ROCKY MOUNTAIN HEALTH PLANS®
Good health. That's the plan.

Plans underwritten by Rocky Mountain HMO (RMHMO)
or Rocky Mountain HealthCare Options, Inc. (RMHCO)

1B

Change Form

Complete this form using black ink only.

Please indicate type of action requested: ❑ ***Add*** ❑ ***Change*** ❑ ***Drop***

Fold and mail or fax to 970-263-5507

Subscriber Name: Last	First	MI	Social Security #:
			Member ID#:
Employer:			Date of Birth: / /

Changes to Existing Health Plan

Address Change: Street City	State	Zip	Phone: Home ( )	Phone: Work ( )
Name Change: From	To:			

Plan Change — Change Coverage To:

Coverage Option: ❑ Single ❑ Employee+Spouse ❑ Employee+Child(ren) ❑ Employee+Spouse+Child(ren)

Change Plan To (Name of Plan):

Good Health National Access (for any employees/dependents residing outside Colorado) ❑ Add ❑ Drop Effective date:
(Certain conditions apply)

Dependent Add / Drop Information

Add*	Drop	Date	Last Name	First Name	MI	Social Security #	Sex M/F	Date of Birth MM/DD/YY	Relationship to Subscriber	Primary Care Physician Name and / or Physician ID#

***Adding dependents on small employer group plans with fewer than 51 employees requires a copy of certificate of creditable coverage provided by previous carrier.**

Reason for Addition of Dependent

❑ Marriage — If adding new spouse, give date of marriage: ____________________

❑ Newborn child — Give date of birth: ____________________ Newborn's hospital discharge date: ____________________

❑ Adoption or placement for adoption. Give adoption or placement date and submit adoption documentation: ____________________

❑ Court ordered coverage for dependent(s) — Give date of court order and submit court order documentation: ____________________

❑ Employer group open enrollment

❑ Dependent lost prior coverage — (Please submit proof of loss of coverage, i.e., HIPAA Certificate of Creditable Coverage)

Type of coverage: ____________________ Date coverage was lost: ____________________

Reason for loss of coverage:

❑ Reduction in hours
❑ Involuntary termination of prior coverage
❑ Other:
❑ Termination of employer contribution toward coverage
❑ Termination of employment or loss of eligibility

Reason for Drop / Disenrollment of Dependent

❑ Dependent no longer meets dependent child eligibility requirements

❑ Enrolled in other health coverage; please designate: ❑ Group Coverage ❑ Individual Coverage ❑ Other ____________________

❑ Divorce / Legal Separation; please provide forwarding address

❑ Death of dependent — requires copy of death certificate

❑ Cannot afford coverage

Is this a drop request for a dependent child whose coverage is required by a court or administrative order? ❑ Yes ❑ No

I understand that if I waive coverage for my dependents (including my spouse) because of other insurance coverage, I may, in the future, be able to enroll my dependents (if I am already enrolled) in this plan as required by applicable law, provided I request enrollment within 30 days after other coverage ends.

❑ CANCEL AUTOMATIC BANK DEDUCTION — BILL QUARTERLY (Medicare Plans / Individual PPO Plans Only)

1. I agree that enrollment, eligibility, coverage, and benefits in my health plan are subject to applicable policies and requirements and to all terms of the applicable contract for my health plan.
2. I agree that the above information is true, and I authorize the above change.

Subscriber Signature	**Date**

MK158R0207P

Stamp
Required

ATTN: MEMBERSHIP ENROLLMENT
Rocky Mountain Health Plans
PO Box 10600
Grand Junction, CO 81502-5600

Fold

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