



## **IMPORTANT – READ FIRST**

- **You have 31 days from your date of benefits eligibility or qualifying life event to complete the enrollment/change form.**
- **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, 2010. Open Enrollment ends May 21, 2010, 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)

\_\_\_\_\_  
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/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:**

- UA Net
- Kaiser Permanente HMO
- HMO Colorado  
(only available to current enrollees)
- Lumenos
- Waive medical coverage
- No change

**Dental Plan Options:**

- Exclusive Panel Option (EPO)
- Delta Dental PPO
- Waive dental coverage
- No change

**Coverage Levels:**

- | 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              |

**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 or Kaiser CO Springs, you must elect a primary care physician. PCP # \_\_\_\_\_ Current patient?  Yes  No

**DEPENDENT ENROLLMENT**

**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 # \_\_\_\_\_

If enrolling in UA Net or Kaiser CO 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

Date of birth \_\_\_\_\_ SSN # \_\_\_\_\_ Qualified tax dependent for health coverage?  Yes  No

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

If enrolling in UA Net or Kaiser CO Springs, you must elect a primary care physician. PCP # \_\_\_\_\_ Current patient?  Yes  No

Name—Last, First, MI \_\_\_\_\_ Gender  Male  Female

Date of birth \_\_\_\_\_ SSN # \_\_\_\_\_ Qualified tax dependent for health coverage?  Yes  No

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

If enrolling in UA Net or Kaiser CO Springs, you must elect a primary care physician. PCP # \_\_\_\_\_ Current patient?  Yes  No

Name—Last, First, MI \_\_\_\_\_ Gender  Male  Female

Date of birth \_\_\_\_\_ SSN # \_\_\_\_\_ Qualified tax dependent for health coverage?  Yes  No

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

If enrolling in UA Net or Kaiser CO Springs, you must elect a primary care physician. PCP # \_\_\_\_\_ Current patient?  Yes  No

Name (Last)

(First)

(Middle Initial)

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

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

- I elect to enroll.  I waive enrollment.  No change.

**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/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.**

**Employee \$50,000 Basic Term Life/AD&D Insurance**—UPI paid. Automatic enrollment.

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.

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

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 \$ \_\_\_\_\_.  
Initial eligibility—maximum amount is three times your annual salary. (\$1,000 increments)

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.

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

**DEPENDENT ENROLLMENT**

**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 \$ \_\_\_\_\_.  
Initial eligibility—maximum amount is \$50,000. (\$1,000 increments)

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.

**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.

Name (Last)

(First)

(Middle Initial)

**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 \$ \_\_\_\_\_.
- I waive enrollment. (\$10,000 increments)
- 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**

**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 \$ \_\_\_\_\_.
- I waive enrollment. (\$10,000 increments)
- 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 up to the maximum weekly benefit of your salary—see the Benefit Costs at [www.upicolo.org/benefits](http://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. *Exception:* If you have had a salary increase which makes you eligible for the next higher coverage level, and you are currently enrolled in the maximum amount, and you submit this form to increase your coverage within 31 days of your salary increase, you are not required to submit a Medical History Statement. Check one box only.

- 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.
- No change.

**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.

Name (Last)

(First)

(Middle Initial)

## 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](http://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 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

## 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.

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.