

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 using 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)				<input type="checkbox"/> Brand Rx <input type="checkbox"/> Generic Only Rx (N/A with HDHP)		Will you be working and residing out of state? <input type="checkbox"/> Yes <input type="checkbox"/> No Are you enrolling dependents who live out of state? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, please note below in Section 4.			
Desired coverage: <input type="checkbox"/> Single <input type="checkbox"/> Double <input type="checkbox"/> Family <input type="checkbox"/> EE & Child(ren) <input type="checkbox"/> COBRA/CCOC – Qualifying event date _____				Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Common Law (statement requested) <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please indicate: <input type="checkbox"/> Auto <input type="checkbox"/> 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									
Common-Law Spouse? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please complete common-law spouse form.					Spouse reside in Colorado? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Dependent									
Disabled age 26 and older? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please complete disabled dependent form.					Dependent reside in Colorado? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Dependent									
Disabled age 26 and older? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please complete disabled dependent form.					Dependent reside in Colorado? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Dependent									
Disabled age 26 and older? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please complete disabled dependent form.					Dependent reside in Colorado? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Dependent									
Disabled age 26 and older? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please complete disabled dependent form.					Dependent reside in Colorado? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Dependent									
* 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

The undersigned, individually and on behalf of the undersigned's dependents ("we"), state as follows:

1. I offer to enter into and agree to the terms of the applicable contract for the health plan designated in this enrollment application and any Rocky Mountain HMO (RMHMO) and/or Rocky Mountain HealthCare Options (RMHCO) health plan that replaces the health plan so designated. We shall have a contract with RMHMO and/or RMHCO upon receipt of all information required for enrollment, approval by RMHMO or RMHCO, and receipt of the first premium. The terms of the contract are set forth in the applicable contract for the health plan and may be amended from time to time by the applicable health plan.
2. I understand and acknowledge that RMHMO or RMHCO or their designated agents/contractors may obtain, use, and disclose information or records related to the health of any person proposed for coverage for the treatment, payment, and health care operations functions of RMHMO or RMHCO. For example, these treatment, payment, and health care operation functions of RMHMO or RMHCO include use of such information for processing and payment of claims, in RMHMO or RMHCO quality assurance programs, or to involve me or my dependent(s) in case management. Such information or records may be obtained 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 and supplement 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, provided I 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, or placement for adoption, I may be able to enroll myself and my dependents provided that I request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. 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 whichever of the following dates occur first (1) the date I enroll for such coverage during an Annual 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 whichever of the following dates occur first (1) the date I enroll for such coverage during an Annual Open Enrollment Period; or (2) the date twelve (12) months following the date I first request such coverage.
4. I agree to the applicable contract 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 applicable contract.
5. I agree that RMHMO and RMHCO shall have the right to terminate coverage and deny benefits if any information on this enrollment application or as otherwise provided by the undersigned 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 the undersigned and the undersigned's dependents for the entire duration of coverage and shall continue thereafter to the extent of any continuing rights or obligations under such health plans.
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 RMHMO HMO Standard Health Benefit Plan for Colorado RMHMO HMO Basic Limited Mandate Health Benefit Plan for Colorado	Good Health Savings HSA PPO Indemnity Plan Rocky Mountain Good Health PPO Rocky Mountain Core Plus Hospital Rocky Mountain VISTA PPO RMHCO PPO Standard Health Benefit Plan for Colorado RMHCO PPO Basic Limited Mandate Health Benefit Plan for Colorado

Colorado law requires carriers to make available a Colorado Health Benefit 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.

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

- I. 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.

- II. Individuals who are dependents of eligible employees, are under twenty six (26) years of age, and who were not previously eligible due to age, marital status or financial independence, may now be eligible to enroll during either Your Plan’s Special Open Enrollment Period or the group’s Annual Open Enrollment Period. If such individuals are now eligible, they will be eligible for coverage until they turn twenty six (26) years of age. The Special Open Enrollment period is September and October, 2010 for either an October 1 or November 1, 2010 effective date.