University Physicians, Inc.
13611 East Colfax Ave.
Aurora, CO 80045
http://www.upicolo.org/benefits

2009-10 Employee-Only Optional Life Enrollment Form
($10,000 No Additional Premium)

EMPLOYEE INFORMATION

Name (Last) (First) (Middle Initial)

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

Home Telephone Campus Telephone E-mail Address

ELECTION

Employees who are in an active, benefits-eligible position have a one-time opportunity to elect $10,000 of employee optional life at no additional premium cost (subject to tax on imputed income). To be eligible for the addtional $10,000, employees must currently be enrolled in optional life or must enroll during the 2009-10 open enrollment.

☐ Yes, I would like to elect this benefit, and I am currently enrolled in optional life.

☐ No, I decline to elect this benefit.

BENEFICIARY INFORMATION

Beneficiary designation(s) for this amount will be those listed on your most current optional life.

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.

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 Colorado benefits as outlined in the Benefits Guide, which is available online at www.cu.edu/pbs/benefits.
- I certify that I have been given the opportunity to enroll for group benefits insurance as offered by and through the University of Colorado. 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.

Signature Date