FY 2025-26 Supplement Program Application

The application period is April 8, 2025, through May 9, 2025, at 11:59 p.m. (MT).

Employee Information

First Name Middle Initial Last Name

Social Security Number

Address City

State Zip Code

Primary Phone Number Secondary Phone Number

Primary Email Address Secondary Email Address

Date of Hire Gender

What agency/institution do you work for?

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Employee Information (continued)

As the employee, are you covered by a State of Colorado Medical Plan?

☐ Yes ☐ No

If you are covered by a State medical plan, which plan do you have?

Who are you covering on this plan?

Are you covering a student?

☐ Yes ☐ No

Is this person a U.S. citizen or legal resident?

Does this person receive Medicaid?

Dependent Information

Spouse Definition: Spouse includes a common law spouse or civil union partner.

Child Definition: A child is defined by state statute as a child, including adopted children, stepchildren, and foster children, who is less than twenty six (26) years of age (or any age for an unmarried child who has either a physical or mental disability, as defined by the health insurance vendor).

If needed, please attach additional sheets for dependent information.

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Dependent Information (continued)

First Name Middle Initial Last Name

Suffix Social Security Number

Address City

State Zip Code

Gender Date of Birth Relationship

Is this dependent covered by a State of Colorado employee?

☐ Yes ☐ No

What coverage do they have?

Is this person a U.S. citizen or legal resident?

Does this person receive Medicaid?

☐ Yes ☐ No

Does this person receive CHP+?

☐ Yes ☐ No

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Dependent Information (continued)

First Name | Middle Initial | Last Name

Suffix | Social Security Number

Address | City

State | Zip Code

Gender | Date of Birth | Relationship

Is this dependent covered by a State of Colorado employee?

☐ Yes ☐ No

What coverage do they have?

Is this person a U.S. citizen or legal resident?

Does this person receive Medicaid?

☐ Yes ☐ No

Does this person receive CHP+?

☐ Yes ☐ No

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Dependent Information (continued)

First Name Middle Initial Last Name

Suffix Social Security Number

Address City

State Zip Code

Gender Date of Birth Relationship

Is this dependent covered by a State of Colorado employee?

☐ Yes ☐ No

What coverage do they have?

Is this person a U.S. citizen or legal resident?

Does this person receive Medicaid?

☐ Yes ☐ No

Does this person receive CHP+?

☐ Yes ☐ No

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Dependent Information (continued)

First Name | Middle Initial | Last Name

Suffix | Social Security Number

Address | City

State | Zip Code

Gender | Date of Birth | Relationship

Is this dependent covered by a State of Colorado employee?

☐ Yes ☐ No

What coverage do they have?

Is this person a U.S. citizen or legal resident?

Does this person receive Medicaid?

☐ Yes ☐ No

Does this person receive CHP+?

☐ Yes ☐ No

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Dependent Information (continued)

First Name Middle Initial Last Name

Suffix Social Security Number

Address City

State Zip Code

Gender Date of Birth Relationship

Is this dependent covered by a State of Colorado employee?

☐ Yes ☐ No

What coverage do they have?

Is this person a U.S. citizen or legal resident?

Does this person receive Medicaid?

☐ Yes ☐ No

Does this person receive CHP+?

☐ Yes ☐ No

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Income Information

Please provide the total income for each household member (age 16 and older) from their 2024 Federal Income Tax Form. You will need to reference the following lines:

- Form 1040 - Line 9
- Form 1040A - N/A
- Form 1040EZ - N/A

Please Note: If you did not file a 2024 Federal Tax Return, you are not eligible to apply for this supplement.

Full Name	2024 Total Income
Full Name	2024 Total Income
Full Name	2024 Total Income
Full Name	2024 Total Income
Full Name	2024 Total Income

Application continues on the next page.

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Required Documentation

If this is your first time applying for the supplement application and you will need to attach the following documentation.

- Registered birth certificates,
- Adoption certificates,
- Allocation of parental responsibility requiring you to provide medical coverage,or
- Foster care documentation

- Registered marriage certificate,
- Civil union certificate,or
- Affidavit of common law

- Unexpired Driver's License,or
- State ID for all adult household members over the age of 16 (except employee and spouse)

If you are a new applicant or are re-applying for the supplement program, you must provide pages one and two of your 2024 Federal Tax Form(s). If you have wage earners age 16 and older who did not make enough to file taxes you must attach their 2024 W-2.

Did someone help you complete this application?

☐ Yes ☐ No

If you answered yes above, please fill out the following information about the person who helped you fill out this application.

Full Name

Phone Number

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Signature

I understand by signing below: I am giving my permission to the State of Colorado and its designees to make contacts to verify the information given on this application; and Under penalty of perjury, I certify all information I have given is true and correct; and I am submitting my signature electronically.

By submitting the Application for the State of Colorado Employee Premium Contribution Supplement, you understand the following:
It is unlawful for any employee, employee's dependent or other individual to knowingly and intentionally provide false, incomplete, or misleading facts or information on any benefits enrollment form, affidavit, or other document for the purpose of defrauding or attempting to defraud the State of Colorado with regards to the application for benefits 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; There is no guarantee that I will receive this supplement. This supplement is based on the information I have provided on my application as well as the income information verification I will be providing and the availability of sufficient funds to cover all employees eligible for the supplement; If I do qualify to receive the supplement, my employee premium contribution may be supplemented by an amount less than 100%; I am responsible for paying my employee plus child or employee plus family premium contribution should I not receive the supplement or if this supplement does not cover 100% of the my premium contribution;
If I do qualify to receive the supplement, the amount of the supplement will not be known until sometime AFTER July 31, 2025; If I qualify for the supplement, I will have to pay my employee plus child or employee plus family premium contributions until the supplement payment begins, after which I will then be reimbursed based on the amount of the supplement; When I enroll for coverage under a health plan, that election is irrevocable and I cannot change my election until the next open enrollment unless I have a Qualified Change in Status Event allowing me to change my coverage. This means that if I enroll myself and my dependents in the medical plan
(and dental plan, if elected) and am not approved for the supplement, I must continue the plan coverage elected and pay the entire employee plus child or employee plus family premium. I will not be allowed to drop coverage for myself or a dependent just because I am not approved for a supplement or due to financial hardship; If I believe the State of Colorado has made an error in assessing my application, I can ask for a review; and Information I have given is confidential. However, it can be used or shared by the program(s) that each of your family member(s) is enrolled in for purposes of treatment, payment, program operations, and other purposes permitted by law. The information may also be used to confirm or deny the eligibility of any child or enrollee who is determined to not be eligible for coverage under the Plan. I understand that if I apply for a supplement for a dependent and the information shows the dependent is not eligible for medical coverage, that dependent's coverage will be terminated.

Signature Date