University of Colorado
Boulder | Colorado Springs | Denver | Anschutz Medical Campus
EMPLOYEE SERVICES

# Benefit Appeal

# Plan Year 2025 - 2026

## Explanation of Appeal Form

## Instructions

This form cannot be completed in a web browser.

1. **Download** the form to your desktop from the web browser**.**
2. **Open** the form in Adobe or Adobe Reader before completing**.**

To submit an appeal for a missed enrollment deadline, a Qualifying Life Change (QLC) deadline, or for another reason, please complete and return this form along with any supporting documentation to support your appeal by following the submission instructions outlined at the bottom of page two. The Appeal's Committee will review the submission to make a determination on your case.

## Employee Information

Date: _____ Ticket # (if known): _____

_____

Employee ID Number – **REQUIRED** Name (Last) (First) (Middle Initial)

? _____

Personal Telephone Email Address

**If requesting to add or drop a dependent please complete the corresponding section(s):**

## Spouse, Common Law, Domestic or Civil Union Partner

☐ Add
☐ Remove
☐ No change

☐ Male
☐ Female
(please check one - required for insurance enrollment)

Name (First, Last, MI): _____ Date of Birth (mm/dd/yyyy): _____

Relationship to Employee: Spouse ☐ Common Law Spouse ☐ Domestic Partner ☐ Civil Union Partner ☐

? Is your domestic/civil union partner your qualified tax dependent for health coverage?
☐ Yes, complete the Tax Certification of Dependency Form found at www.cu.edu/node/164116 with your enrollment.
☐ No, you will be subject to imputed income (taxable income). For more information, go to www.cu.edu/node/56944

## Child 1

☐ Add
☐ Remove
☐ No change

☐ Male
☐ Female
(please check one - required for insurance enrollment)

Name (First, Last, MI): _____ Date of Birth (mm/dd/yyyy): _____

Relationship to employee: ☐ biological/adopted child ☐ step-child
☐ child for whom you have legal responsibility - Relationship: _____

? Is the child a child of a domestic/civil union partner a qualified tax dependent for health coverage?
☐ Yes, complete the Tax Certification of Dependency Form found at www.cu.edu/node/164116 with your enrollment.
☐ No, you will be subject to imputed income (taxable income). For more information, go to www.cu.edu/node/56944.

Name: _____ ID #:_____

*Check one box only*

☐ **New Hire/Newly Eligible** - Date of hire or new eligibility: _____

*mm/dd/yyyy*

☐ **Qualifying Life Change** (If applicable, choose from the list below)

- ☐ Birth or adoption
- ☐ Change University/Faculty Staff to Classified Staff
- ☐ Change in dependent care needs
- ☐ Change of residence out of health plan's network
- ☐ Death of a spouse or partner
- ☐ Death of a child
- ☐ Dependent gaining eligibility
- ☐ Dependent losing eligibilty
- ☐ Divorce or legal separation
- ☐ Employee gaining eligibility
- ☐ Employee losing eligibility
- ☐ Marriage or Partnership
- ☐ Medical child support order
- ☐ Other - _____

_____

**Date of event:**

_____

**What benefit(s) does your appeal affect?**

- ☐ CU Health Plan Medical
- ☐ CU Health Plan Dental
- ☐ CU Health Plan Vision
- ☐ Health Care FSA
- ☐ Dependent Care FSA
- ☐ Short Term Disability
- ☐ Long Term Disability
- ☐ Optional Life Insurance
- ☐ Voluntary AD&D

**What do you want to do?**

- ☐ Change plans
- ☐ Drop a plan
- ☐ Add a plan
- ☐ Drop a dependent
- ☐ Add a dependent
- ☐ Other

**What is your desired outcome?**

**If appealing to enroll in an HCFSA or the DCFSA, please illustrate the intended plan year amount in this section.*

**What extenuating circumstances led to the need for this appeal?**

**List any additional information relevant to the appeal.**

Signature: _____ Date: _____

## How to Return Your Explanation of Appeal Form

**ELECTONICALLY**

If you are ready to submit your form, click on the submit button.
Wait for the automatically generated email and select SEND.

**SUBMIT**

**BY MAIL**

Make a copy for your records and send the original to:

University of Colorado
Employee Services
1800 Grant Street, Suite 400
Denver, Colorado 80203

**BY FAX (secured)**

303-860-4299

Keep a copy of the fax transmission report with your form for your records.