Colorado State Employees Group Benefits
Instructions for Benefits Eligibility Determination Appeals

This form is to be used to appeal the eligibility determination for the State of Colorado benefit plans. Please provide complete and specific information to prevent any delay of your appeal.

This form is not to be used to appeal claims, such as a determination by an insurance company regarding what is and is not covered. Appeals concerning claims must follow the specific group benefit plan's grievance and appeal process in the plan's Summary Plan Description, Certificate of Coverage, or Plan Document.

The filing deadline to appeal a benefits eligibility determination is **31 calendar days** from the date on which you receive notice of the decision. The day you receive the decision is not counted in the 31days. If the 31st day falls on a weekend or an official state holiday, the filing deadline is extended to the next business day.

Type or print legibly in ink. An appeal may be filed by one of the following methods.

1. Email scanned documents to the State Personnel Director at State_Benefits@state.co.us by close of business (5:00 p.m.) on or before the 31st day.
2. Fax to the State Personnel Director at 303-866-3879 by close of business (5:00 p.m.) on or before the 31st day.
3. Mail to the following address. The appeal **must** be postmarked on or before the 31st day.
   State Personnel Director
   Division of Human Resources
   1313 Sherman Street, 1st Floor
   Denver, CO 80203
4. Hand deliver to the above address by close of business (5:00 p.m.) on or before the 31st day.

The Director's written response will be final agency action to your appeal for purposes of §24-4-106 C.R.S. The Director can overturn the benefits eligibility determination only if it is found to be arbitrary, capricious, or contrary to rule or law. Arbitrary and capricious means there is no rational basis or competent evidence to support the eligibility determination. Contrary to rule or law means the decision violates a specific provision of law, rule, or the Plan Documents.

Additional Information

Chapter 11 – State Benefit Plans, Colorado State Personnel System Rules and Procedures (rules), http://www.colorado.gov/cs/Satellite/DPA-DHR/DHR/1185870965353, click on "Rules and Procedures (effective 7/1/05 or later)."

Plan Descriptions, Certificates, Documents, and contact information, for each benefit, **www.colorado.gov/dpa/dhr/benefits.** Use the gray bars on the left of the screen to navigate to each benefit area (medical, dental, life, disability, flexible spending). If researching medical insurance, navigate to your particular insurance option using the gray bars on the left of the screen.

Colorado State Employees Group Benefits Eligibility Determination Appeal Form

This form is provided for employees who are appealing a decision related to benefits eligibility for enrollment in a state benefits plan. Appeals of claim denials must be filed with the insurance company. You may attach additional sheets. Pursuant to the Americans with Disabilities Act as Amended, copies of this form may be available in alternate formats. Mail or hand deliver the form to the State Personnel Director, 1313 Sherman Street, 1st Floor, Denver, CO 80203, or fax it to 303-866-3879.

Your Full Name :		
Street Address:		
City:	State:	Zip:
Phone:	E-mail:	
Department / Division:		
Date of Birth:	Social Security Number (last 4 digits)	

Benefit programs involved (check all that apply)

- ☐ Medical
- ☐ Dental
- ☐ Flexible Spending Account (FSA)
- ☐ Life
- ☐ Disability (STD or LTD)

1. Describe the specific eligibility determination being appealed. Include names, dates and any other detailed facts or circumstances. Attach additional sheets or documentation if necessary.

2. Date of receipt of notice of the ineligibility determination being appealed (attach a copy of any document related to the ineligibility decision):

3. Explain why you believe the ineligibility determination was arbitrary, capricious or contrary to rule or law.

4. What do you want to happen as a result of your appeal? Please be specific, for example, "Approve family medical coverage effective July 1, 2008."

☐ Check if additional sheets or supporting documentation are attached. Please note the question number that the additional sheets apply to.

This form must be signed by the employee.

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Signature Date Signed