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

6J

Individual Plan Subscriber Change

For Individual/Family Plans

Please print. Be sure to complete all information. Unanswered questions or omitted information will result in the return of this form and delay the change you want.

Section 1

Current Subscriber: Last Name	First Name	MI	Date of Birth / /	Home Phone ( )
Social Security Number:			Member ID#:	

Section 2

Change to Subscriber: Last Name	First Name	MI	Date of Birth / /	Social Security Number			Home Phone ( )
Address	City			State	County	Zip Code	Business Phone ( )
Proposed effective date of change:							

Section 3

Please list all dependents continuing coverage through the new subscriber:

Last Name	First Name	MI	Date of Birth / /	Sex M/F	Social Security Number	Relationship to Subscriber	RMHP USE
Dependent							
Dependent							
Dependent							

Section 4

Reason for subscriber change: ☐ Death ☐ Divorce ☐ Medicare Eligibility ☐ Other: Explain:

Subscriber change requests are subject to medical underwriting and approval (except in the case of death of a subscriber, divorce, or subscribers eligibility for Medicare.)

Section 5

Payment Authorization Section

Rocky Mountain HealthCare Options, Inc. / Rocky Mountain HMO offers flexible payment options. Choose one frequency and one of the following payment methods:

Frequency — ☐ Monthly ☐ Quarterly (every three months) ☐ Biannual (every six months) ☐ Annual (every 12 months)
Payment Method — ☐ Automatic Bank Withdrawal (complete authorization below) ☐ Check ☐ Credit Card

Authorization for Automatic Withdrawal

I hereby authorize Rocky Mountain HealthCare Options, Inc. / Rocky Mountain HMO to initiate debit entries to the account indicated below, and I hereby authorize the depository (DEPOSITORY) named below to debit the same account.

This authority is to remain in full force and effect until RMHCO/RMHMO and DEPOSITORY have received written notification from me of termination in such time and in such manner as to afford RMHCO/RMHMO and DEPOSITORY a reasonable opportunity to act on it. If RMHCO/RMHMO does not receive written notification from me of termination of authority prior to the first day of the month, such termination shall not be effective until the last day of that month. I understand that this information will become part of the application and the policy.

Payor's Name: (Please Print — payor shall be the person who owns and controls the account)

Payor's Address:

City, State, Zip:

Depository (payor's financial institution):

Account Number:

Premiums are due on the 1st day of the month. Drafts on payor's account will be made on approximately the 4th day of the month in which coverage will be in effect. RMHCO/RMHMO reserves the right to cancel any policy for which RMHCO/RMHMO receives a nonpayment notice from the depository. This shall be considered a failure to pay premiums. Any changes to your account must be received in writing no later than the 25th day of the prior month.

Signature of Payor X	**Date Signed**

IN THIS SPACE, STAPLE OR TAPE A SAMPLE VOIDED CHECK

FROM THE ACCOUNT YOU WANT DEBITED

1234

Pay to the order of ____________________ $ ______

MEMO ________________ VOID

MK82R0706P

Subscriber Change: Please see reverse side - signatures required on the back

Section 5

The undersigned, individually, and on behalf of the undersigned's dependents, agree as follows:

1. The current subscriber wishes to terminate enrollment in the RMHCO/RMHMO plan under which she/he is enrolled. By signing below, the current subscriber is providing notice of termination.
2. The undersigned new subscriber is presently enrolled as a dependent under the current subscriber's RMHCO/RMHMO health plan.
3. The current subscriber and new subscriber wish to retain enrollment under the current subscriber's RMHCO/RMHMO health plan for dependent(s) already enrolled in such plan.
4. The new subscriber will replace the current subscriber in the health plan contract with RMHCO/RMHMO, the terms of which contract are set forth in the applicable contract, which may be amended from time to time by RMHCO/RMHMO in accordance with applicable law.
5. The new subscriber assumes all duties and obligations under the health plan contract previously entered into by the current subscriber and which is presently in effect.
6. Completion of this form will not result in termination of enrollment for any other dependent(s) presently enrolled in the current subscriber's RMHCO/RMHMO plan. Separate notice to RMHCO/RMHMO is required for this to occur.
7. **Termination by a subscriber or other dependent member is effective the first day of the next month following the effective date of the notice of termination, unless the subscriber requests a different date and such different date of termination is accepted by RMHCO/RMHMO.**
8. If the dependent who is to become the new subscriber under the plan is a minor, the person signing below for the minor dependent also agrees to be bound to the terms of this Subscriber Change Form and the applicable health plan contract, and further warrants that they have legal authority to enter this contract on behalf of the minor dependent.

WE ACKNOWLEGE AND CERTIFY THAT WE HAVE READ THIS SUBSCRIBER CHANGE FORM AND THAT THE FOREGOING INFORMATION IS TRUE, AND WE UNDERSTAND AND AGREE TO ALL MATTERS COVERED IN THIS FORM.

Dependent/New Subscriber: (print name) X **Date:**

If signing for a minor, print name/relationship below:

Current Subscriber: X **Date:**

Colorado law requires carriers to make available a Colorado Health Plan Description Form, which is intended to facilitate comparison of health plans. The form must be provided automatically within three (3) 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 three (3) 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 shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.