



Notice to Rocky Mountain Health Plans of Qualifying Event for Continuation of Coverage

Complete this form using black ink only.

Employee Information					
Employee Name	Last	First	MI	Date of Birth / /	Member #: Social Security # - -
Employer Name			Address		
City	State	Zip	Phone ()		
1. Type of qualifying event: Please check ONE only. <input type="checkbox"/> Termination of employment <input type="checkbox"/> Divorce or legal separation <input type="checkbox"/> Reduction in hours (COBRA only) <input type="checkbox"/> Death of employee <input type="checkbox"/> Employee's eligibility for Medicare <input type="checkbox"/> Retirement <input type="checkbox"/> Child – loss of dependent status (COBRA only) <input type="checkbox"/> Other					
2. Date of qualifying event:					
Names, social security numbers, and current addresses of all Rocky Mountain Health Plans members to be extended continuation of coverage.					
Name	Employee Social Security #	Address			
		Street	City	State	Zip
Employee	- -				
Spouse	- -				
Dependent					
Dependent					
Dependent					
Dependent					

Send this form to:

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