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

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

Enrollment Form
(for Employer Groups with 51 or more employees)

In order to expedite employee's enrollment, please make certain Sections 1, 2, 3, 4, and 5 are completed fully. Please use black ink only.

Section 1 – Employee Information

Employer Name			Date of Employment	Job/Occupation		Hours Worked per Week
Employee Last Name	First Name	MI	Social Security #*	Home Phone		Business Phone
Address (include PO Box)		City		State	Zip Code	County of Residence

Section 2 – Plan Selection / Desired Coverage

Name of health plan selected by your employer (See back of form for plan names):	☐ Brand Rx ☐ Generic Only Rx (N/A with HDHP)	Will you be working and residing out of state? ☐ Yes ☐ No Are you enrolling dependents who live out of state? ☐ Yes ☐ No If Yes, please note below in Section 4.

Desired coverage:
☐ Single ☐ Double ☐ Family ☐ EE & Child(ren)
☐ COBRA/CCOC – Qualifying event date:_______________________

Marital Status:
☐ Single ☐ Married ☐ Common Law (form required) ☐ Domestic Partner (form required)
☐ Designated Beneficiary (form required) ☐ Widowed ☐ Divorced ☐ Legally Separated

Section 3 – Other Health Coverage

While covered under this plan, will you or any family members applying for coverage have other active health insurance? ☐ Yes ☐ No

If yes, please provide name of other insurance: ________________________________ Policy Holder: ________________________________	Phone #:	Plan # :________________________ or Social Security #*: ____________________

Have you or any family member ever been treated for a serious accident or injury within the last 5 years? ☐ Yes ☐ No

If yes, please indicate: ☐ Auto ☐ Workers' Compensation Other: ________________________________

Section 4 – Persons Enrolling in the Plan

Last Name	First Name	MI	Social Security #*	Sex M/F	Birthdate MM/DD/YY	Relationship to Subscriber	Primary Care Physician Name and/or Physician ID#
Self:							
Spouse/Partner:							
				Spouse reside in Colorado? ☐ Yes ☐ No			
Dependent:							
Disabled age 26 and older? ☐ Yes ☐ No	If yes, please complete disabled dependent form.			Dependent reside in Colorado? ☐ Yes ☐ No			
Dependent:							
Disabled age 26 and older? ☐ Yes ☐ No	If yes, please complete disabled dependent form.			Dependent reside in Colorado? ☐ Yes ☐ No			
Dependent:							
Disabled age 26 and older? ☐ Yes ☐ No	If yes, please complete disabled dependent form.			Dependent reside in Colorado? ☐ Yes ☐ No			
Dependent:							
Disabled age 26 and older? ☐ Yes ☐ No	If yes, please complete disabled dependent form.			Dependent reside in Colorado? ☐ Yes ☐ No			

* Please supply social security numbers if known. Missing numbers will be requested after enrollment.

Signature required on back of this form.
RMHP Fax 970-263-5507

Section 5 – Agreement – SIGNATURE REQUIRED

2A

The undersigned, individually ("I") and on behalf of my dependents ("We"), state as follows:

1. I enter into and agree to the terms of the contract for the health plan designated in this application and any RMHMO and/or RMHCO health plan that replaces the health plan designated (herein the "Evidence of Coverage" or "EOC"). We will have a contract with RMHMO and/or RMHCO upon (1) receipt of all information required for enrollment, (2) approval by RMHMO or RMHCO, and (3) receipt of the first premium. The terms of the contract are set forth in the EOC. The terms may be amended from time to time by RMHMO or RMHCO, as applicable.
2. I understand and acknowledge that RMHMO, RMHCO or their designated agents/contractors may obtain, use, and disclose information or records related to the health of any person proposed for coverage. This information includes the treatment, payment, and health care operations functions of RMHMO or RMHCO. For example, the information could be used for processing of claims, in quality assurance programs, or to involve me or my dependent(s) in case management. Such information or records may come from any physician, health care provider, hospital, clinic, other medical facility, insurance company, or other entity. All information is subject to confidentiality laws. I authorize any physician, health care provider, hospital or other medical facility, insurance company, or other entity or person that now or hereafter has records or knowledge of the health of any person proposed for coverage, to give the health plan such information as requested.
3. I understand that if I decline coverage for myself or my dependents (including my spouse) because of other insurance coverage, I may, in the future, be able to enroll myself or my dependents (if I am already enrolled) in this plan, as required by applicable law. To enroll I must request enrollment within 30 days after other coverage ends. I also understand that if I have a new dependent as a result of marriage, birth, adoption, placement for adoption or placement in foster care, I may be able to enroll myself and my dependents. I can do this if I request enrollment within 30 days after the marriage, birth, adoption, placement for adoption or placement in foster care. I understand that if I do not request enrollment within 30 days for the above events, I will not be eligible for enrollment for such coverage until the first of the following: (1) the date I enroll for such coverage during a Yearly Open Enrollment Period; or (2) the date twelve (12) months following the date I first request such coverage. I also understand that if I do not list a dependent on this form who has other coverage, I can't enroll this dependent until the first of the following: (1) the date I enroll for such coverage during a Yearly Open Enrollment Period; or (2) the date twelve (12) months following the date I first request such coverage.
4. I agree to the applicable EOC provisions for the resolution of disagreements and disputes, including arbitration when required. We agree to resolve such disagreements and disputes as set forth in the EOC.
5. I agree that RMHMO and RMHCO will have the right to terminate coverage and deny benefits if any information on this application or as otherwise provided by me for enrollment purposes is knowingly false, misleading, or inaccurate in any material respect.
6. I agree that the above provisions will remain in effect for me and my dependents for the entire duration of coverage. The provisions will continue to the extent of any continuing rights or obligations under the EOC.
7. I have read the information on the back of this enrollment form.

Subscriber Signature:	**Date:**

Plans underwritten by Rocky Mountain HMO (RMHMO)	Plans underwritten by Rocky Mountain HealthCare Options (RMHCO)
Good Health Savings HSA HMO Rocky Mountain Good Health HMO Rocky Mountain VISTA HMO	Good Health Savings HSA PPO Rocky Mountain Good Health PPO Rocky Mountain VISTA PPO

Colorado law requires carriers to make available a Colorado Supplement to the Summary of Benefits of Coverage, which is intended to facilitate comparison of health plans. The form must be provided automatically within seven (7) business days to a potential policyholder who has expressed interest in a particular plan or who has selected the plan as a finalist from which the ultimate selection will be made. The carrier also must provide the form, upon oral or written request, within seven (7) business days to any person who is interested in coverage under or who is covered by a health benefit plan of the carrier.

An access plan is available for each managed care network offered by Rocky Mountain Health Plans to any interested party upon request. Such access plans contain information on providers, hospitals, referral and grievance procedures, quality assurance, access for members with special needs, emergency coverage provisions, and other information on how to access services.

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include: imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company 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 will be reported to the Colorado Division of Insurance.

Patient Protection and Affordable Care Act Group Notices for Rocky Mountain Health Plans ("Your Plan")

Your Plan may require the designation of a primary care provider (PCP). A Member has the right to designate any PCP who participates in RMHP's network and who is available to accept the Member as a patient. If required, until a Member makes this designation, a PCP will be designated for the Member. For information on how to select a PCP, and for a list of the participating PCPs, contact customer service at 970-243-7050 or 800-346-4643. For children, a pediatrician may be designated as the PCP. A Member does not need prior authorization in order to obtain access to obstetrical or gynecological care from a health care professional in RMHP's network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact customer service at 970-243-7050 or 800-346-4643.

Collection, Use, and Disclosure of Medical Information

As your health plan, RMHP must ask for and use personal information in the administration of your health care benefits. You have the right to have this personal information kept private. Your personal health care information is protected in the following ways:

1. All employees of Rocky Mountain Health Management Corporation, the company that administers Rocky Mountain HMO (RMHMO) and Rocky Mountain HealthCare Options (RMHCO) health benefit plans, agree to follow procedures for safeguarding the privacy of our Members' personal health information.
2. RHMHO and RMHCO do not keep complete medical records about our Members. Members can review their medical records by asking their primary care physician or other health care provider.
3. Some employers may request information about their employees' care. Unless otherwise allowed by law or your specific written permission is first obtained, data is only provided to employers when it can be presented as a data group and cannot be connected to specific health plan Members.