DEPARTMENT OF REGULATORY AGENCIES

Division of Insurance

3 CCR 702-4

LIFE, ACCIDENT AND HEALTH

Amended Regulation 4-2-45

UNIFORM INDIVIDUAL AND SMALL GROUP HEALTH BENEFIT PLAN APPLICATIONS

Section 1 Authority

This regulation is promulgated and adopted by the Commissioner of Insurance under the authority of §§ 10-1-109, 10-16-107.5(1), and 10-16-109, C.R.S.

Section 2 Scope and Purpose

The purpose of this regulation is to promulgate rules concerning the uniform individual and small group health benefit plan applications.

Section 3 Applicability

This regulation applies to all carriers offering individual and small group health benefit plans that are subject to Colorado insurance laws accepting applications for coverage on or after January 1, 2025. This includes carriers offering coverage under Parts 2, 3, and 4 of Article 16 of Title 10 of the Colorado Revised Statutes.

Section 4 Definitions

A. “Exchange” shall have the same meaning as found at § 10-16-102(26), C.R.S.

B. “Uniform Individual Application” means, for purposes of this regulation, the individual application developed and published by the Division of Insurance (Division) for use by carriers in collecting information from an applicant to determine what plans are appropriate for the applicant to consider.

C. “Uniform Small Group Application” means, for purposes of this regulation, the small group application developed and published by the Division of Insurance (Division) for

use by carriers in collecting information from employees to determine what plans are appropriate for the employee to consider.

Section 5 Rules

A. Carriers must comply with the following requirements concerning electronic and non-electronic applications:

1. All carriers offering individual health benefit plans outside of the Exchange must use the Uniform Individual Application when collecting enrollment information from consumers. The Uniform Individual Application can be found in Appendix A of this regulation.

2. All carriers offering individual health benefit plans within the Exchange will use the Uniform Individual Application for the non-electronic collection of enrollment information from consumers.

3. All carriers offering small group health benefit plans must use the Uniform Small Group Application when collecting enrollment information from employees and their dependents.

    a. This application will be utilized by the Exchange as the non-electronic enrollment application for small group employees in the Small Business Health Options Program (SHOP).

    b. The Uniform Small Group Application can be found in Appendix B of this regulation.

4. Carriers may not alter, modify, or change the uniform applications developed by the Division.

5. Carriers may not add logos or other graphics or text to the uniform applications except where designated on the uniform applications found in Appendix A and Appendix B.

6. A carrier shall not deny an application for a health benefit plan solely on the basis of an applicant electing to not provide a Social Security Number, Tax Identification Number, or Alternative Identification Number.

B. The Exchange may require additional information, through the use of an electronic application or a supplemental questionnaire, to collect information to comply with federal law for on-Exchange products.

C. Carriers shall make electronic and non-electronic applications available in Spanish.

Section 6 Severability

If any provision of this regulation or the application of it to any person or circumstance is for any reason held to be invalid, the remainder of this regulation shall not be affected.

Section 7 Enforcement

Noncompliance with this regulation may result in the imposition of any of the sanctions made available in the Colorado statutes pertaining to the business of insurance, or other laws, which

include the imposition of civil penalties, issuance of cease and desist orders, and/or suspensions or revocation of license, subject to the requirements of due process.

Section 8 Effective Date

This regulation shall become effective on January 1, 2025.

Section 9 History

New regulation effective October 15, 2013.
Amended regulation effective November 1, 2020.
Amended regulation effective November 1, 2021.
Amended regulation effective January 1, 2025.

Appendix A

[CARRIER LOGO]

COLORADO UNIFORM **INDIVIDUAL** APPLICATION FOR MAJOR MEDICAL HEALTH BENEFIT PLANS

This form is designed for an individual's application for coverage. Please contact your carrier with questions regarding this form.

Federal financial assistance may be available for coverage purchased through Connect for Health Colorado. If purchasing coverage through Connect for Health Colorado, you will need to provide additional information for determination of eligibility for federal financial assistance. Further information may be found at www.connectforhealthco.com.

COVERAGE INFORMATION

Application Type: (check all that apply)	☐ New Coverage ☐ Change/Modification to Existing Coverage ☐ Open Enrollment ☐ Special Enrollment*				
Is the applicant purchasing this plan using a reimbursement arrangement (if applicable):	☐ Yes ☐ No	If so, what type:	☐ HRA	☐ ICHRA	☐ QSEHRA
Special Enrollment Period Qualifying event: ☐ Loss of Coverage ☐ Birth/Adoption/Placement for Adoption ☐ Marriage ☐ Other:_____ Date of Event:_____					
Requested Effective Date:	_____/_____/_____(MM/DD/YYYY)				

* Proof of eligibility for special enrollment will be required – information available on the DOI website at: https://www.colorado.gov/pacific/dora/division-insurance

PRIMARY APPLICANT/INSURED INFORMATION

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. If a person is currently enrolled in Medicare, this application should not be completed for that enrolled individual. If additional pages are needed to fully complete this application please attach, sign, and date each page.

First Name:		Middle Initial:		Last Name:	
SSN/TIN/ALT ID #: (Optional)		Date of Birth:	/ /	Current Age:	Gender: ☐ M ☐ F ☐ X

SSN is only necessary to determine eligibility for federal Advance Premium Tax Credit and Cost Sharing Reductions. Not filling out this field shall not be a reason to deny an application for coverage.

Physical Address:				City:	
County:		State:		Zip:	
Mailing Address (If different, can be P.O. Box):				City:	
County:		State:		Zip:	
Home Phone:		Alternate Phone:		Email:	

Are you (check one): ☐ Single ☐ Married ☐ Common Law ☐ Civil Union ☐ Legally Separated ☐ Divorced ☐ Under 21

Are you or is anyone in your family American Indian or Alaskan Native? ☐ Yes ☐ No

This question is being asked as American Indians and Alaskan Natives have an enhanced ability to enroll in health benefit plans.

Tell us about your race. *This information is confidential and will only be used to help us improve service to all Coloradans. We use this information to make sure everyone gets fair access to coverage. Providing this information will not impact eligibility, plan options, or costs.*

What is your race? (Select all that apply) *(optional)*

☐ American Indian/Alaskan Native ☐ Asian/Asian American ☐ Black/African American ☐ Hispanic/Latino ☐ Middle Eastern/North African
☐ Native Hawaiian/Pacific Islander ☐ White/European ☐ Not Listed or Other: _____ ☐ Prefer not to answer

ADDITIONAL APPLICANTS

Complete ONLY if your spouse/partner, and/or child(ren) under the age of 26 (older if medically disabled) are applying for coverage. If a dependent child is applying as an individual rather than as part of a family, list the child as the primary applicant. If there is not enough space provided, please attach additional family information. Please sign and date the additional sheet. SSN is only necessary to determine eligibility for federal Advance Premium Tax Credit and Cost Sharing Reductions. Not filling out that field shall not be a reason to deny an application for coverage.

Name (First, MI, Last)	SSN/TIN/ALT ID #:	Gender	Relationship	Disability Y/N	Birth Date (MM/DD/YY)
		☐ M ☐ F ☐ X	SPOUSE/PARTNER	☐ Yes ☐ No	
		☐ M ☐ F ☐ X	☐ Child ☐ Dependent	☐ Yes ☐ No	
		☐ M ☐ F ☐ X	☐ Child ☐ Dependent	☐ Yes ☐ No	
		☐ M ☐ F ☐ X	☐ Child ☐ Dependent	☐ Yes ☐ No	

		☐ M ☐ F ☐ X	☐ Child ☐ Dependent	☐ Yes ☐ No	
		☐ M ☐ F ☐ X	☐ Child ☐ Dependent	☐ Yes ☐ No	

Do(es) the child(ren) named within the application live with you at the same physical address shown above? ☐ Yes ☐ No (if no, complete below)

Child(ren)'s Name:		Mailing Address (If different):					
City:		County:		State:		Zip:	
Home Phone:		Alternate Phone:		Email:			

Name of the Legal Guardian or Parent responsible for carrying health insurance for the child:							
If the primary applicant is under the age of 21 and different from above, provide the name and mailing address of the legal guardian or custodial parent:							
Legal Guardian or Custodial Parent's Name:		Mailing Address (If different):					
City:		County:		State:		Zip:	
Home Phone:		Alternate Phone:		Email:			

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	
	☐ Yes	☐ No
	☐ Yes	☐ No
	☐ Yes	☐ No
	☐ Yes	☐ No

MEDICARE/MEDICAID INFORMATION		
Is any applicant enrolled in Medicare?	☐ Yes	☐ No
Name of person covered by Medicare: _____. **For this applicant, please stop here, this insurance may duplicate existing Medicare coverage.**		
Is any applicant enrolled in Medicaid, CHIP+, or other governmental health program?	☐ Yes	☐ No
Name of person covered by Medicaid or other governmental health program: _____. For this applicant, please be aware that obtaining individual health insurance may affect which coverage is primary and/or applicant's eligibility for APTC.		

CURRENT MEDICAL COVERAGE

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

(Dental Coverage in next Section)

Name	Carrier Name	Effective Date of Coverage (MM/DD/YY)	Termination Date of Coverage (MM/DD/YY)	Coverage Type

If any applicant has current health coverage, will that applicant cancel current coverage if this application is accepted? ☐ Yes ☐ No

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:_____

CERTIFICATION OF DENTAL INSURANCE COVERAGE Certification of dental insurance coverage is not required when purchasing coverage through Connect for Health Colorado or for consumers without children under the age of nineteen (19)	
Pediatric dental coverage is a required essential health benefit. The plan you select may not include pediatric dental coverage. Do you have pediatric dental coverage under another plan?	☐ Yes ☐ No Note: you may be required to provide proof that you have obtained coverage before this policy will be approved

TERMS AND CONDITIONS

I acknowledge that I have read all sections of this 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 that my answers, together with any supplements or additional pages, are the basis for the certificate or policy that is issued. I agree that no insurance will be effective until the date specified by the carrier on the certificate or policy.

I understand that my signature constitutes an attestation that I have obtained the required pediatric dental coverage under a separate policy, and may be required to provide proof of this pediatric dental policy prior to this policy being issued and approved. (Certification of dental insurance coverage is not required when purchasing coverage through Connect for Health Colorado)

I understand that any intentional misrepresentation relied upon by the carrier may be used to deny a claim. I further understand that this contract can be voided if, within the first 24 months from the date of the policy or certificate, it is determined that I or a family member made an intentional misrepresentation in this application.

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.

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, or the information contained herein, will become a part of the contract when coverage is approved and issued.

I would like to receive all policy notices, premium notices, and other notices relating to this policy through the supplied email address above. ☐ Yes ☐ No

I understand I can change this designation at a later date by contacting my carrier directly, and understand it is my responsibility to notify my carrier of any changes to my email address.

Signature of Primary Applicant/Parent or Legal Guardian for Child-Only Plans	Date Signed:
Complete this section if someone assisted you in the completion of this Application	
The following person assisted me in completing the Application:	Please explain the assistant's relationship to you and your family:

AGENT/PRODUCER INFORMATION	
This section is to be completed by Agent or Producer.	
Agent / Agency of Record: (for commissions and correspondence)	Writing Agent / Producer:
Name (print):	Name (print):
Agent ID # (NPN):	Agent ID #(NPN):
Agent replacement questions: Will this policy replace any existing accident and sickness insurance policy(s)? ☐ Yes ☐ No As the Writing Agent/Producer, I acknowledge that I am responsible to personally interact with the primary applicant submitting this application in order to fully and accurately represent the terms and conditions of the plans and services of the offering or insuring entity, or one of its subsidiaries. These provisions are available to me and the primary applicant in the benefits summary document or other plan literature.	
Writing Agent Signature	Date

DISCLOSURES

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://doi.colorado.gov. For questions regarding coverage or enrollment please see your carrier.

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

Signature of Primary Applicant: _____ Date Signed: _____

Appendix B

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*
Special Enrollment Period Qualifying event: ☐ Loss of Coverage ☐ Birth/Adoption/Placement for Adoption ☐ Marriage ☐ Other:_____ Date of Event:_____				

* Proof of eligibility for special enrollment will be required – information on special enrollment periods is available at: https://www.colorado.gov/pacific/dora/division-insurance

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:	
SSN/TIN/ALT ID #: Not filing out this field shall not be a reason to deny an application for coverage		Date of Birth:	/ /	Current Age:	Gender: ☐ M ☐ F ☐ X
Physical Address:				City:	
County:		State:		Zip:	
Mailing Address (If different, can be P.O. Box):				City:	
County:		State:		Zip:	
Home Phone:		Alternate Phone:		Email:	Home / Work
First day of employment?		How many hours, on average, do you work each week?		Work Phone:	

Are you (check one): ☐ Single ☐ Married ☐ Civil Union ☐ Legally Separated ☐ Divorced ☐ Designated Beneficiary ☐ Widow/Widower ☐ Common Law ☐ Designated Beneficiary - A common law or designated beneficiary certification may be required by the carrier

Are you on COBRA or State Continuation?	☐ Yes	☐ No	Start Date:		Stop Date:	

It should be noted that American Indians and Alaskan Natives have an enhanced ability to enroll in individual health benefit plans under the Affordable Care Act.

Tell us about your race. *This information is confidential and will only be used to help us improve service to all Coloradans. We use this information to make sure everyone gets fair access to coverage. Providing this information will not impact eligibility, plan options, or costs.*

What is your race? (Select all that apply) *(optional)*

☐ American Indian/Alaskan Native ☐ Asian/Asian American ☐ Black/African American ☐ Hispanic/Latino ☐ Middle Eastern/North African
☐ Native Hawaiian/Pacific Islander ☐ White/European ☐ Not Listed or Other: _____ ☐ Prefer not to answer

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 & Spouse	☐ Employee & Child	☐ Employee & Family

Name of plan selected: _____

Dependent Information- List all dependents to be covered

Name (First, MI, Last)	SSN/TIN/ALT ID # (can leave blank):	Gender	Relationship	Disability Y/N	Birth Date (MM/DD/YY)
		☐ M ☐ F ☐ X	SPOUSE/PARTNER	☐ Yes ☐ No	

		☐ M ☐ F ☐ X	☐ Child ☐ Dependent	☐ Yes ☐ No	
		☐ M ☐ F ☐ X	☐ Child ☐ Dependent	☐ Yes ☐ No	
		☐ M ☐ F ☐ X	☐ Child ☐ Dependent	☐ 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
	☐ Yes ☐ No
	☐ Yes ☐ No

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		
Dependent 4		
Dependent 5		
Dependent 6		

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+	Effective Date:	☐ Disability	Effective Date:
	☐ End-stage Renal Disease (ESRD)	Effective Date:	☐ Disability and ESRD	Effective Date:

Name of person covered by Medicare:

CURRENT MEDICAL COVERAGE

Will you, your spouse/partner, or your dependent child(ren) listed in this application have other health insurance coverage that will be in effect at the same time as the coverage you are applying for on this application? ☐ 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; D = Dental Coverage Only O=Other, please explain:_____

This is being asked to determine if there will be coordination of benefits if any of the individuals on the application have existing coverage

PRIMARY CARE PHYSICIAN SELECTION, IF APPLICABLE

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. 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:

CERTIFICATION OF DENTAL INSURANCE COVERAGE Certification of dental insurance coverage is not required when purchasing coverage through Connect for Health Colorado or for consumers without children under the age of nineteen (19)	
Pediatric dental coverage is a required essential health benefit. The plan you select may not include pediatric dental coverage. Do you have pediatric dental coverage under another plan?	☐ Yes ☐ No Note: you may be required to provide proof that you have obtained coverage before this policy will be approved

TERMS – CONDITIONS- DISCLOSURES

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.

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 https://www.colorado.gov/pacific/dora/division-insurance. For questions regarding coverage or enrollment please see your employer.

Signature of Employee:_____ Date Signed:_____