ROCKY MOUNTAIN HEALTH PLANS®

Plans underwritten by Rocky Mountain HMO (RMHMO)

Enrollment Form

(for Employer Groups with 101 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 Optional Rx for Grandfathered Plans	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* ☐ Civil Union ☐ Domestic Partner* ☐ Designated Beneficiary* ☐ Widowed/Divorced ☐ Legally Separated *Form Required

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 health plan that replaces the health plan designated (herein the “Evidence of Coverage” or “EOC”). We will have a contract with RMHMO upon (1) receipt of all information required for enrollment, (2) approval by RMHMO and (3) receipt of the first premium. If the fully completed application is received by RMHMO between the first and the fifteenth day of the month, the first effective day of the health plan will be no later than the first day of the following month. If the fully completed application is received by RMHMO between the sixteenth and the last day of the month, the first effective day of the health plan will be no later than the first day of the second following month. The terms of the contract are set forth in the EOC. The terms may be amended from time to time by RMHMO as applicable.
2. I understand and acknowledge that RMHMO, 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. 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) for whatever reason, I may, in the future, be limited in my ability to enroll myself or my dependents (if I am already enrolled) in this plan. I understand that my ability to enroll in the future will be limited to: (1) future open enrollment periods; or (2) experiencing a qualifying event which entitles me to a special enrollment period. To enroll after a qualifying event I must request enrollment within thirty (30) days after the qualifying event occurs. If the qualifying event is losing coverage under the “Colorado Medical Assistance Act,” becoming eligible for premium assistance under the “Colorado Medical Assistance Act” or the Children’s Basic Health Plan, or a dependent dis-enrolling or becoming ineligible for the Children’s Basic Health Plan, I must request enrollment within sixty (60) days.
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 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)

Good Health Savings HSA HMO
Rocky Mountain Good Health HMO
Rocky Mountain VISTA HMO

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) health benefit plans, agree to follow procedures for safeguarding the privacy of our Members' personal health information.
2. RHMHO 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.

Multi-Language Insert for Notices

ROCKY MOUNTAIN HEALTH PLANS®

English

There is important information about your coverage or application with Rocky Mountain Health Plans (RMHP) in this notice. Review it carefully. Look for actions you may need to take and deadlines. You have the right to get information in your language at no cost. Call 800-346-4643 for assistance.

Spanish

Hay información importante sobre su cobertura o solicitud de Rocky Mountain Health Plans (RMHP) en este aviso. Revíselo meticulosamente. Tome las acciones necesarias y considere las fechas de vigencia. Usted tiene el derecho a obtener esta información en su idioma sin ningún cargo. Llame al 800-346-4643 para obtener asistencia.

Arabic

في هذه المذكرة هناك معلومات هامة بخصوص التغطية الخاصة بك أو التطبيق الخاص بك مع الخطط الصحية لروكي ماونتن (RMHP). عليك مراجعتها بعناية. وقم بالبحث عن التصرف الذي قد يكون عليك القيام به ومدد المهلة المطلوبة لذلك. إن من حقك الحصول على المعلومات بلغتك بدون مقابل. ويكون عليك الاتصال على الرقم 800-346-4643 للمساعدة.

German

Es gibt wichtige Informationen über Ihre Absicherung oder Anwendung bei Rocky Mountain Health Plans (RMHP) in dieser Mitteilung. Sehen Sie diese sorgfältig durch. Schauen Sie, ob sie Maßnahmen ergreifen oder Termine einhalten müssen. Sie haben das Recht, kostenlos Informationen in Ihrer Sprache zu erhalten. Rufen Sie 800-346-4643 an, wenn Sie Hilfe benötigen.

French

Cette notice comprend des informations importantes sur votre assurance ou votre demande aux régimes de Rocky Mountain Health Plans (RMHP). Veuillez l'examiner attentivement. Voyez quelles actions que vous devez prendre et leurs échéances. Vous avez le droit d'obtenir gratuitement des renseignements dans votre langue. Appelez le 800-346-4643 pour obtenir de l'aide.

Japanese

この通知にはロッキー・マウンテン・ヘルス・プラン (RMHP) の補償範囲と申請に関する重要な情報が掲載されていますので、よくお読みください。行う必要のある手続きおよび締め切り日にご注意ください。お客様には、関連情報を無料で母国語で受け取る権利があります。**800-346-4643** までご連絡いただきサポートをご依頼ください。

Korean

이 안내문은 로키 마운틴 의료 보험 (Rocky Mountain Health Plans (RMHP))의 보험 적용 범위 또는 신청서에 대한 중요한 정보를 포함하고 있습니다. 신중하게 검토하시기 바랍니다. 취해야 할 조치와 마감기일에 유의하세요. 고객님의 언어로 된 정보를 무료로 받으실 수 있습니다. 서비스 관련 문의는**800-346-4643** 로 전화주시기 바랍니다.

Nepali

यो सूचनामा तपाईंको बीमाकृत राशि वा रकी माउन्टेन हेल्थ प्लान्स् (RMHP) लाई तपाईंले पेश गर्नुभएको आवेदनका बारेमा महत्त्वपूर्ण जानकारीहरू छन्। यसलाई ध्यानपूर्वक हेर्नुहोस्। तपाईंले चाल्न आवश्यक हुन सक्ने कदमहरू र समय सीमाबारे थाहा पाउनुहोस्। तपाईंसँग आफ्नो भाषामा निःशुल्क रूपमा जानकारीहरू प्राप्त गर्ने अधिकार छ। सहायताका लागि 800-346-4643 मा फोन गर्नुहोस्।

Persian

در این يادداشت اطلاعات مهمی راجع به درخواست يا پوشش مد نظر شما از سوی Rocky Mountain Health Plans (RMHP) ارائه می شود. با دقت آنرا مطالعه فرماييد. به اقداماتی که باید انجام دهید و مهلت مقرر آنها توجه نمایید. شما حق دارید اطلاعات را به زبان خودتان بدون پرداخت هزينه ای دريافت کنيد. برای درخواست کمک به شماره 800-346-4643 زنگ بزنيد.

Russian

В данном уведомлении содержится важная информация касательно Вашего страхового покрытия или заявления в организацию Rocky Mountain Health Plans (RMHP). Просим Вас внимательно его изучить. Вам необходимо наметить порядок действий и сроки. У Вас есть право на бесплатное получение информации на родном языке. За помощью обращайтесь по номеру телефона 800-346-4643 .

Simplified Chinese

本通知中包含有矣落矶山健康计划（**RMHP**）范围和应用的重要信息。请仔细阅读。寻找您可能需要采取的措施和最终期限。您有权免费获得以自己的语言提供的信息。请致电 **800-346-4643** 寻求帮助。

Vietnamese

Trong thông báo này có thông tin quan trọng về phạm vi bảo hiểm hoặc đơn xin của quý vị với Chương Trình Chăm Sóc Sức Khỏe Rocky Mountain Health Plans (RMHP). Vui lòng xem kỹ thông báo này. Hãy tìm các hành động quý vị cần thực hiện và hạn chót của các hành động đó. Quý vị có quyền nhận thông tin bằng ngôn ngữ của quý vị mà không bị tính phí. Hãy gọi 800-346-4643 để được hỗ trợ.

Yoruba

Ìfitónilétí pàtàkì wà nípa ìdarapọ̀ rẹ àbí ìbéèrè rẹ pẹ̀lú Àwọn Èto Ìlera Rocky Mountain [RMHP] nínú àfiyèsí yìí. Fi pẹ̀lépẹ̀lẹ́ gbé e yẹ̀wò. Wò àwọn ìgbésẹ̀ tí o lè gbé àti àwọn àkókò tí ó dópin. O ní ẹ̀tọ́ láti gbà ìfitónilétí yìí ní èdè rẹ lọ́fẹ̀ẹ́. Pè 800-346-4643 fún ìrànlọ́wọ́.

Ibo/Igbo

Enwere ozi dị mkpa gbasara mkpuchi ma ọ bụ akwụkwọ anamachọihe gị na Rocky Mountain Health Plans (RMHP) n'ọkwa a. Gụgharịa ya nke ọma. Chọọ ihe ndị ị ga-eme yana nduzi. Ị nwere ikike ịnweta ozi n'asụsụ gị na akwụghị ụgwọ ọ bụla. Kpọọ 800-346-4643 maka enyemaka.

Tagalog

May mahalagang impormasyon tungkol sa iyong coverage o aplikasyon sa Rocky Mountain Health Plans (RMHP) sa paalalang ito. Suriin ito nang mabuti. Alamin ang mga pagkilos na maaaring kailangan mong gawin at hanggang kailan mo dapat maisagawa ang mga iyon. May karapatan kang humiling ng impormasyon sa iyong wika nang libre. Tumawag sa 800-346-4643 para sa tulong.

Amharic

በዚህ ማስታወቂያ ላይ **Rocky Mountain Health Plans (RMHP)** ስለሚሰጥዎት ሽፋን ወይም ማመልከቻዎን በተመለከተ ጠቃሚ መረጃ ኣይገኛል። በጥንቃቄ ይገምግሙት። መውሰድ ሊኖርብዎት ስለሚችሉ እርምጃዎችና የግዜ ገደብ ላይ ያተኩሩ። ያለምንም ክፍያ በቋንቋዎ መረጃ የማግኘት መብት አለዎት። እርዳታ ለማግኘት በ **800-346-4643** ይደውሉ።

Cushite — Oromo

Facaatii yokin iyyanoo kee Rocky Mountain Health Plans (RMHP) walin qabiduu ilalichisee odeeffannoo baribaachisaatu jiraa. Irra deebi'an siriti xiinxalii. Kan itifuxachoo qabidu fi guyyaa itti xumramuu itti hojachofi ilaalii. Kafalitii malle odeeffanno afani ketiinarigachofi miriga qabidaa. Garigarisafi 800-346-4643 lakofisaa kananii bilibili.

Kru-Bassa

Li bihne lini li gwe banga bi niigana. Li bihne lini li gwe banga bi niigana nyu mam ma kolbaha ndjombi yong tole ma teeda mong ngueda Rocky Mountain Health Plans (RMHP). Yeng ma kel ma ngui munu li bihne lini. Bebeg le u nlama bon nguim man nwaale guim di loo i nkwo nyu I teda mateda ma mboo yong tole I bana mi nsombog mi mahola. U gwee Kundei kosna biniiguene bini ni mahola i hop wong nni nsaa wogui wo. Sebel 800-346-4643.

ROCKY MOUNTAIN HEALTH PLANS®

Notice of Nondiscrimination

Rocky Mountain Health Plans (RMHP) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. RMHP does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

RMHP takes reasonable steps to ensure meaningful access and effective communication is provided timely and free of charge:

- Provides free auxiliary aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters (remote interpreting service or on-site appearance)
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language assistance services to people whose primary language is not English, such as:
  - Qualified interpreters (remote or on-site)
  - Information written in other languages

If you need these services, contact the RMHP Member Concerns Coordinator at 800-346-4643, 970-243-7050, or TTY 970-248-5019, 800-704-6370, Relay 711; para asistencia en español llame al 800-346-4643.

If you believe that RMHP has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: the RMHP EEO Officer at 800-346-4643, 970-244-7760, ext. 7883, or TTY 970-248-5019, 800-704-6370, Relay 711; para asistencia en español llame al 800-346-4643, or eeoofficer@rmhp.org. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the RMHP EEO Officer is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf*, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-868-1019, 800-537-7697 (TDD).

Complaint forms are available at *http://www.hhs.gov/ocr/office/file/index.html*.