decrease due to a qualifying life event, contact HR. You may not exceed $5,000/calendar year (January–December).

☐ I elect to enroll for an **annual** amount of $______________ (minimum $10/month, maximum $5,000/plan year).

☐ I waive enrollment.

*Example: Form received in February, plan begins in March, deductions taken for March—June (4 months).

SECTION 5: BASIC TERM LIFE/AD&D, OPTIONAL TERM LIFE/AD&D, AND VOLUNTARY AD&D

$40,000 BASIC TERM LIFE/AD&D INSURANCE

Benefits-eligible employees are automatically enrolled in Basic Term Life/AD&D insurance. The premium is paid by UPI. List your Basic Life/AD&D 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 Basic Term Life/AD&D, Optional Term Life/AD&D, or Voluntary AD&D, benefits will be paid according to the provisions of the Group Policy.

Beneficiary designations on this form revoke all prior designations.

The UPI employee is automatically the sole beneficiary for spouse/SGDP and/or dependent Optional Term Life/AD&D or Voluntary AD&D insurance.

PRIMARY BENEFICIARY(IES) will receive the benefit in the event of your death. If you name more than one primary beneficiary, please indicate the percentage assigned to each and make sure the total in this category equals 100 percent.

CONTINGENT BENEFICIARY(IES) will receive the benefit only if your primary beneficiary(ies) are deceased. If you name more than one contingent beneficiary, please indicate the percentage assigned to each and make sure the total in this category equals 100 percent.

Name (Last) (First) (Middle Initial)

OPTIONAL TERM LIFE/AD&D INSURANCE

EMPLOYEE ENROLLMENT—$1,000 increments. If electing more than the maximum allowed, you MUST complete a Medical History Statement (available on the UPI website) and be approved by Standard Insurance Company.

- ☐ I elect to enroll in Optional Term Life/AD&D insurance in the amount of $ ________________. ($1,000 increments)
  Initial eligibility—maximum amount is three times your annual salary.
  Qualifying Life Event—maximum amount is $10,000, not to exceed three times your annual salary.
  - ☐ Standard Rate
  - ☐ Non-tobacco discount rate (no tobacco use in the last 12 months)
  - ☐ I submitted my Medical History Statement to Standard Insurance Company for approval to enroll in more than the maximum amount allowed.
- ☐ I waive enrollment.

List your Optional Term Life/AD&D beneficiary(ies) below.

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

SPOUSE/SGDP ENROLLMENT—$1,000 increments. Coverage cannot exceed employee's Optional Term Life/AD&D insurance coverage amount. If electing more than the maximum allowed, you MUST complete a Medical History Statement and be approved by Standard Insurance Company.

- ☐ I elect to enroll my spouse/SGDP in Optional Term Life/AD&D insurance in the amount of $ ________________. ($1,000 increments)
  Initial eligibility—maximum amount is $50,000.
  Qualifying Life Event—maximum amount is $10,000, not to exceed $50,000.
  - ☐ Standard Rate
  - ☐ Non-tobacco discount rate (no tobacco use in the last 12 months)
  - ☐ I submitted my Medical History Statement to Standard Insurance Company for approval to enroll in more than the maximum amount allowed.
- ☐ I waive enrollment.

DEPENDENT ENROLLMENT—Coverage cannot exceed employee's Optional Term Life/AD&D insurance coverage amount.

- ☐ I elect to enroll my child(ren) for $5,000 per child.
- ☐ I elect to enroll my child(ren) for $10,000 per child.
- ☐ I waive enrollment.

VOLUNTARY ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) INSURANCE

EMPLOYEE ENROLLMENT—$10,000 increments up to ten times your annual salary or $250,000, whichever is less.

- ☐ I elect to enroll in Voluntary AD&D insurance in the amount of $________________. ($10,000 increments)
- ☐ I waive enrollment.

List your Voluntary AD&D beneficiary(ies) below.

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

Name (Last) (First) (Middle Initial)

SPOUSE/SGDP ENROLLMENT—$10,000 increments. Coverage cannot exceed employee's Voluntary/AD&D insurance coverage amount. Maximum amount is same as employee's.

- ☐ I elect to enroll my spouse/SGDP in Voluntary AD&D insurance in the amount of $ ______________. ($10,000 increments)
- ☐ I waive enrollment.

DEPENDENT ENROLLMENT—Coverage cannot exceed employee's Voluntary/AD&D insurance coverage amount.

- ☐ I elect to enroll my child(ren) in Voluntary AD&D insurance in the amount of $5,000.
- ☐ I waive enrollment.

SECTION 6: SHORT-TERM DISABILITY INSURANCE

You may elect a benefit amount up to the maximum weekly benefit of your salary—see the Rate Sheet at **www.upicolo.org/benefits**.

If enrolling outside your 31-day eligibility period, you MUST complete a Medical History Statement and be approved by Standard Insurance Company.

- ☐ I am within my 31-day eligibility period and I elect to enroll.

  Annual salary $______________ Maximum weekly benefit amount $______________
- ☐ I elect to change (increase/decrease) amount.*

  Annual salary $______________ Maximum weekly benefit amount $______________
  - ☐ I submitted my Medical History Statement to Standard Insurance Company for approval.
- ☐ I waive enrollment.

*May increase without providing Medical History Statement if submitted within 31 days of salary increase.

SECTION 7: DEFINITION OF FEDERAL TAX DEPENDENT

An individual is a taxpayer's "dependent" for federal income tax purposes; that is, a federal tax dependent, if he or she meets one of the definitions below:

- A "qualifying child" is an individual: (a) who is a child (including an adopted child or an eligible foster child—i.e., one who is placed with the employee by an authorized placement agency or by judgment, decree, or other order of court), stepchild, sibling, or step-sibling (or descendant of any of these), and (b) who has the same principal place of residence as the taxpayer for more than one-half of the calendar year, and (c) who (other than in the case of total disability) has not yet attained age 19 by the end of the calendar year (age 24 if a full-time student for at least five months), and (d) who receives more than one-half of his or her support from you.
- A "qualifying relative" is an individual: (a) who is not your qualifying child or the qualifying child of any other taxpayer, (b) who is related to you, *or* who is not related to you but has the same principal place of residence as you for more than one-half of the calendar year *and* is a member of your household, and (c) who receives more than one-half of his or her support from you.

SECTION 8: 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, affidavit, or other document for the purpose of defrauding or attempting to defraud UPI'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 UPI's benefits plans, or as provided in regulations, statutes, and applicable written directives.

Name (Last) (First) (Middle Initial)

SECTION 9: 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 Physicians, Inc. benefits as outlined in the Benefits Guide, which is available online at **www.upicolo.org/benefits**.
- I certify that I have been given the opportunity to enroll for group benefits insurance as offered by and through University Physicians, Inc. I understand that I cannot change certain elections until the next open enrollment period unless I have a qualifying life event.
- I agree to utilize the appeal procedure(s) established by the carrier(s) 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 University Physicians, Inc. to deduct the necessary premiums, if any, from my paycheck or bill me directly.

Signature Date

HR will mail a statement confirming your benefits enrollments and changes within two weeks after receipt of the Benefits Enrollment/Change Form. Contact HR immediately if your statement is incorrect or you do not receive your statement within two weeks.

HOW TO RETURN YOUR BENEFITS ENROLLMENT/CHANGE FORM

BY MAIL	BY FAX	IN PERSON
Make a copy for your records and send the original to: University Physicians, Inc. Attn: Human Resources 13611 E. Colfax Ave. Aurora, CO 80045-5701	303-493-7601 Keep a copy of the fax transmission report with your form for your records.	Bring your completed original form to HR. Retain a copy for your records.