

SOLO Health Plan Application

Thank you for your interest in the SOLO plan, underwritten by Rocky Mountain HealthCare Options, Inc. (RMHCO). Read every section carefully and be sure to complete all items. **Unanswered questions or incomplete/omitted information will result in the return of this application to you and will delay your enrollment in this health care plan.** The SOLO plan is medically underwritten. This means that health care coverage is not guaranteed. Applicants **must** complete a health questionnaire that will be considered before an application is accepted or rejected.

Applicants age 50 or older are required to submit with the initial application a current (within the past 12 months) medical history and physical examination record. The physical exam record must include any health screening tests (including mammogram, PAP, or PSA) or procedures, a fasting blood glucose, and a lipid panel. **Infants** who are at least two months of age and under six months of age will require medical records from their two and/or four month well-child check along with immunization records. Costs associated with such services will be the responsibility of the applicant.

If you are age 65 or older or you have a disability and qualify for Medicare, this Individual Plan is not available to you. Call 800-346-4643 for information on Medicare benefit options.

If you have questions or need additional information as you complete this application, call your broker or RMHP at 800-453-2981, option 4.

Fax the completed application and medical records to 970-244-7992.

Please check the plan for which you are applying below. Be sure to check the Accident Rider or Prescription Drug rider if you want to add those to the medical plan. Generic drug coverage will be included if a different drug rider option is not selected.

| SOLO VIEW PLANS | |
|--|---|
| Choose Plan Deductible Option | Prescription Drug Rider \$15 copay for Generic drugs is included in the plan unless another option is selected. |
| <input type="checkbox"/> SOLO \$500 | <input type="checkbox"/> Discount Plan – You pay 100% of the RMHP discounted rate for prescription drugs |
| <input type="checkbox"/> SOLO \$500 w/ Maternity rider | <input type="checkbox"/> Brand Name Drug Rider \$15 / \$40 / \$60 |
| <input type="checkbox"/> SOLO \$1,500 | <input type="checkbox"/> Brand Name with \$250 Deductible Rider \$15 Generic copay (no deductible) \$40 / \$60 Brand Name copay after \$250 deductible |
| <input type="checkbox"/> SOLO \$2,500 | Optional Accident Rider |
| <input type="checkbox"/> SOLO \$4,000 | <input type="checkbox"/> Optional Accident Rider \$1 to \$1,000 covered in full for each accident, then deductible and coinsurance apply. |

| SOLO VIEW HSA PLANS | |
|---|---|
| Choose Plan Deductible Option | Prescription Drug Rider Generic prescription drug coverage is included with the plan and covered at 100% after deductible. |
| <input type="checkbox"/> SOLO HSA \$2,500/100 | <input type="checkbox"/> Brand Name Drug Rider Generic and Brand Name prescription drugs are covered at 100% after deductible. |
| <input type="checkbox"/> SOLO HSA \$3,250/100 | Optional Accident Rider |
| <input type="checkbox"/> SOLO HSA \$5,000/100 | <input type="checkbox"/> Optional Accident Rider \$1 to \$1,000 covered in full for each accident, then deductible and coinsurance apply. |

Effective Date

The effective date of coverage is the first of the month following the application approval date unless a later effective date is requested.

- 1st of the month following application approval date
- 15th of the month following application approval date
- 1st of _____ (write month here)
- 15th of _____ (write month here)

Please Tell Us How You Heard About Us

- Family member Broker Friend Newspaper/radio Health plan member Website Other _____

Did you work with a SOLO Sales Representative? Yes No **Sales Representative Name:** _____

**APPLICATION MUST BE COMPLETED BY SUBSCRIBER/APPLICANT
PRINT ALL INFORMATION CLEARLY IN BLACK INK**

| | | | | | |
|---|------------|-------------------------|----------------------------|---------------------|---|
| Are you applying to add a dependent to your existing SOLO Health Plan policy? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| Subscriber: Last Name ¹ | First Name | MI | Social Sec. # ² | Home Phone () | |
| Address | City | State | County | Zip Code | Alternate Phone () |
| Tobacco use in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | Email Address: | | |
| Birth Date — Mo/Day/Year _____ | | Birth Place: City _____ | | State _____ | Height _____ Weight _____ <input type="checkbox"/> M <input type="checkbox"/> F |
| <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Legally separated <input type="checkbox"/> Common law marriage (statement will be required) | | | | | |

(continued on page 2)

PROVIDE ALL INFORMATION FOR EACH FAMILY MEMBER APPLYING FOR COVERAGE UNDER THIS PLAN.

| Last Name | First Name | MI | HT | WT | Social Sec # ² | Sex M/F | Relationship to Subscriber | Tobacco Use in the Past 12 Months? |
|--|------------|--------------------|----|----|---------------------------|---------|----------------------------|--|
| Spouse | | | | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Birth Date Mo/Day/Yr: | | Birth Place: City: | | | State: | | | |
| Dependent | | | | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Birth Date Mo/Day/Yr: | | Birth Place: City: | | | State: | | | |
| Dependent over age 19 and under 25: Married? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Financially dependent or same household as the subscriber | | | | | | | | |
| Dependent | | | | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Birth Date Mo/Day/Yr: | | Birth Place: City: | | | State: | | | |
| Dependent over age 19 and under 25: Married? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Financially dependent or same household as the subscriber | | | | | | | | |
| Dependent | | | | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Birth Date Mo/Day/Yr: | | Birth Place: City: | | | State: | | | |
| Dependent over age 19 and under 25: Married? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Financially dependent or same household as the subscriber | | | | | | | | |
| Dependent | | | | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Birth Date Mo/Day/Yr: | | Birth Place: City: | | | State: | | | |
| Dependent over age 19 and under 25: Married? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Financially dependent or same household as the subscriber | | | | | | | | |
| Dependent | | | | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Birth Date Mo/Day/Yr: | | Birth Place: City: | | | State: | | | |
| Dependent over age 19 and under 25: Married? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Financially dependent or same household as the subscriber | | | | | | | | |
| ¹ If a dependent child is applying as an individual rather than as part of a family, list the child as the subscriber. If more than one dependent child is applying as an individual, <u>complete an application for each child subscriber.</u> | | | | | | | | |
| ² Supply social sec. #s if known. Missing numbers will be requested after enrollment. | | | | | | | | |

If you have had health insurance coverage in the last 12 months, provide a certificate of creditable coverage from the insurance company. Your claims may be pended until we receive the certificate of coverage from your previous health insurance company.

Policyholder's Name: _____

Name of Insurance Company: _____

Fax the certificate to: 970-263-5507 or attach it with this application.

Pre-Existing Condition Limitation Period

A pre-existing condition is an injury, sickness, or pregnancy for which the Member has, during the 12 consecutive months immediately preceding the Member's effective date of coverage under the plan applicable, either: (a) incurred charges, (b) received medical treatment, (c) consulted a health care professional, or (d) taken prescription drugs. Rocky Mountain Health Plans will not pay for services related to a preexisting condition for 12 consecutive months after the Member's original membership Effective Date. (This 12 months is the pre-existing condition limitation period.)

Upon approval of your application, the length of the Pre-Existing Condition Limitation Period will be reduced or eliminated for you and each family member who has creditable coverage. The creditable coverage must have ended within 90 days prior to your enrollment in RMHP. Creditable coverage includes health care coverage provided under: (a) Medicare or Medicaid; (b) an employee welfare benefit plan, group health insurance, or group health benefit plan; (c) an individual health benefit plan; (d) a state health benefits risk pool (including but not limited to the Cover Colorado Uninsurable Health Insurance Plan and CHP+) or (e) other federal coverage. **You must provide proof of creditable coverage for every family member listed on this application who has had health care coverage within the last 12 months.**

Such creditable coverage reduces the Pre-Existing Condition Limitation Period by one day for each day of creditable coverage. For example: If you had creditable coverage for three months before enrolling in the SOLO plan and such creditable coverage ended less than 90 days prior to your enrollment date, then your Pre-Existing Condition Limitation Period will be reduced from 12 months to nine months. If the creditable coverage ended more than 90 days prior to your enrollment date, then the full 12-month Pre-Existing Condition Limitation Period will apply.

The insurance company or health plan that provided your previous health care coverage should have given you a certificate stating that you had creditable coverage and specifying the time period of such creditable coverage. If you are still covered under another health care plan or you do not have a certificate evidencing your prior creditable coverage, you can ask RMHP to help you obtain proof of creditable coverage. Contact RMHP at 970-244-7800, option 4 or 800-453-2981, option 4.

Complete the chart above for yourself and each family member listed on this application. List all current health care coverage policies and/or all previous health care coverage policies in effect during the last 12 months. Add and label additional pages if necessary.

Health Questionnaire

All questions must be answered completely for each person applying for coverage on this application or the application will be returned.

Any knowing misrepresentation as to the presence or severity of any health condition, impairment, or disease could result in retroactive termination of coverage. Any failure to notify RMHP of any medical condition, impairment, disease, or change in any applicant's health status that occurs or is diagnosed between the date of application and the later of the effective date of coverage or the date coverage is approved could also result in retroactive termination of coverage. RMHP shall have the right to request and review additional information regarding health history and any change in health status that occurs between the date of application and the effective date of coverage. This additional information may be used to determine if RMHP will accept or decline your application prior to the effective date of coverage. No notice of acceptance related to your application can bind RMHP to coverage prior to the effective date of coverage, and failure to provide additional requested information could result in your application not being accepted.

1. In the past five years, have you or any family member listed on this application ever had, been treated for, been diagnosed with, or had any indication of any of the following conditions, diseases, or disorders? **Mark EACH condition/disease/disorder either YES or NO.**

| CONDITION/DISEASE/DISORDER | YES | NO |
|--|-----|----|
| Abdominal /Bowel Problem (including colitis, diverticulosis, ulcers, regional enteritis, or hernias) | | |
| Alcohol/Drug/Substance Abuse | | |
| Arthritis, Rheumatoid/Osteoarthritis (specify type) | | |
| Asthma/Bronchitis/Emphysema or Other Lung/Breathing Disorder (including sleep apnea, tuberculosis) | | |
| Back/Spine/Bone Problems (including fractures, joint disease/injury, scoliosis/osteochondrosis/osteoporosis) | | |
| Birth Abnormality/Defect/Congenital Problem | | |
| Bleeding Disorder/Anemia | | |
| Brain/Nervous System Disorder (including disabling headaches, epilepsy/seizures, paralysis, stroke, Multiple Sclerosis or Parkinson's Disease) | | |
| Cancer/Malignant Condition (including leukemia, Hodgkin's Disease) | | |
| Cardiovascular/Heart Disorder (including chest pain, heart attack/murmur, valve problems, hypertension, elevated cholesterol) | | |
| Cataract or Other Eye Disorders | | |
| Chronic Fatigue Syndrome/Fibromyalgia | | |
| Diabetes or high blood sugar | | |
| HIV/AIDS Virus (including positive test result for the HIV/AIDS virus) | | |
| Kidney/Bladder/Urinary Disorder (including stones, tumor, renal failure, dialysis, prostate problem) | | |
| Liver/Pancreas Disorder (including pancreatitis, cirrhosis, hepatitis) | | |
| Male/Female Genital/Reproductive Disorders (including STDs, infertility) | | |
| Mental Disorders (including anxiety, attention deficit, depression, eating disorders, paranoia, or schizophrenia) | | |
| Organ Transplant Recipient or on Waiting List for Transplant | | |
| Skin Disorder (including rash, lesions, Lupus) | | |
| Varicose Veins | | |

If you answered yes to any of the conditions, diseases, or disorders in Question #1, complete the chart below. Add and label another page if necessary.

| Name of person with condition marked "Yes" above | Condition/Disease/Disorder | Date of Last Treatment | Date of Last Hospitalization | Doctor's Name and City |
|--|----------------------------|------------------------|------------------------------|------------------------|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

2. Have you or any family member listed on this application received advice for, been diagnosed with, or been treated for any condition(s), disease(s), or disorder(s) not listed in Question #1? Yes No (If yes, explain disease, condition, or disorder.)

Person's name: _____

3. Have you or any family member listed on this application been advised or are planning to have medical or surgical treatment that has not yet been performed?

Yes No (If yes, please explain.) Person's name: _____

4. Have you or any family member listed on this application incurred medical/surgical and/or hospital expenses of \$5,000 or more within the last 12 months? Yes No (If yes, please explain.) Person's name: _____

5. Have you or any family member listed on this application seen a provider for **ANY** reason in the past 12 months (including but not limited to **sickness, physical exam, mammogram, Pap smear, prostate screening, injury, labwork, etc.**)?

Yes No If yes, complete the chart below for each visit in the past 12 months. Add and label another page if necessary.

| Family Member | Reason for Treatment | Date of Treatment | Doctor's Name and Address |
|---------------|----------------------|-------------------|---------------------------|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

6. Have you or any family member listed on this application taken any prescription medications in the last 12 months?

Yes No If yes, complete the chart below. Add and label another page if necessary.

| Family Member | Medication Name | Quantity/ Dosage Taken | Prescribing Physician | Illness for Which Medication Prescribed | Date Prescription Last Received |
|---------------|-----------------|---------------------------|--------------------------|--|---------------------------------------|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

7. Have you or any family member listed on this application had any surgical procedures, operations, and hospitalizations within the last five years?

Yes No If yes, complete the chart below. Add and label another page if necessary.

| Family Member | Operation/Procedure | Date | Reason for Operation/Procedure | Surgeon and Hospital Name and Address |
|---------------|---------------------|------|-----------------------------------|--|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

8. Does anyone listed on this application drink alcohol? Yes No

If yes, person's name: _____ How much weekly? _____

Name: _____ How much weekly? _____

9. At this time, is any family member pregnant (**whether or not applying for coverage**)?
 Yes *If yes, give person's name and relationship to subscriber: _____
 No **If no, list female family members and dates of their last menstrual period (whether or not they are applying for coverage):**
 Name: _____ Month _____ Day _____ Year _____
 Name: _____ Month _____ Day _____ Year _____
 If no cycle, why? _____
 If any member's initial menstrual cycle has not yet begun, give her name: _____
 * If you or your spouse is pregnant, this plan is not available to you, regardless of whether or not the pregnant person is applying for coverage.
10. Is any person applying for coverage expecting a child or in the process of adoption or surrogacy with anyone, whether or not that other person is also applying for coverage on this application? Yes No
 Applicant Name: _____ When is the child expected to be born or adopted? _____
11. Have you or any female listed on this application ever had any abnormality of the female organs, abnormal menstrual periods, or any unexplained vaginal bleeding? Yes No If yes, explain: _____
 Name: _____
12. Have you or any family member listed on this application ever had an
 abnormal Pap smear? Yes No
 abnormal mammogram? Yes No
 abnormal PSA? Yes No
 If yes, explain: _____
 Name: _____
 * If you answered "Yes", provide the results from your last two screenings with your application.
13. Disclose occupation and type of work all applicants do:

14. Disclose all hobbies all applicants participate in:

15. Have you or any family member listed on this application had a weight change during the past year? Yes No If yes, provide name(s):
 Increased by 10 lbs. or more: _____
 Decreased by 10 lbs. or more: _____
 Reason for each person's weight change: _____
16. If any family member listed on the application is six months of age or younger, fill in below and **submit medical records from the two and/or four month well-child check along with immunization records**.
 Birth weight: _____ lbs. _____ oz.
 Current weight: _____ lbs. _____ oz.
 Date of last well-baby check: _____
 As a newborn: a) was the baby kept in an incubator? Yes No
 b) did the baby require oxygen? Yes No
17. Have all applicants under the age of 18 years had all recommended immunizations? Yes No
 If no, list child's name and explain: _____

Qualification for Coverage Through CoverColorado

If you ended a COBRA or State Continuation of Benefit Plan within the past 62 days in which you have **exhausted ALL** eligible coverage (18 months or 36 months, you may qualify for health coverage with no medical screening through CoverColorado*. For information about CoverColorado benefits, exclusions, enrollment, and premium subsidies, contact CoverColorado at:

425 S. Cherry St., Suite 160
Glendale, CO 80246
303-863-1960
www.covercolorado.org

**You do not qualify if (a) you are eligible for a group health benefit plan, Medicare, Medicaid, or have other health benefit plan coverage; (b) your most recent coverage was terminated as a result of nonpayment of premiums or fraud; or (c) you turned down an offer of continuation coverage or did not exhaust such coverage.*

Determining if This Is an Employer-Sponsored Plan

Rocky Mountain Health Plans does not market or sell individual plans to eligible employees of an employer-sponsored plan or to self-employed Business Groups of One. Under certain conditions, an individual plan is available to noneligible employees and all dependents in an employer-sponsored plan.

Answer the following questions so RMHP can determine if you are eligible for individual medical coverage or if, due to the premium arrangement for the coverage, you are subject to the Colorado small employer group health insurance reform laws.

I pay the **ENTIRE** premium for the coverage out of my own **PERSONAL** funds. Yes No

My employer or my business will be paying **ALL OR A PORTION** of the benefit or premium for coverage. Yes No

My employer or my business will be reimbursing me or any of my dependents for **ALL OR A PORTION** of the premium through wage adjustment or any other way. Yes No

ALL OR ANY PORTION of the premium for the coverage will be deducted from my salary/wages. Yes No

My employer or I will take a tax deduction for the premiums for this coverage. Yes No

If YES, is the premium paid through a Section 125 (cafeteria) plan? Yes No

If YES, my employer:

a) will contribute to the cafeteria plan, OR Yes No

b) will pay for **ALL OR ANY PORTION** of the premium, OR Yes No

c) has other health coverage for employees Yes No

I, _____, certify that the answers to these questions are true and correct.

Printed Name of Applicant

Signature of Applicant

X _____

Date _____

If you are a Business Group of One (BG1), you may apply for a BG1 Plan. A BG1 is an individual, a sole proprietor, or a single full-time employee of a subchapter S corporation, C corporation, nonprofit corporation, limited liability company, or partnership who works at least 24 hours a week on a permanent basis and who has carried on significant business activity for a period of at least one year prior to application, which generated enough gross income to pay the annual premium or that provided at least a substantial part of such individual's income for one year out of the most recent consecutive 3-year period.

If you: 1) believe you may be a BG1, and/or 2) intend this plan to be an employer-sponsored plan, you cannot file this application, and you must contact RMHP for an application for a BG1 plan.

COLORADO INSURANCE LAW REQUIRES ALL CARRIERS IN THE SMALL GROUP MARKET TO ISSUE ANY HEALTH BENEFIT PLAN IT MARKETS IN COLORADO TO SMALL EMPLOYERS OF 2-50 EMPLOYEES, INCLUDING A BASIC OR STANDARD HEALTH BENEFIT PLAN, UPON THE REQUEST OF A SMALL EMPLOYER TO THE ENTIRE SMALL GROUP, REGARDLESS OF THE HEALTH STATUS OF ANY OF THE INDIVIDUALS IN THE GROUP. BUSINESS GROUPS OF ONE CANNOT BE REJECTED UNDER A BASIC OR STANDARD HEALTH BENEFIT PLAN DURING OPEN ENROLLMENT PERIODS AS SPECIFIED BY LAW.

SOLO Payment Options

Rocky Mountain Health Plans (RMHP) offers three different options for your SOLO premium payment. Check the box for the payment plan you wish to use:

- Monthly Bank Draft.** RMHP can withdraw your monthly premiums directly from your bank account. With this option, no invoice is mailed and you do not have to worry about mailing your payment in time. *Simply complete the Account Deduction Authorization form (below) and attach a voided check.* RMHP will draft your first premium on the 4th of each month after you are approved.
- Monthly Credit Card Automation.** RMHP can automatically request monthly payment from your credit card company. With this option, there is no invoice sent and you do not have to worry about mailing your payment in time. As an added convenience, **you only need to give us your Credit Card information and approval one time.** *Simply complete the Credit Card Authorization form below.* RMHP will take your first premium on the 4th of each month after you are approved.
- Quarterly Invoice Billing.** RMHP will mail you a quarterly premium billing invoice based on a calendar year quarter. This option requires pre-payment for the entire quarter. Quarterly payments are due the first business day of the month and the amount due is for the full three months.

Thank you for your Membership with Rocky Mountain Health Plans.

Please note: The premium may change when you have been enrolled for 12 months or if you move to a different county in Colorado.

Account Deduction Authorization

I, _____, authorize the monthly deduction of
(Print Name)
 Rocky Mountain Health Plans premiums from my account _____
(Account Number)
 at _____
(Bank Name) (Routing Number)
 for _____
(Subscriber name, if different)

I understand that if the bank fails to remit my premium, my membership will not be terminated until I have been given the opportunity to pay the amount due.

Signature _____ Date _____

Attach a voided check from your bank account.

Credit Card Authorization for Automatic Recurring Billing

Member Name: _____

Name of Account Holder (if different from member name): _____

CREDIT CARD: VISA DISCOVER MASTERCARD

Credit Card Number: _____ Expiration Date: Mo. _____ Yr. _____

X _____ Date: _____

Signature of Account Holder

PO Box 10600, Grand Junction, CO 81502-5600 — 800-453-2981, option 4
 Fax: 970-244-7992

If you are hearing impaired and use TTY equipment, call 800-704-6370

MIB PRE-NOTICE

Information regarding your insurability will be treated as confidential. Rocky Mountain Health Maintenance Organization, Inc., Rocky Mountain HealthCare Options, Inc., and its affiliates and subsidiaries, collectively referred to below as the "Companies," or their reinsurers may, however, make a brief report thereon to the MIB, Inc., formerly known as Medical Information Bureau, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information about you in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at 866-692-6901 (TIT 866 346-3642). If you question the accuracy of the information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.

The Companies, or their reinsurers, may also release information from their files to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.

AUTHORIZATION BY ENROLLEE

Authorization: I, the Proposed Enrollee, authorize Rocky Mountain Health Maintenance Organization, Inc., Rocky Mountain HealthCare Options, Inc., and its affiliates and subsidiaries, collectively referred to below as the "Companies," to collect the Types of Information (described below) from the Sources (described below). I authorize the persons and organizations described as Sources to release the Types of Information to the Companies or to any persons authorized by the Companies to assist with the collection of such information, including its agents and brokers. In addition I further authorize the Companies to disclose and report my protected health information to MIB, Inc., formerly Medical Information Bureau ("MIB") in the form of a brief coded report that will be stored in the MIB database for such period as may be allowed by law and I specifically authorize release of such information to other MIB member companies if I apply to a MIB member company for life or health insurance or a claim for benefits is submitted to a MIB member company. I understand that the information obtained by the Companies will be used to detect insurance fraud or abuse or for compliance activities, which may include disclosure to MIB, Inc. and participation in MIB's fraud prevention and detection programs.

Purposes: I authorize the release and collection of these Types of Information for underwriting including the underwriting of any application for insurance or health care coverage for myself, my dependent children under the age of 18, and others for whom I am a Personal Representative under the laws of the State of Colorado and may be requesting coverage for, and for the investigation of contestable claim(s) or grounds for contesting the policy.

Sources of Information ("Sources"): The following persons and organizations are authorized to disclose my personal financial and health information (and all other Types of Information without limitation) to the Companies or its authorized representative(s): any physician, healthcare provider, health plan or medical practitioner; any hospital, clinic or other medically-related healthcare facility (or any other "covered entity" under the HIPAA Privacy Rule); any financial source; business associate; current employer; benefit plan sponsor; association; government unit, including the Department of Motor Vehicles; consumer reporting agency; MIB, Inc., formerly Medical Information Bureau (MIB); any insurer or reinsurer that has medical record information about me or information about current or pending insurance.

Types of Information: Personal health information (and medical records), including "protected health information" under the HIPAA Privacy Rule and "nonpublic personal financial and health information" under Gramm-Leach-Bliley Act and related laws and regulations, concerning my past, present or reasonably anticipated future mental, physical or behavioral health or condition; the provision of all instances of healthcare or treatment, including all outpatient care and admissions and findings, examinations and surgery, as reflected in my entire medical record; other insurance coverage; hazardous activities; character general reputation; finances; occupation; information collected by a consumer reporting agency about my credit history, credit worthiness, credit standing and credit capacity; avocation(s); motor vehicle driving record(s); and personal traits. I further understand that the specific type of personal health information to be disclosed may, if applicable, include: diagnosis, prognosis, and treatment for physical or emotional illness (or both), including treatment for alcohol or substance abuse (information protected by federal regulation 42 CFR Pt.2) and serious communicable disease or infection, including sexually transmitted diseases; diagnosis, prognosis, and treatment of HIV infection, including HIV test results, sometimes described as "AIDS Confidential Information" under state laws. The following types of medical record information are excluded: HIV test results obtained anonymously at alternate test sites in MN or by a crime victim or offender in MN; "psychotherapy notes," as defined under the HIPAA Privacy Rule (65 CFR 82462).

Re-disclosure: I understand and agree that the Companies may disclose all or some of the information that it collects about me to MIB, company reinsurers, and contractors and others who may perform business services for the Companies relating to my application or insurance coverage (generally known as "business associates"). The Companies do not re-disclose HIV antibody test results obtained under its own testing requirements. However, the Companies will report to MIB a nonspecific code if it obtains an abnormal HIV antibody test result.

Duration and Revocation: This authorization will be valid for as long as I am a member of the Companies or for 24 months from the date of this Authorization, which ever is longer, but I understand that I may revoke it at any time by giving written notice to the Companies at the above address. If this authorization is used to collect information in connection with a claim for benefits, it will be valid for the duration of the claim. Any action taken in reliance on this authorization will be valid if such action has been taken prior to either expiration of this notice or receipt of notice of revocation. If the law of your state so provides, this authorization may not be revoked during a contestable investigation. I also understand that my revocation of this authorization will not result in the deletion of codes in the MIB database if such codes have already been reported by the Companies while this authorization is in force, and that such revocation will have no effect on access to information contained in the database by MIB member companies.

Acknowledgments: I acknowledge that I am entitled to obtain a copy of this authorization (or that one can be provided to my authorized representative) and that a copy (facsimile copy or photocopy) will be just as valid as the original. I also understand that the Companies may have to decline my application if I refuse to sign this authorization or I materially alter it. I understand that the Companies have adopted Privacy Policies for customers and individuals respecting their confidential nonpublic personal health and financial information and protected health information and that such information is protected under federal and state laws, and cannot be disclosed without my written consent unless otherwise provided by law.

Signature of Proposed Enrollee: _____
(Applicant signing on behalf of all family members listed on the application who are applying for health care coverage)

Date: _____

Signature and Certification

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

1. Upon approval of application, coverage will begin on the first of the month following the date of approval.
2. First premium will be due and collected on the 4th day of the month in which your coverage begins.
3. We offer to enter into the health care plan contract for the plan designated in this enrollment application. Upon receipt of all information required for enrollment, approval thereof by Rocky Mountain Health Plans (RMHP) and RMHP acceptance of the first premium, we shall have a contract with RMHP, the terms of which are set forth in the applicable contract, which contract may be amended from time to time by RMHP in accordance with applicable law.
4. We 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 RMHP such records and information and supplement such records and information as RMHP requests. This authorization shall include all medical records and medical information. Such records and information may be used by RMHP or made available by RMHP to others for treatment, payment, or health care operations purposes, including but not limited to any quality assurance programs conducted by RMHP or its designated agents or contractors. A copy of this authorization shall be as valid as the original until contract is terminated.
5. We consent to RMHP performing case management.
6. The contract contains provisions for the arbitration of disagreements and disputes. We agree to arbitrate such disagreements and disputes as set forth in the applicable contract.
7. RMHP has the right to terminate coverage and deny benefits if any information on this enrollment application, or as otherwise provided by the undersigned to RMHP for enrollment purposes, is knowingly false, incomplete, or misleading in any material respect. RMHP has the right to deny coverage if any outstanding premiums or other payments are owed to RMHP by the undersigned.
8. All information and answers provided in this application are true and correct.
9. This application will remain valid for 90 days from date of applicant's signature below.
10. Any fraud or intentional misrepresentation as to the presence of any health condition, impairment, disease, or disorder will result in retroactive termination of coverage. As a result, RMHP will not be responsible for payment of any claims for services received up to and including the date of retroactive termination of coverage. RMHP shall have the right to request and review additional information regarding health history. RMHP retains the right to accept or deny an application until the effective date of coverage, regardless of any prior notice of acceptance or receipt of premium. Any additional information regarding your health history or change in health status that occurs between the date of application and the later of the effective date of coverage or the date a coverage decision is made may be used to determine if RMHP will accept or decline your application, or revoke a prior notice of acceptance related to your application. No notice of acceptance related to your application can bind RMHP to coverage until the effective date of coverage.
11. We understand that the policy applied for will not pay for services unless they are medically necessary as determined by RMHP.
12. We understand that a plan change request must be made 31 days prior to my anniversary to be effective on my anniversary date, subject to medical underwriting.
13. We further understand that the policy applied for will not pay benefits for any loss incurred during the first 12 months after the issue date because of any pre-existing condition unless reduced because of Creditable Coverage as described herein.
14. We understand that any information regarding this application, including associated medical records, may be shared with our broker, if applicable. We understand that any information regarding this application may be shared with our broker, if applicable. Specifically, we provide our consent to RMHP to disclose to our broker information regarding the status of the application, such as the specific reason for a denial of coverage, which may include our medical information or status.

The above provisions will remain in effect for the entire duration of RMHP membership of the undersigned and the undersigned's dependents.

We acknowledge that we have read this application and that the foregoing answers are true, and we certify that we understand and agree to all matters covered in the application.

APPLICANT SIGNATURE

(If signing for minor, so indicate.)

Date _____

*This application will expire 90 days from date of signature.

SIGNATURE OF SPOUSE APPLICANT (If applying for family membership)

Date _____

SIGNATURE OF ALL DEPENDENTS APPLYING WHO ARE AGE 18 OR OLDER

Date _____

— BROKER COMPLETE — PRINT CLEARLY —

Broker Name: _____ Address: _____

Broker License #: _____ Broker Agency: _____

Broker Fax #: _____ Broker Phone #: _____

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.

For RMHP USE