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Employee Disenrollment Form

All covered family members will be disenrolled from the plan.

Complete this form using black ink only.

Subscriber Information					
Subscriber Name	Last	First	MI	Date of Birth / /	Member #: Social Security # - -
Address		City		State	Zip
Employer:				Effective Date of Disenrollment	
Please Complete for Disenrollment from Plan					
Please cancel the coverage above for the following reasons:					
Eligibility for Continuation Coverage 1. Type of qualifying event – Please check one only: <input type="checkbox"/> Voluntary loss of employment (JT) <input type="checkbox"/> Involuntary loss of employment (IS) <input type="checkbox"/> Death of employee <input type="checkbox"/> Employee's enrollment in Medicare <input type="checkbox"/> Reduction in hours (COBRA only) <input type="checkbox"/> Retirement 2. Date of qualifying event: _____			Please check any that apply: <input type="checkbox"/> No longer eligible for benefits (LB) <input type="checkbox"/> Unsatisfactory benefits (BN) <input type="checkbox"/> Rates too high (VR) <input type="checkbox"/> Unsatisfactory benefits/rates too high (BR) <input type="checkbox"/> Moving from plan service area (MT) <input type="checkbox"/> Quality of care (QT) <input type="checkbox"/> PCP does not participate (NP) <input type="checkbox"/> Other: _____		
Are any dependent children disenrolling from this plan subject to a court order for health coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please supply written proof that: 1) any such court order is no longer in effect; or 2) any such child is enrolled in a comparable plan through another insurer.					
The undersigned individually and on behalf of the undersigned's dependents agrees as follows:					
I agree that the above information is true, and I authorize Rocky Mountain Health Plans to make the above change.					
Subscriber Signature: _____				Date Signed: _____	
Employer Signature: _____				Date Signed: _____	

Send this form to:

Membership Enrollment
Rocky Mountain Health Plans
PO Box 10600
Grand Junction, CO 81502-5600

Or fax to:

Attn: Enrollment
970-263-5507