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

ROCKY MOUNTAIN HEALTH PLANS®
We understand Colorado. We understand you.

Employee Change Form

Mail to:
PO Box 10600
Grand Junction, CO 81502-5600
Fax to: 970-263-5507
Email to: commercialenrollment@rmhp.org

To terminate an employee from the group plan, please use the Employee Disenrollment Form.

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

Name Change / Address Change

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

Plan Change

Change Plan To (Name of Plan):

Good Health National Access (for employees/dependents residing outside Colorado) ☐ Add ☐ Drop Name: Effective date:

Dependent Only - Add / Drop Information

Please make change to: (Check all that apply.) *** If you are adding dependents to a dental or vision plan, a separate form is required.**

Add *	Drop	Date of change	Last Name	First Name	MI	Social Security #	Sex M/F	Date of Birth	Relationship to Subscriber	Primary Care Physician Name
☐ Medical	☐ Medical ☐ Dental ☐ Vision							/ /		
☐ Medical	☐ Medical ☐ Dental ☐ Vision							/ /		
☐ Medical	☐ Medical ☐ Dental ☐ Vision							/ /		

Reason for Addition of Dependent

☐ Marriage/Civil Union/ Domestic Partner/Designated Beneficiary — If adding a new spouse/partner, give date of marriage or date of partnership: _____
A separate form is required for Common Law Marriage, Domestic Partnership or Designated Beneficiary.
☐ 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)
Type of coverage lost: ☐ Employer group ☐ Child Health Plan ☐ Medicaid ☐ Other_____ Date coverage was lost:_____

A request to add a dependent must be received by RMHP within 30 days of the qualifying event, *except* that a request to add a dependent due to loss of Medicaid or Child Health Plan coverage must be received within 90 days of the loss of coverage.

Reason for Drop of Dependent

☐ Dependent no longer meets dependent child eligibility requirements ☐ Death of dependent — death certificate required ☐ Cannot afford coverage
☐ Divorce / Legal Separation; please provide forwarding address ☐ Termination of Domestic Partnership, Civil Union or Designated Beneficiary
☐ Enrolled in other health coverage; please designate: ☐ Group Coverage ☐ Individual Coverage ☐ Other _____

Dependent Address:
Name:_____Street:_____City:_____State:____Zip:_____

Is this a drop request for a dependent child whose coverage is required by a court or administrative order? ☐ Yes ☐ No If Yes, attach proof of other coverage.
Name of Dependent:

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:**