COLORADO
Division of Human Resources
Department of Personnel & Administration

Supplement Program Attestation of Unemployment

Employee Name: _____ Last Four of SSN: _____

Agency Department: _____

Email: _____ Phone: _____

I attest the following household members, age 16 and older, did not receive *any* wages during 2024:

Name: _____ Date of Birth: _____

Name: _____ Date of Birth: _____

Name: _____ Date of Birth: _____

Name: _____ Date of Birth: _____

Name: _____ Date of Birth: _____

Name: _____ Date of Birth: _____

By my signature below, I attest to the following:

- I am a current State of Colorado benefits eligible employee;
- I am applying for the FY 2025-26 Medical Premium Supplement Program;
- The individuals above listed are part of my current household and are age 16 and older;
- The individuals above listed did not receive any wages during 2024; they did not file an income tax return, nor did they receive a W2.

I attest that the information contained herein is true and complete.

Signature: _____ Date Signed: _____

It is unlawful for any person 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 benefits 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.