

## 2020-2021 CU GME Health/Dental Benefits Plan ENROLLMENT & CHANGE FORM

### Coverage Level

Choose One	To enroll dependents on the plan for the first time, documentation of dependent eligibility <b>MUST</b> be provided, e.g. birth or marriage certificate. An updated enrollment form must be submitted to add a newly acquired dependent even when it does not change current coverage level, e.g. "Resident + Child(ren)" or "Resident + Family" level.	Monthly Premium Contribution
<input type="checkbox"/>	Resident Only (Note: CU GME Residents married to each other with no additional dependents each carry an individual policy at this level.)	\$10.00
<input type="checkbox"/>	Resident + Child(ren) (Birth certificate or other dependent eligibility documentation required for dependent enrollment.)	\$28.00
<input type="checkbox"/>	Resident + Spouse* (Marriage certificate or other dependent eligibility documentation required for spouse enrollment.)	\$30.00
<input type="checkbox"/>	Resident + Family (Marriage certificate/birth certificates or other dependent eligibility documentation required for family enrollment.)	\$43.00

### Enrollment Type

- ☐ **Open Enrollment:** Current primary insurance is CU GME Health Benefits Plan and resident is continuing within a CU GME training program. Resident is requesting a change in status.
- ☐ **Newly Eligible:** Starting a CU GME training program for the first time OR returning after a break in active CU GME Health Benefits Plan coverage.
- ☐ **Qualifying Life Event:** A qualifying event that allows changes in enrollment status has occurred. **Date of qualifying life event:** \_\_\_\_/\_\_\_\_/\_\_\_\_  
This form and supporting documentation of dependent eligibility is due to the CU GME Benefits office within **31 days of the qualifying event.** (See eligibility and enrollment provisions in Plan Document for further details.)
- Add Dependent:** ☐ Marriage ☐ Birth ☐ Other \_\_\_\_\_
- Drop Dependent:** ☐ Legal Separation ☐ Divorce ☐ Other \_\_\_\_\_
- ☐ **Waive Coverage:** Decline coverage with the CU GME Health Benefits Plan. (See Enrollment Information for instructions and additional documentation requirement.)

### Resident

<p>Name: _____ Last First MI</p> <p>Social Security #: ____ - ____ - ____</p> <p>Date of Birth: ____/____/____</p> <p>Street Address: _____</p> <p>City, State, Zip: _____</p> <p>Home Phone: (____) _____ Day/Cell Phone: (____) _____</p>	<p><b>Gender:</b> <input type="checkbox"/> Male <input type="checkbox"/> Female</p> <p><b>Marital Status:</b> Do not request coverage for a "future" dependent on this form. Single Married Civil Union/Domestic Partnership</p> <p>Date of Marriage/Partnership: ____/____/____</p> <p>Divorced/Legally Separated Date of Divorce or Separation: ____/____/____</p>
---	--

### Spouse—includes common-law, civil union, domestic partner

Documentation of dependent eligibility (marriage certificate, domestic partnership or common-law marriage affidavit, civil union certificate) is required for new addition.

Full Name of Spouse: \_\_\_\_\_ ☐ Male ☐ Female  
Last First MI

SSN: \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Relationship to Resident: ☐ Spouse ☐ Common-law spouse ☐ Civil Union ☐ Domestic Partner

Is Spouse Employed? ☐ Yes ☐ No If Yes, name of employer? \_\_\_\_\_

Does your spouse have other insurance? Medical: Yes No Dental: Yes No (See Other Insurance Information on pg. 2 if answering YES.)

Are you requesting CU GME coverage for your spouse? ☐ Yes ☐ No (See Plan Enrollment Information if covered by more than one health insurance plan)

## Dependent Children

Documentation of dependent eligibility required for new addition

Last Name	First Name	MI	SSN (leave blank for newborn*)	Date of Birth	M/F	Relationship (Son, Daughter, Step-Child, etc.)	Enroll this dependent?		Other than this plan, does this dependent have any other insurance coverage?			
							Yes	No	Medical		Dental	
									Yes	No	Yes	No
			- -	/ /			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			- -	/ /			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			- -	/ /			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			- -	/ /			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

\*You may submit this form without a SSN for a newborn. Please forward SSN for newborns to GME Benefits office when received.

To list additional dependent children, include a separate sheet of paper with information and check here ☐

## Other Insurance Coverage

If you answered "yes" to any of the "Other Insurance Coverage" questions (for spouse or dependent), OR if you are waiving CU GME Health Plan coverage, please complete the following:

**Medical:** Name of Individual Carrying Policy: \_\_\_\_\_  
 Name of Insurance Company: \_\_\_\_\_

**Dental:** Name of Individual Carrying Policy: \_\_\_\_\_  
 Name of Insurance Company: \_\_\_\_\_

**All benefits are subject to the provisions of the Plan Document, posted at [medschool.cuanschutz.edu/GMEBenefits](https://medschool.cuanschutz.edu/GMEBenefits).**

The Plan is committed to protecting the privacy of your protected health information (PHI) to the extent of and in accordance with the uses and disclosures permitted by the Health Insurance Portability and Accountability Act (HIPAA), or as required or permitted by law. Specifically, the Plan will use and disclose PHI for purposes related to health care treatment, payment for healthcare and healthcare operations. The Plan's *Notice of Privacy Practices* is included in the Required Notices provided with new resident and annual/open enrollment information. It explains our privacy practices in detail. A copy of the *Notice* is posted on the website and a printed copy is available from the GME Benefits Office upon request.

- 1) I acknowledge it is the member's/participant's responsibility to know the terms of this insurance coverage.
- 2) I authorize those persons or institutions providing care, treatment, consultation, drugs, or supplies to furnish information regarding history, condition, consultation, or treatment rendered including copies of their records.
- 3) I authorize any insurance carrier, service plan, union or trust fund or employer to furnish information regarding benefits which I may be entitled to and authorize release of any information relevant to a determination of the applicability or implementation of Coordination of Benefits provision.
- 4) I understand that if any benefits are paid under the Plan for a condition or injury which is reimbursed to the member/participant by a third party, the Plan is entitled to a refund of such benefits to the extent such expenses are reimbursed for the same condition/injury/occurrence.
- 5) I authorize direct payment to providers or institutions for medical benefits when they have submitted a claim on behalf of an eligible family member. A photocopy of this authorization shall be considered as effective and valid as the original.
- 6) I certify that I have been given the opportunity to enroll for this Plan and understand that I cannot change certain elections until the next open enrollment period unless I have a qualifying event and adhere to the timeframes to change an election.
- 7) I understand that such coverage is provided through a self-funded stop loss program in lieu of an insurance plan and through an agreement between the University and its residents, not through an insurance carrier.
- 8) I hereby enroll for health care coverage for which I may be eligible as a trainee of the University of Colorado School of Medicine Training Programs.
- 9) I authorize the University to deduct the necessary premiums, if any, from my monthly stipend.

REQUIRED AUTHORIZATION: By checking this box, I certify that the information I provided on and in connection with this form is true, accurate and complete and that I have reviewed and acknowledge the above statements.

Last Name: \_\_\_\_\_

First Name: \_\_\_\_\_

Today's Date: \_\_\_\_\_

Last Four Digits of SSN: \_\_\_\_\_

Save and email: [Joseph.lafond@cuanschutz.edu](mailto:Joseph.lafond@cuanschutz.edu)

Mail: GME Benefits Office; Mailstop C293; 13001

East 17th Place, Aurora, CO 80045

Fax: 303-724-6034

This form is for enrollment in or waiver of the CU GME HEALTH/DENTAL BENEFITS PLAN.

For information and enrollment in optional vision care plan, visit [medschool.cuanschutz.edu/GMEBenefits](https://medschool.cuanschutz.edu/GMEBenefits) or contact the GME Benefits Office.

### GME USE ONLY

Effective Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Level Change from \_\_\_\_ to \_\_\_\_

Employee ID: \_\_\_\_\_

Roster Adjustments ☐

To TPA \_\_\_\_/\_\_\_\_/\_\_\_\_

Confirmation Email \_\_\_\_/\_\_\_\_/\_\_\_\_

**General CU GME Health/Dental Benefits Plan Enrollment Information**

- A complete, accurate form listing you (the resident) and all eligible dependents for whom coverage is requested is required when you start training (onboarding) and within 31 days of a qualifying event in order to add or remove a dependent. Plan year is July 1-June 30.
- After initial enrollment, the annual open enrollment period (April/May to take effect July 1) or **within 31 days of a qualifying event** are the only times an eligible dependent may be added to coverage.
- **To add new dependent(s) within 31 days of a qualifying event**, complete and return an updated Enrollment & Change form listing ALL dependents, including those already covered AND the new dependent(s), along with required documentation (e.g. marriage or birth certificate, applicable affidavits). This paperwork must be submitted within the 31-day timeframe. *Your dependent will not be enrolled if documentation is not provided.* If the deadline is missed, you must wait to add the dependent during the annual open enrollment period for coverage effective the next plan year.
- Do not request coverage for a “future dependent.” Enrollment of a newly eligible dependent must be requested within 31 days of the qualifying event (e.g. marriage or birth of a child) and include an updated Enrollment & Change Form and documentation of the new dependent’s eligibility.
- Claims will not be processed until the completed Enrollment & Change Form and required documentation is on file with the GME office.

**OPTIONAL OPT OUT of DENTAL COVERAGE**

- You are allowed to elect medical coverage only and opt out of (waive) dental coverage. Dental coverage is provided at no monthly premium cost to you. If you choose to opt out of dental coverage, please contact the GME Benefits Office ([Joseph.LaFond@cuanschutz.edu](mailto:Joseph.LaFond@cuanschutz.edu)).

**TO WAIVE COVERAGE with the CU GME HEALTH/DENTAL BENEFITS PLAN**

- On the Enrollment & Change Form, check the “Waive Coverage” box in the “Enrollment Type” area, enter your name in the “Resident” area on page 1, complete the “Other Insurance Coverage” information and “Required Authorization” area on page 2.
- Submission of completed enrollment form AND documentation of alternate health insurance coverage is required to waive coverage. When these items are received in the GME office by the 8th of the month, waive will be effective as of the first day of that same month. Submissions received after the 8th will make waive effective as of the first day of the following month.
- Verify the start date of your alternate insurance. Once the CU GME Health Plan is waived, enrollment is available only within 31 days of a qualifying event or during the annual enrollment period.
- *You must maintain medical insurance throughout your training.*

**COORDINATION OF BENEFITS (Coverage by more than one insurance plan)**

- Insureds cannot choose which insurance will serve as primary insurance. Benefits of the plan that covers the person directly (CU GME Health Benefits Plan for residents, or spouse’s employer plan for spouse) are determined before those of the plan that covers the person as a dependent.
- Spouses who are both CU GME Residents have “Resident Only” coverage and are not dependents of each other for the purposes of this plan. (Complete and submit *separate* enrollment forms, listing spouse as a “CU GME resident” on the “Name of Employer” in the Spouse’s section.)
- *Generally*, when a child is covered by the resident’s CU GME Plan and spouse’s insurance, the benefits of the plan of the parent whose birthday falls earlier in the calendar year are determined before those of the plan of the parent whose birthday falls later in the year. When both parents are CU GME residents, only the parent with the earliest birthday in the year will cover the child.
- If your spouse intends to waive or drop his/her coverage, making CU GME his/her primary (and only) insurance, provide proof of termination of the other coverage when it occurs.
- Notify your providers AND the CU GME Benefits Office immediately of any change in insurance status, including the addition of a primary insurance for your spouse, should s/he obtain insurance due to new employment, etc.

**NEWLY ELIGIBLE** The first day of coverage eligibility for CU GME benefits is your individual training agreement effective date (typically 6/23 for interns and 7/1 for PGY 2s and above), provided you have returned the required paperwork. If interim coverage prior to your first date of eligibility is desired, you may choose to purchase coverage, such as continuation of coverage through previous insurance carrier (e.g. COBRA), an individual interim insurance plan or the Health Insurance Marketplace ([www.healthcare.gov](http://www.healthcare.gov)).

**PLAN INFORMATION** Review Plan Document, Provider Directory and additional information about the CU GME Health Benefits Plan at [medchool.cuanschutz.edu/GMEBenefits](http://medchool.cuanschutz.edu/GMEBenefits). Contact CU GME Benefits Office, 303-724-6024 or 303-724-7325, with questions. *This is not considered a contract for benefits. Contract plan provisions prevail over any written or verbal interpretation.*