CONNECT for HEALTH COLORADO

ELG-005-06
V0.5

Small Business Report Life Change Events Form

Employers or their authorized representative will need to fill out this form and include a signed Colorado Uniform Employee Application with the employee changes updated.

Use this form to report Life Change Events

- **If your small business has a health plan through the Marketplace, employers must report changes within 30 days of a qualifying life change event.**
- If your household has a health plan through the Marketplace AND Medicaid/CHP+, you MUST report changes on this form AND to the State through your county office or online through the Colorado Program Eligibility and Application Kit (PEAK) at Colorado.gov/PEAK within 10 days of any change.

Note: General changes may also be reported using this form. Please only provide supporting documentation upon request.

Examples of Life Change Events

Events that allow current employees to Shop for a new plan or change an existing plan:	Events that allow new employees to Shop for a health plan:	Events that allow current employees to Update current plan only:
-Marriage or civil union -Birth or adoption -Change of residence (if moving out of a service area) -Incorrect or inappropriate enrollment NOT due to customer error -A customer demonstrates that their health plan has substantially violated a material provision of its contract	-Loss of minimum essential coverage (MEC) -Employer-sponsored coverage becomes unaffordable -Change in incarceration status -A customer demonstrates that their health plan has substantially violated a material provision of its contract	-Removal of dependent due to divorce/annulment/separation -Removal of dependent due to child age out (dependent turns 26) -Removal of dependent due to death

What happens next?

- Employers need to send the completed, signed form along with any applicable Colorado Uniform Employee Application Forms to the address in **Part D**.

Get help with this form free of charge

- If someone is helping you fill out this form, you may need to complete **LCE Worksheet D** if you have not provided the information to the Marketplace before.
- If you need help in a language other than English, call and tell the customer service representative the language you need.
- **En Español:** Llame a nuestro centro de servicio gratis para ayuda en Español.

Online:	ConnectforHealthCO.com
Phone:	1-855-PLANS-4-YOU (1-855-752-6749)
In Person:	Visit the Connect for Health Colorado website for a list of Certified Connect for Health Colorado Health Coverage Guides(i) and Agents/Brokers(i) in your area who can help.
TTY/TDD:	1-855-346-3432

Additional Language Assistance

English	If you need help understanding this document, please call 1-855-752-6749. We can provide an interpreter for free.
Español	Si necesita ayuda para entender mejor este documento comuníquese al 1-855-752-6749. Le podemos asistir gratuitamente con un intérprete.
普通话	如果您在理解本文方面需要帮助，请致电 1-855-752-6749。我们将免费提供口译服务。
Tiếng Việt	Nếubạncầntrợgiúptìmhiểutàiliệunày, vuilònggọi 1-855-752-6749. Chúngtôicóthểcungcấp-phiêndịchviênmiễnphí.
한국어	이문서를이해하는데있어도움이필요할경우 1-855-752-6749번으로전화하십시오. 무료통역서비스를제공해드립니다.
Русский	Если вам нужна помощь, чтобы понять этот документ, пожалуйста, позвоните по номеру 1 855 752 6749. Мы можем предоставить бесплатные услуги переводчика.
العربية	إذا كنت بحاجة إلى مساعدة في فهم هذا المستند، فالرجاء الاتصال على 1-855-752-6749. يمكنك توفير مترجم مجاناً.
Ntawv Hmoob	Yogkojxav tau kevpabqhiakomnkagsiabcovntaubntawvno, thovhurau 1-855-752-6749. Pebtua-jyeempabib tug kwstxhaislus pub dawbraukoj.
አማርኛ	ይህን ሰነድ ለመረዳት እገዛ ከፈለጉ እባክዎ በስ.ቁ. 1-855-752-6749 ይደውሉ። አስተርጓሚ በነፃ ልናቀርብልዎት እንችላለን።
नेपाली	यदि तपाईलाई यो कागजात बुझ्न सहयोगको चहनि्छ भने, कृपया 1-855-752-6749 मा टेलफिोन सम्पर्क गर्नुहोस् । हामी तपाईलाई नि:शुल्क दोभाषे उपलब्ध गराउन सक्छौं ।
Soomaali	Haddii aad u baahantahay kaalmo si aad u fahanto xogtan, fadlan la soo hadal 1-855-752-6749. Waxa aannu kuu heli karaynaa afceliyeen (turjubaan) bilaa lacag ah.
Français	Veuillez téléphoner au 1-855-752-6749 si vous avez besoin d'aide concernant l'explication de ce document. Nous pouvons vous proposer un interprète gratuitement.
Deutsch	Wenn Sie zum besseren Verständis dieses Dokuments Hilfe benötigen, rufen Sie uns unter 1-855-752-6749 an. Wir können Ihnen kostenlos einen Dolmetscher zur Verfügung stellen.

Privacy Statement

We will keep your information private as required by law. Your answers on this form will only be used to see if your business or organization is eligible for Small Business Health Insurance and, if eligible to facilitate and support your enrollment.

Part A Small Business Account Information

Employer, please fill out the following information about yourself and your business.

1. Legal First name, Middle name, Last name, & Suffix	2. Effective date of change

3. Legal Business Name as it appears on your Marketplace account	4. Marketplace Employer Group Number

5. Email Address	6. Phone number

Part B Employee/Dependent Information Table

Employee/Dependent Information Table

This table is for the addition of new people to the account or deletion of people from the account. Please specify whether or not this is an addition or deletion from the account along with filling out the field associated with each individual.

NOTE: All changes should also be reported by the employee using the Colorado Uniform Employee Application form and be attached to this employer form.

Employee/ Dependent Info	Legal Name (First, Middle, Last, & Suffix)	EE or Dep	Qualifying Life Change Event	Date of Event	If Dep, Employee Name & Relationship to EE
PERSON 1 ☐ Add ☐ Drop					
PERSON 2 ☐ Add ☐ Drop					
PERSON 3 ☐ Add ☐ Drop					
PERSON 4 ☐ Add ☐ Drop					
PERSON 5 ☐ Add ☐ Drop					

Relationship Type Suggestions:
You may write in other relationships if needed.
Husband, Wife, Domestic Partner, Mother, Father, Stepmother, Stepfather, Parent's domestic partner, Son, Daughter, Stepson Stepdaughter, Child of domestic partner, Brother Sister, Stepbrother, Stepsister, Half brother, Half sister, Disabled Adult Dependent, Unrelated

Suggested Qualifying Life Change Events:
New Hire, Termination of Employment, Change of Address, Marriage, Civil Union, Divorce or Annulment, Legal Separation, Death, Birth, Adoption or Placement for Adoption, Dependent Child Ages Off (26+yrs old), Gain of Dependent - Other, Loss of Minimum Essential Coverage (MEC), Incarceration, Newly Eligible for other coverage (Medicare, Medicaid, CHP+, Employer Sponsored Plan), Erroneous Enrollment,
Other - Explain

In the space below, please add any details you would like to include regarding the Life Change Event(s) you have selected above or details about any other change you would like to report.

Part C Rights, Responsibilities, and Penalties

1. I understand that my answers, together with any supplements or additional pages, are the basis for the health insurance policy that is issued. I agree that no insurance will be effective until the date specified by the insurance company or organization providing the certificate, policy, or notice. I understand that I may request a copy of this form. I agree that a photographic copy of this form shall be as valid as the original. A legible copy signature shall have the same force and effectiveness as the original. This document, or the information contained herein, will become a part of the contract when coverage is approved and issued.

2. I know that under federal law, discrimination is not permitted on the basis of race, color, national origin, sex, age, sexual orientation, gender identity, or disability. I can file a complaint of discrimination by visiting www.hhs.gov/ocr/office/file.

My right to appeal:

3. If I think Connect for Health Colorado has made a mistake, I can appeal its decision. To appeal means to tell someone at Connect for Health Colorado that I think the action is wrong and ask for a fair review of the action. I know that I can find out how to appeal by contacting the Marketplace at 1-855-PLANS-4-YOU or by visiting their website at ConnectforHealthCO.com. I know that I can be represented in the process by someone other than myself. My eligibility and other important information will be explained to me.

☐ **By checking this box**, I agree to allow my information to be used and collected from data sources for this form. I have consent for all people I list on the form allowing collection of information about them from data sources for this form. (See page 3 for full Privacy Statement.)

Sign this form. The Account Holder should sign this form. If you are an authorized representative, you may sign here as long as you have provided the information required to the Marketplace on **LCE Worksheet D** either now or in the past.

Signature of Account Holder or Authorized Representative	Date (mm/dd/yyyy)
Employer's Signature	Date (mm/dd/yyyy)

Note:

Part D Mail or Fax Completed Form

Connect for Health Colorado
Report Account Changes
P.O. Box 35033
Colorado Springs, CO 80935

Fax: 1-855-346-5175

ConnectforHealthCO.com

1-855-PLANS-4-YOU (1-855-752-6749)

Note: If you need help in a language other than English, call and tell the customer service representative the language you need.

En Español: Llame a nuestro centro de servicio gratis para ayuda en Español, al 1-855-PLANS-4-YOU (1-855-752-6749).
TTY/TDD: 1-855-346-3432

LCE Worksheet D Name of Account Holder_____

Assistance with Completing this Form

You can choose an authorized representative.

This trusted person would be given permission to talk about this form with us, see your information, and act for you on matters related to this form, including getting information about your form and signing your form on your behalf. This person is called an "authorized representative" and takes legal responsibility for the information provided in this form.

1. Name of authorized representative (First name, Middle name, Last name, & Suffix)

2. Address		3. Apartment or suite number
4. City	5. State	6. ZIP code

7. Phone number ( ) – Ext. _____	Phone Type: ☐ Cell ☐ Home ☐ Work

8. Email address

9. Company/Organization name (if applicable)	10. Company/Organization ID number (if applicable)

By signing, you allow this person to sign your form, get official information about this form, and act for you on all future matters with this agency.

11. Your signature	12. Date (mm/dd/yyyy)

☐ I, the **authorized representative**, would like to submit proof of a legal reason that the ACCOUNT HOLDER cannot represent themselves. (Please provide a copy of one of the following documents with this form when it is submitted: a power of attorney, court order establishing legal guardianship, a copy of a photo ID of the applicant who you are representing as his/her authorized representative, or other legal document explicitly stating that you may legally act on behalf of the customer.)

For certified application counselors, health coverage guides(i), agents(i), and brokers(i) only. Complete this section if you are a certified application counselor, health coverage guide, agent, or broker filling out this form for somebody else.

1. Form start date (mm/dd/yyyy)

2. Select one: ☐ counselor ☐ health coverage guide ☐ agent/broker

3. First name, Middle name, Last name, & Suffix

4. ID number (Guide ID or state license number, as applicable.)

Note: If you wish to change and/or revoke your current Authorized Representative or Agent/Broker, please fill out LCE Worksheet F for Connect for Health Colorado.

LCE Worksheet F Name of Account Holder_____

Change or Revocation Form

This form can be used to change or revoke your current Authorized Representative or Agent/Broker.

An Authorized Representative is a trusted person who would be given permission to talk about an application, form, or appeal request with us, see your information, and act for you on matters related to the application, form, or appeal, including getting information about your application, form, or appeal request and signing your application, form, or appeal request on your behalf. This person takes legal responsibility for the information provided on your application, form, or appeal request.

An agent or broker is a licensed professional who offers policies from one or several insurers that they are contracted to represent. Agents and brokers can provide assistance in comparing the rates and benefits of health plans from several companies. An experienced agent or broker can provide expert and detailed information on plan specific features and limitations of various policies.

What would you like to do?

- ☐ **Add an Authorized Representative or Agent(i)/Broker(i) for the first time, complete LCE Worksheet D**
- ☐ **Change your current Authorized Representative, complete section 1**
- ☐ **Revoke permission for your current Authorized Representative, complete section 2**
- ☐ **Change your current Agent/Broker, complete Section 3**
- ☐ **Revoke permission for your current Agent/Broker, complete Section 4**

Section 1 Change your Authorized Representative

1. Name of new authorized representative (First name, Middle name, Last name, & Suffix)

2. Address		3. Apartment or suite number
4. City	5. State	6. ZIP code
7. Phone number ( ) – Ext. _____		8. Phone Type: ☐ Cell ☐ Home ☐ Work

9. Email address

10. Company/Organization name (if applicable)	11. Company/Organization ID number (if applicable)

By signing, you allow this person to sign your application, form, or appeal request, get official information about your application, form, or appeal, and act for you on all future matters with this agency.

12. Your signature	13. Date (mm/dd/yyyy)

☐ I, the **authorized representative**, would like to submit proof of a legal reason that **PERSON 1** cannot represent themselves. (Please provide one of the following documents with this application or appeal request when it is submitted: a power of attorney, court order establishing legal guardianship, a copy of a photo ID of the applicant who you are representing as his/her authorized representative, or other legal document explicitly stating that you may legally act on behalf of the customer.)

Section 2 Revoke Permission for Authorized Representative

This Authorized Representative will no longer have permission to talk about an application, form, or appeal request with us, see your information, and act for you on matters related to an application, form, or appeal request, including getting information about or signing your application, form, or appeal request on your behalf.

1. Name of authorized representative you wish to revoke(First name, Middle name, Last name, & Suffix)

2. Phone number ( ) – Ext. _____	3. Phone Type: ☐ Cell ☐ Home ☐ Work
4. Company/Organization name (if applicable)	5. Company/Organization ID number (if applicable)

By signing, you are no longer allowing this person to sign your application, form, or appeal request, get official information about this application, form, or appeal, and act for you on all future matters with this agency.

6. Your signature	7. Date (mm/dd/yyyy)

Section 3 Change your Agent/Broker

1. Name of new Agent/Broker (First name, Middle name, Last name, & Suffix)

2. Address		3. Apartment or suite number
4. City	5. State	6. ZIP code
7. Phone number ( ) – Ext. _____		8. Phone Type: ☐ Cell ☐ Home ☐ Work

9. Email address

10. Company/Organization name (if applicable)	11. State License Number
12. Your signature	13. Date (mm/dd/yyyy)

Section 4 Revoke Permission for Agent/Broker

This Agent/Broker will no longer have permission to be the Agent/Broker of Record on your Connect for Health Colorado account. See your Agent/Broker to see if there are any additional steps required to revoke them as your Agent/Broker outside of the Marketplace.

1. Name of Agent/Broker you wish to revoke (First name, Middle name, Last name, & Suffix)

2. Phone number ( ) – Ext. _____	3. Phone Type: ☐ Cell ☐ Home ☐ Work
4. Company/Organization name (if applicable)	5. State License Number
6. Your signature	7. Date (mm/dd/yyyy)

Division of Insurance

COLORADO UNIFORM EMPLOYEE APPLICATION FOR SMALL GROUP HEALTH BENEFIT PLANS

This form is designed for an employee's initial application for coverage. Please contact your agent or the carrier to determine if this form should be used in other situations once the group is enrolled with the carrier.

COVERAGE INFORMATION				
Application Type:	☐ New Coverage	☐ Change/Modification to Existing Policy	☐ Open Enrollment	☐ Special Enrollment*

* Proof of eligibility for special enrollment will be required – information on eligibility for special enrollment periods is available at: www.dora.colorado.gov/DOI/HealthApp

EMPLOYER INFORMATION			
Employee Name:		**Employer Name:**	
Proposed Effective Date:		**Group Number (if known):**	

EMPLOYEE INFORMATION							
Employee Instructions: Please type or print using black or blue ink. Please fill out the entire application for each person for whom coverage is being sought.							
First Name:		Middle Initial:		Last Name:			
Social Security #:		Date of Birth:	/ /	Current Age:		Sex:	☐ M ☐ F
Address:				City:			
County:		State:		Zip:			
Mailing Address (If different):				City:			
County:		State:		Zip:			
Home Phone:		Email:		☐ Home	☐ Work		
What is your job title at your current employer?				Work Phone:			
What was your first day of employment?		How many hours, on average, do you work each week?					
Are you (check one):	☐ Single	☐ Married	☐ Common Law*	☐ Civil Union*			
	☐ Designated Beneficiary*	☐ Legally Separated	☐ Divorced	☐ Widow or Widower			
* A common law, civil union, or designated beneficiary certification may be required by the carrier							
Are you on COBRA or State Continuation?	☐ Yes	☐ No	Start Date:		Stop Date:		

TYPE OF HEALTH COVERAGE

List all dependents (spouse/partner and child(ren)) applying for coverage. **If you need additional space, please use a separate sheet of paper and attach it to this application (please print your name and sign and date the additional sheet).**

Please select the type of health insurance coverage for which you are applying: ☐ Employee Only ☐ Employee & Family

DEPENDENT INFORMATION
(list all dependents to be covered)

Name (First, MI, Last)	Sex	Social Security Number	Relationship	Disabled	Birth Date (MM/DD/YY)
	☐ M ☐ F		SPOUSE/PARTNER		
	☐ M ☐ F		☐ CHILD ☐ STEPCHILD	☐ Yes ☐ No	
	☐ M ☐ F		☐ CHILD ☐ STEPCHILD	☐ Yes ☐ No	
	☐ M ☐ F		☐ CHILD ☐ STEPCHILD	☐ Yes ☐ No	

Employee Name:	Employer Name:

TOBACCO USE

Please answer the following questions to the best of your knowledge. 45 CFR 147.102(a)(1)(iv) "For purposes of this section, tobacco use means use of tobacco on average four or more times per week within no longer than the past 6 months. This includes all tobacco products, except that tobacco use does not include religious or ceremonial use of tobacco. Further, tobacco use must be defined in terms of when a tobacco product was last used."

Has anyone named in this application used tobacco or smokeless tobacco during the past 6 months? If yes, provide the information requested below.

Name of Person	Used Tobacco Products	If Yes, check all that apply	Duration	Frequency
	☐ Yes ☐ No	☐ Cigarettes ☐ Chewing Tobacco ☐ Pipe/Cigars		
	☐ Yes ☐ No	☐ Cigarettes ☐ Chewing Tobacco ☐ Pipe/Cigars		
	☐ Yes ☐ No	☐ Cigarettes ☐ Chewing Tobacco ☐ Pipe/Cigars		
	☐ Yes ☐ No	☐ Cigarettes ☐ Chewing Tobacco ☐ Pipe/Cigars		

EMPLOYEE/DEPENDENT WAIVER OF COVERAGE

Complete this section ONLY if you are not enrolling yourself or your spouse/partner or dependents. Waiver must be completed for all of your dependents to be eligible for enrollment on this plan in the event of changing circumstances. I understand that I am eligible to apply for group health coverage through my employer. I do **NOT** want, and hereby waive, group health coverage for:

	Name (Last, First, MI)	Birth Date (Mo/Day/Year)
Employee		
Spouse/Partner		
Dependent 1		
Dependent 2		
Dependent 3		

I am **waiving** group health coverage for myself and/or the dependents listed above because (check all that apply, **copy of ID card may be required**):

- ☐ I am covered under my spouse/partner's group policy.
- ☐ My spouse/partner is covered under another plan (including this plan, if spouse/partner is also an employee).
- ☐ My dependents are covered under another plan.
- ☐ I wish to continue other coverage obtained through an Individual Plan or Medicare
- ☐ Other (Please explain): _____

WAIVER: I certify that I have been given the opportunity to apply for group health coverage and decline to enroll as indicated above, on behalf of myself, my spouse/partner and my dependent child(ren). I understand that by signing this waiver, I, my spouse/partner, and my dependent child(ren) forfeit the right to coverage. I was not pressured, forced or unfairly induced by my employer, the agent or the carrier(s) into waiving or declining the group health coverage. If in the future I apply for coverage, I, my spouse/partner, or any of my dependent child(ren) may be treated as a late enrollee and subject to postponement of coverage for up to 12 months.

I understand that if I am declining enrollment for myself, my spouse/partner, or my dependent child(ren) because of other health coverage, I may, in the future, be able to enroll myself, my spouse/partner, or my dependent child(ren) in this plan, as required by law, provided that I request enrollment within 30 days after my other health coverage ends or a qualifying event occurs. **If I do not request enrollment within 30 days of the above events, I understand that I may not be able to enroll for coverage until my company's Open Enrollment period. I understand that I can obtain information related to my enrollment eligibility from my employer or small group health carrier.**

Signature of Employee: **Date Signed:**

Employee Name:	Employer Name:

MEDICARE INFORMATION

If you need to complete this section for more than one person, please use a separate sheet of paper and attach it to this application (please sign and date the additional sheet). A copy of your ID card may be required.

Are you, your spouse/partner or your child(ren) covered by:

Medicare Part A? ☐Yes ☐No Medicare Part B? ☐Yes ☐No Medicare Part D? ☐Yes ☐No

If "Yes," reason for Medicare: ☐ 65+ Eff. Date_____ ☐Disability Eff. Date_____

☐ End-Stage Renal Disease (ESRD) Eff. Date_____ ☐ Disability and ESRD Eff. Date_____

Name of person covered by Medicare:

CURRENT MEDICAL COVERAGE

Do you, your spouse/partner, or your dependent child(ren) listed in this application currently have health insurance coverage? ☐ Yes ☐No

Is the plan information listed below the same for your spouse/partner and all dependents? If yes, skip to next section. ☐ Yes ☐No

Your information will help the small employer carrier(s) to coordinate benefits with any other group health coverage you may have.

Name	Carrier Name Carrier Phone Number	Plan Name Group Number Subscriber ID#	Effective Date of Coverage (MM/DD/YY)	Termination Date of Coverage (MM/DD/YY)	Type of Coverage (See Key Below)

Type of Coverage Key: G = Group Comprehensive Major Medical; I = Individual Comprehensive Major Medical; MS = Medicare Supplement; H = Hospital Coverage Only; V = Vision Coverage Only O=Other, please explain:_____

HEALTH PROVIDER OR PRODUCT SELECTION, IF APPLICABLE

Please select the type of coverage for which you are applying from the plans offered by your employer and issued by the carrier. This section should be completed only if the small employer group insurance for which you are applying requires the selection of a primary care provider. A selection should be made for each individual applying for such coverage and for each carrier from which insurance coverage is being sought. The provider information may be listed in the provider materials that are supplied by each carrier to your employer. Use additional sheets if necessary.

Covered Person's Name	Medical Plan	Primary Care Physician Name:	Primary Care Physician Address: (optional)	Is this your current provider?

Employee Name:	Employer Name:

TERMS AND CONDITIONS

I acknowledge that I have read all sections of this Colorado Uniform Employee Application for Small Employer Group Health Coverage (Application), and I certify on behalf of my eligible family dependents and myself that the answers contained in this Application are complete and accurate to the best of my knowledge. I understand and agree that neither my employer nor any insurance agents have any authority to waive my complete answer to any question, agree to insurability, alter any contract, or waive any Colorado small employer carrier's other rights or requirements.

I hereby apply for enrollment for myself and for my eligible family dependents listed. On behalf of my eligible family dependents and myself, I agree to all of the terms and conditions of the group contract(s) with Colorado small employer carrier(s) under which I wish to enroll for coverage. I have indicated in this Application, if required, what product(s) or provider(s) I have selected. **I agree that no coverage will be effective until the date specified by the Colorado small employer carrier(s) with whom I enroll, after this application has been accepted by such carrier(s)**.

I understand and agree that any information obtained in connection with this Application will be used by Colorado small employer carrier(s) to determine eligibility for coverage.

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance carrier for the purpose of defrauding or attempting to defraud the carrier. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance carrier or agent of an insurance carrier who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

When applicable, I authorize my employer to deduct contributions from my earnings to be applied to the cost of coverage.

I agree to any applicable group contract provisions for the resolution of disagreements and disputes, including arbitration when required and as allowed by law. Please refer to any arbitration provisions in the group contract(s).

I understand that I may request a copy of this Application. I agree that a photographic copy of this Application shall be as valid as the original. A legible facsimile signature shall have the same force and effectiveness as the original. This document will become a part of the contract when coverage is approved and issued.

Signature of Employee: _____ **Date Signed:** _____

DISCLOSURES

COLORADO INSURANCE LAW REQUIRES ALL CARRIERS IN THE SMALL GROUP MARKET TO ISSUE ANY APPLICABLE HEALTH BENEFIT PLAN IT MARKETS IN COLORADO TO ANY SMALL EMPLOYER THAT APPLIES FOR THE PLAN AND AGREES TO MAKE THE REQUIRED PREMIUM PAYMENTS, AND SATISFIES THE OTHER PROVISIONS OF THE HEALTH BENEFIT PLAN.

This document is a publication of the Colorado Division of Insurance. If you have questions about the content of this document please contact our offices at 303-894-7499 or visit our website at http://dora.colorado.gov/insurance. For questions regarding coverage or enrollment please see your employer.

Employee Name:	Employer Name:

This page may be used to provide additional information that was required in the sections above and did not fit in the space provided.

Signature of Employee: _____ Date Signed: _____