



IMPORTANT – READ FIRST

- You have 31 days from your date of benefits eligibility or qualifying life event to complete the enrollment/change form.
- If enrolling any dependents in medical, dental, optional life, and/or voluntary AD&D plans, you *must* attach the required documents as listed on the UPI 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 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

- OPEN ENROLLMENT** Effective July 1, 2011. Open Enrollment ends May 27, 2011, at 4:00 p.m. Mountain Daylight Time.
- NEWLY HIRED/NEWLY ELIGIBLE** Date of hire _____ or date of new eligibility _____.
(mm/dd/yyyy) (mm/dd/yyyy)
- QUALIFYING LIFE EVENT**
Type of qualifying life event _____ Date of qualifying life event _____
(mm/dd/yyyy)
- BENEFICIARY(IES) UPDATE** Effective the date of employee’s signature on this form.

EMPLOYEE INFORMATION – YOU ARE REQUIRED TO COMPLETE ALL SECTIONS.

Name (Last) _____ (First) _____ (Middle Initial) _____

Home Telephone _____ Campus Telephone _____

Home Address _____

Name (Last) _____ (First) _____ (Middle Initial) _____

SECTION 1: MEDICAL/DENTAL Check one box under Medical Plan Options, one box under Dental Plan Options, and elect your Coverage Levels. You must elect at least employee-only dental coverage if electing a medical plan option.

Medical Plan Options:	Dental Plan Options:	Coverage Levels:																		
<input type="checkbox"/> UA Net Plan <input type="checkbox"/> Kaiser Permanente Plan <input type="checkbox"/> Lumenos <input type="checkbox"/> Waive medical coverage <input type="checkbox"/> No change	<input type="checkbox"/> Exclusive Panel Option (EPO) <input type="checkbox"/> Delta Dental PPO <input type="checkbox"/> Waive dental coverage <input type="checkbox"/> No change	<table border="0"> <thead> <tr> <th>Medical</th> <th>Dental</th> <th></th> </tr> </thead> <tbody> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Employee only</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Employee + Child(ren)</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Employee + Spouse/SGDP</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Family</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>No change</td> </tr> </tbody> </table>	Medical	Dental		<input type="checkbox"/>	<input type="checkbox"/>	Employee only	<input type="checkbox"/>	<input type="checkbox"/>	Employee + Child(ren)	<input type="checkbox"/>	<input type="checkbox"/>	Employee + Spouse/SGDP	<input type="checkbox"/>	<input type="checkbox"/>	Family	<input type="checkbox"/>	<input type="checkbox"/>	No change
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<input type="checkbox"/>	<input type="checkbox"/>	Family																		
<input type="checkbox"/>	<input type="checkbox"/>	No change																		

PREMIUM ONLY PLAN (POP)—Election is irrevocable for the plan year.

- I elect to have my premium portion for the above chosen plan(s) deducted from my pay on a pre-tax basis.
- I do *not* want my premium portion to be deducted from my pay on a pre-tax basis.
- No change.

EMPLOYEE ENROLLMENT Complete all boxes. If not applicable, write N/A.

Name Last, First, MI _____ Date of birth _____ Gender Male Female

If enrolling in UA Net Plan or Kaiser Permanente Plan in Colorado Springs, you must elect a primary care physician. PCP # _____ Current patient? Yes No

DEPENDENT ENROLLMENT

IMPORTANT: Dependent eligibility verification REQUIRED.

Spouse, common-law spouse, or same gender domestic partner (SGDP) Complete all boxes. If not applicable, write N/A.

Name—Last, First, MI _____ Gender Male Female

Relationship to employee Spouse Common-law spouse SGDP Qualified tax dependent for health coverage? Yes No

Date of birth _____ SSN # _____ Medical Dental Optional Life Voluntary AD&D

If enrolling in UA Net Plan or Kaiser Permanente Plan in Colorado Springs, you must elect a primary care physician. PCP # _____ Current patient? Yes No

Child(ren) Complete all boxes. If not applicable, write N/A.

Name—Last, First, MI _____ Gender Male Female

Relationship to employee Biological child Stepchild Child for whom you have legal responsibility. List relationship _____

Qualified tax dependent for health coverage? Yes No

Date of birth _____ SSN # _____ Medical Dental Optional Life Voluntary AD&D

If enrolling in UA Net Plan or Kaiser Permanente Plan in Colorado Springs, you must elect a primary care physician. PCP # _____ Current patient? Yes No

Name—Last, First, MI _____ Gender Male Female

Relationship to employee Biological child Stepchild Child for whom you have legal responsibility. List relationship _____

Qualified tax dependent for health coverage? Yes No

Date of birth _____ SSN # _____ Medical Dental Optional Life Voluntary AD&D

If enrolling in UA Net Plan or Kaiser Permanente Plan in Colorado Springs, you must elect a primary care physician. PCP # _____ Current patient? Yes No

Name (Last) _____ (First) _____ (Middle Initial) _____

Name—Last, First, MI _____ Gender Male Female

Relationship to employee Biological child Stepchild Child for whom you have legal responsibility. List relationship _____

Qualified tax dependent for health coverage? Yes No

Date of birth _____ SSN # _____ Medical Dental Optional Life Voluntary AD&D

If enrolling in UA Net Plan or Kaiser Permanente Plan in Colorado Springs, you must elect a primary care physician.

PCP # _____ Current patient? Yes No

SECTION 2: CAFETERIA PLANS Check one box only for each plan. Elections are **irrevocable** for the plan year. Effective first of month following receipt of form by HR.

HEALTH CARE FLEXIBLE SPENDING ACCOUNT (HCFA)—Covers eligible healthcare expenses for you and your 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.* If you are making a mid-year increase or decrease due to a qualifying life event, contact HR. Check one box only.

- 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.
- No change.

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

DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT (DCFA)—Covers eligible day care expenses for your 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.* If you are making a mid-year increase or decrease due to a qualifying life event, contact HR. You may not exceed \$5,000 per household in a calendar year (January–December). Check one box only.

- I elect to enroll for an **ANNUAL** amount of \$ _____ (minimum \$10/month, maximum \$5,000/plan year).
- I waive enrollment.
- No change.

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

SECTION 3: BASIC TERM LIFE/AD&D, OPTIONAL TERM LIFE/AD&D, AND VOLUNTARY AD&D For Employee, Dependent Spouse, and Dependent Children.

BASIC TERM LIFE/AD&D INSURANCE

EMPLOYEE ENROLLMENT—Automatic UPI-paid \$50,000 Basic Term Life/AD&D Insurance

Complete and designate your primary and contingent beneficiaries in this section.

- If you do not designate a beneficiary for your life insurance plans, benefits will be paid according to the provisions of the group policy.
- Beneficiary designations on your most current form revoke all prior designations.
- The UPI employee is automatically the sole beneficiary for all dependent life insurance plans.
- Primary beneficiary—Receives the benefit in the event of your death.
- Contingent beneficiary—Receives the benefit only if your primary beneficiary(ies) are deceased.
- If you name more than one primary or contingent beneficiary, indicate the percentage assigned to each and make sure the total in each category equals 100 percent.

Name (Last) (First) (Middle Initial)

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

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.
- No change.

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			%

DEPENDENT ENROLLMENT

IMPORTANT: Dependent eligibility verification REQUIRED.

Spouse/SGDP—\$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 spouse’s/SGDP’s Medical History Statement to Standard Insurance Company for approval to enroll in more than the maximum amount allowed.
- I waive enrollment.
- No change.

Name (Last) _____ (First) _____ (Middle Initial) _____

Child(ren)—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.
- No change.

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.
- No change.

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			%

DEPENDENT ENROLLMENT

IMPORTANT: Dependent eligibility verification REQUIRED.

Spouse/SGDP—\$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.
- No change.

Child(ren)—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.
- No change.

SECTION 4: SHORT-TERM DISABILITY INSURANCE

You may elect a benefit amount under Option 1 or Option 2. Monthly benefit costs are available at www.upicolo.org/benefits.

- I am within my 31-day eligibility period (new hire or salary increase) **or**
- I am outside my 31-day eligibility period **and**

I elect to enroll in

- Option 1—Your choice of \$100 up to the \$850 maximum weekly benefit based on earnings equal to or less than your pre-disability earnings
Annual Salary \$ _____ Maximum Weekly Benefit Amount \$ _____
- Option 2—60 percent of your weekly pre-disability earnings up to a maximum weekly benefit of \$1,500
- I waive enrollment
- No change

Name (Last)

(First)

(Middle Initial)

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 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.

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 on the UPI website at www.upicolo.org/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 UPI 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 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)/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 Physicians, Inc. to deduct the necessary premiums, if any, from my paycheck or bill me directly.

Signature

Date

HOW TO RETURN YOUR BENEFITS ENROLLMENT/CHANGE FORM

BY MAIL

Make a copy for your records and send the original to:

University Physicians, Inc.
Attn: Human Resources.
13199 E. Montview Blvd.
Aurora, CO 80045

BY FAX

303-493-7601
Keep a copy of the fax transmission report with your form for your records.

IN PERSON

Bring your completed original form to HR. Retain a copy for your records.

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 at 303-493-7600 if your statement is incorrect or you do not receive your statement within two weeks.