COLORADO
Division of Human Resources
Department of Personnel & Administration

FY 2024-25 Supplement Program
Special Enrollment Form

If you have questions or need assistance with this form, contact the employee benefits unit at ***(303) 866-3434*** or ***1-(800)-719-3434*** or send an email to ***state_benefits@state.co.us***.

First Name: _____ Last Name: _____ SSN: _____

Agency/Institution: _____ Email Address: _____

Day Telephone: _____ Alternate Telephone: _____

This form is to be used by employees who have applied and were initially approved for the supplement program. You may enroll eligible dependent children in your current medical plan. You CANNOT add a spouse on this application as the supplement program is designed to provide medical coverage for eligible dependent children. You must complete this form and return it to the employee benefits unit no later than **5:00 p.m. MDT, on Monday, June 3, 2024.**

Email: state_benefits@state.co.us Subject: Special Enrollment for Supplement Program
Fax: (303) 866-3879, Subject: Special Enrollment for Supplement Program

You must sign the acknowledgements at the end of this form. Dependent eligibility documentation is ***required*** for any dependent added to your benefits at any time.

Medical Coverage

Your election is irrevocable and **cannot** be changed during the plan year, except as provided in the State of Colorado Salary Reduction Plan document.

PLAN:

- ☐ Cigna HDHP
- ☐ Cigna Copay Basic
- ☐ Cigna Copay Plus
- ☐ Kaiser HDHP
- ☐ Kaiser Copay Basic
- ☐ Kaiser Copay Plus

PREMIUM DEDUCTED:

- ☐ Pre-Tax
- ☐ Post-Tax

Covered Person(s):

Name	DOB	Relationship
		Self (employee)

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Dental Coverage

Your election is irrevocable and **cannot** be changed during the plan year, except as provided in the State of Colorado Salary Reduction Plan document.

PLAN:

- ☐ Delta Dental Basic
- ☐ Delta Dental Basic Plus

PREMIUM DEDUCTED:

- ☐ Pre-Tax
- ☐ Post-Tax

Covered Person(s):

Name	DOB	Relationship
		Self (employee)

Signature **Date**

Fraud

It is unlawful for any person to knowingly and intentionally provide false, incomplete, or misleading facts or information for any benefits enrollment or application process, affidavit, or other document or process for the purpose of defrauding or attempting to defraud the State of Colorado with regards to the application for benefits, benefits premiums or claim for benefits. Penalties may include imprisonment, fines, denial of enrollment in any or all of the state's group benefit plans, civil damages, termination of enrollment in any or all of the state's benefit plans, or as provided in regulations, statutes, and written directives.