*Required if enrolling in Medical,Dental, or Vision

CHEIBA Trust Employee Benefit Plan

Adams State College
Auraria Higher Education Center
Colorado School of Mines
Colorado State University – Pueblo
Colorado State University System and
Colorado State University Global Campus
Fort Lewis College
Metropolitan State College of Denver
University of Northern Colorado
Western State College

SECTION 125 PREMIUM ONLY PLAN
Enrollment/Change Form

Employee Name: _____ SS #: _____

Type of Enrollment: (Check One)
____ New Enrollment
____ Annual Enrollment
____ Status Change

Effective Date: _____

☐ I authorize the employer to use a portion of my salary; before taxes, PERA or DCPP retirements are calculated, for coverage of the following insurance premiums (if applicable at your institution). I understand this election will continue automatically until the agreement is amended or terminated. I agree not to deduct insurance premiums on my tax return. I further understand that in the absence of a status change, this election is irrevocable for the plan year (January 1 – December 31).

☐ Medical and Dental ☐ Vision

☐ I do not wish to participate in the Section 125 premium only plan.

FOR STATUS CHANGE ONLY

☐ I wish to terminate the reduction of my salary for insurance premiums. A change, unless due to a status change, can only take place at the beginning of the plan year. A change must be requested within 31 days of the change and be consistent, necessary and appropriate as a result of the status change which occurred. My status changed on _____ as a result of:

_____ Change in legal marital status
_____ Change in Employee's number of tax eligible dependents
_____ Attainment or loss of dependent eligibility as defined by the plan
_____ Commencement of/or return from a Family and Medical Leave Act (FMLA) or other approved unpaid leave of absence
_____ Termination/Commencement of employment (employee, spouse or eligible dependent)
_____ Change in the place of residence or worksite (employee, spouse or eligible dependent)
_____ Change in employment status (employee, spouse or eligible dependent)
_____ Significant change in available benefits and/or their costs, when imposed by a third party
_____ Entitlement to/or loss of Medicaid or Medicare coverage (employee, spouse or eligible dependent)
_____ Open enrollment for benefits of spouse or eligible dependent

Employee Signature _____ Date _____

NOTE: Please remember that pre-tax deductions affect your Highest Average Salary as calculated by PERA under the Defined Benefit Plan. For more information, please contact PERA.