



Attestation for Business Group of One

Section 1 – Company Information			
Company Name		Type of Business	
Address	City	State	Zip Code
Billing Address (if different)	City	State	Zip Code
E-Mail	Fax ()	Business Phone ()	Industry Code (SIC)

Section 2 – Coverage	
Desired Coverage <input type="checkbox"/> Self <input type="checkbox"/> Self + Spouse <input type="checkbox"/> Self + Spouse + Child(ren) <input type="checkbox"/> Self + Child(ren) <input type="checkbox"/> Waiver (see waiver form)	Medical Plan: _____ Rx Plan: <input type="checkbox"/> Brand <input type="checkbox"/> Generic Only Are you adding the Accident Rider? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A (HSA & HMO Classic Plans) Are you enrolling dependents who live out of state? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please note "out of state" on the Uniform Employee Application in the dependent's medical plan name box. Have you been insured on a nongroup, individual/family plan in the past 3 years? <input type="checkbox"/> Yes <input type="checkbox"/> No

ALL ELIGIBLE PERSONS must enroll unless waiver form is completed (include spouse, dependent children). Complete the waiver form on page 2 of the Uniform Employee Application if you are not enrolling your spouse or your dependents. Waiver must be completed for future special enrollment on this plan.

Section 3 – Attestation for Business Group of One

This form must be fully completed to be processed for coverage. The undersigned individual, who is an applicant for a business group of one, hereby attests as follows:

Company Information

1. I attest that I work 24 hours or more per week on a permanent basis and I am: an individual or a sole proprietor or single (the only) full-time employee of the following:

<input type="checkbox"/> Nonprofit corporation	<input type="checkbox"/> Sub S corporation
<input type="checkbox"/> C corporation	<input type="checkbox"/> LLC corporation
<input type="checkbox"/> Partnership	

2. The name of my business is: _____
 my business activity is: _____
 and I attest that I have carried on significant business activity for a period of at least 1 year prior to the date of this application for insurance coverage.

3. The business activity has had gross income as indicated on Federal Internal Revenue Service forms 1040, Schedule C, F, or SE; or other forms recognized by the Federal Internal Revenue Service for income reporting purposes that generated gross income from which I have derived at least a substantial part of my individual income for 1 year out of the most recent consecutive 3-year period.

4. **I have provided supporting Federal Internal Revenue Service forms or other forms recognized by the Federal Internal Revenue Service for incoming reporting purposes. (Please attach this attestation.)**

I understand that if I decline coverage for my dependents (including my spouse) because of other insurance coverage, I may, in the future, be able to enroll 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 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, my dependent(s) will not be eligible for enrollment for such coverage until whichever of the following dates occur first (1) the date I enroll my dependents for such coverage during an Annual Open Enrollment Period; or (2) the date 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 cannot enroll this dependent until whichever of the following dates occur first (1) the date I enroll my dependent(s) for such coverage during an Annual Open Enrollment Period; or (2) the date 12 months following the date I first request such coverage. I also understand that, upon enrollment, my dependent(s) may be subject to a pre-existing condition limitation period. I further understand that if my dependent(s) (other than a newborn, adopted child, child placed for adoption, or child subject to a court order for health care coverage) were not medically underwritten at the time I initially enrolled in this plan, then my dependent(s) must pass medical underwriting to enroll in any plan subject to the above requirements, except that no medical screening will be required to enroll in an RMHMO HMO or RMHCO PPO Basic Limited Mandate Health Benefit Plan or Standard Health Benefit Plan for Colorado. To request special enrollment or obtain more information, please call Customer Service at 970-243-7050 or 800-346-4643.

Name of Subscriber (Please Print):	Signature of Subscriber:	Date:
Broker Signature:	Name of Agency:	

Application for Household Employee

Employer Information

1. The applicant household employee	Has been employed by me since Date: / /
2. I have employed at least one household employee on at least 50% of the days in a normal work week during the preceding calendar quarter.	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. The household employee applicant is a full-time employee who works 24 or more hours per week on a permanent basis as a household employee.	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. For initial qualification for enrollment of this employee, I am attaching a copy of the employee's quarterly employment-related tax and withholding statement for the past quarter.	<input type="checkbox"/> Yes <input type="checkbox"/> No

I certify that the information stated above is correct and represents true facts and information. I understand that I may be required to provide employment related tax and withholding information, as requested by Rocky Mountain Health Plans, for continuing qualification and enrollment of the household employee identified above.

Household Employer Signature: _____ Date: _____

Employee Information

1. I am a full-time household employee who works 24 or more hours a week on a permanent basis.	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. A substantial part of my income in at least one of the last three years has been earned from household employment.	<input type="checkbox"/> Yes <input type="checkbox"/> No

I certify that the information stated above is correct and represents true facts and information. I also certify that my household employment with the employer noted above is not seasonal or temporary employment.

Household Employee Signature: _____ Date: _____

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.

For small employer groups, see the enclosed Disclosure Notice for Small Employer Groups, which is incorporated into this document by reference.

Attestation for Business Group of One is on the back of this form.