

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: _____ New Enrollment
(Check One) _____ Annual Enrollment Effective Date: _____
_____ Status Change

I authorize the employer to use a portion of my salary; before taxes, PERA or DCPD 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 the place of residence or worksite (employee, spouse or eligible dependent) |
| _____ Change in Employee's number of tax eligible dependents | _____ Change in employment status (employee, spouse or eligible dependent) |
| _____ Attainment or loss of dependent eligibility as defined by the plan | _____ Significant change in available benefits and/or their costs, when imposed by a third party |
| _____ Commencement of/or return from a Family and Medical Leave Act (FMLA) or other approved unpaid leave of absence | _____ Entitlement to/or loss of Medicaid or Medicare coverage (employee, spouse or eligible dependent) |
| _____ Termination/Commencement of employment (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.