ROCKY MOUNTAIN HEALTH PLANS®
We understand Colorado. We understand you.

6E

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.** Applicants **must** complete a health questionnaire that will be considered before an application is accepted or rejected.

For details on required medical records, refer to the SOLO Application Checklist and Medical Record Requirements directly following this application.

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 OUTLOOK PLANS – SELECT ONE Deductible or HSA Plan			
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 OUTLOOK DEDUCTIBLE PLANS			
☐ **SOLO $500**	☐ **SOLO $1,500**	☐ **SOLO $2,500**	☐ **SOLO $4,000**
☐ *Optional Accident Rider – $1 to $1,000 covered in full for each accident, then deductible and coinsurance apply.*			
☐ **SOLO Active 75** Includes $2,000 Accident Rider		☐ **SOLO Active 10** Includes $2,000 Accident Rider	
☐ Optional Accident Rider for SOLO Active 75 – Additional $2,001 to $7,500 covered in full for each accident, then deductible and coinsurance apply.		☐ Optional Accident Rider for SOLO Active 10 – Additional $2,001 to $10,000 covered in full for each accident, then deductible and coinsurance apply	
PRESCRIPTION DRUG RIDERS FOR DEDUCTIBLE PLANS			
$15 Generic Drug Rider – Included unless another Rx option is selected.	☐ Brand Name Drug Rider $15/$40/$60	☐ Brand Name with $250 Deductible Rider $15 Generic Copay (No Deductible) $40 / $60 Brand Name Copay after $250 Deductible	☐ Discount Plan – You pay 100% of the RMHP discounted rate for prescription drugs (The Discount Plan removes the $15 Generic Copay Coverage)
SOLO OUTLOOK HSA PLANS			
☐ **SOLO HSA $2500/100**	☐ **SOLO HSA $3250/100**	☐ **SOLO HSA $5000/100**	
☐ Optional Accident Rider - $1 to $1,000 covered in full for each accident, then deductible and coinsurance apply.			
PRESCRIPTION DRUG RIDERS FOR HSA PLANS - Generic prescription drug coverage is included with the HSA plans, covered at 100% after deductible			
☐ Brand Name Drug Rider - Generic and Brand Name Prescription drugs are covered at 100% after deductible.			

Effective Date
Select the effective date below for adult and family plans. For Child Only plans, see page 2.

☐ 1st of ____________________ (write month here)
☐ 15th of ___________________ (write month here) (not available for Child Only plans)

Please Tell Us How You Heard About Us
☐ Family member ☐ Broker ☐ Friend ☐ Newspaper/radio ☐ Health plan member ☐ Website ☐ Other____________

BROKER COMPLETE — PRINT CLEARLY —

Broker Name:______________________________ Address: ______________________________

Broker License #:___________________________ Broker Agency:___________________________

Broker Fax #: ______________________________ Broker Phone #: ____________________________

For RMHP Use ____

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? ☐ Yes ☐ No

Subscriber: Last Name	First Name	MI	Social Sec. # [3]			Home Phone ( )
Address	City	State		Zip Code	County	Alternate Phone ( )

Tobacco use in the past 12 months? ☐ Yes ☐ No Type: ☐ Smoking ☐ Smokeless ☐ Both smoking and smokeless

Email Address:

Birth Date — Mo/Day/Year________________ Height__________Weight___________ ☐ M ☐ F

Have you lost or gained 20 lbs or more in the last 12 months? ☐ Yes ☐ No

☐ Single ☐ Married ☐ Divorced ☐ Legally separated ☐ Common law marriage (statement will be required)

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

Last Name	First Name	MI	HT	WT	Social Sec. # [3]	Sex M/F	Relationship to Subscriber	Tobacco Use in the Past 12 Months?
Spouse Information								☐ Yes ☐ No
Birth Date Mo/Day/Yr:			Have you lost or gained 20 lbs or more in the last 12 months? ☐ Yes ☐ No					

Dependent children may apply with parent(s) up to age 26.

Last Name	First Name	MI	HT	WT	Social Sec. # [3]	Sex M/F	Relationship to Subscriber	Tobacco Use in the Past 12 Months?
Dependent Information[4]								☐ Yes ☐ No
Birth Date Mo/Day/Yr:			If you are age 19 or older, have you lost or gained 20 lbs. or more in the last 12 months? ☐ Yes ☐ No					
Dependent Information[4]								☐ Yes ☐ No
Birth Date Mo/Day/Yr:			If you are age 19 or older, have you lost or gained 20 lbs. or more in the last 12 months? ☐ Yes ☐ No					
Dependent Information[4]								☐ Yes ☐ No
Birth Date Mo/Day/Yr:			If you are age 19 or older, have you lost or gained 20 lbs. or more in the last 12 months? ☐ Yes ☐ No					

[3] Supply social sec. #s if known.

[4] 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, complete an application for each child. Each enrolling child will be the subscriber on his or her own policy.

Child Only Plan Open Enrollment Period

Open enrollment for child-only SOLO plans will be held semi-annually in January and July. During the open enrollment period, applications will be accepted. Coverage will be offered to all children under the age of 19 on a guaranteed issue basis, without any limitations or riders based on health status following a 30-day waiting period.

In addition, enrollment will be permitted for qualifying events consistent with state law, which includes birth, adoption, marriage, dissolution of marriage, loss of employer-sponsored insurance, loss of eligibility for Medicaid or the Children's Basic Health Plan, a valid court order mandating the child be covered, or involuntary loss of other existing coverage for any reason other than fraud, misrepresentation or failure to pay premium. Applications for enrollment following a qualifying event must be received within 30 days after the date of the qualifying event.

Child Only Plan Qualifying Events

☐ Marriage ☐ Divorce

☐ Newborn child — Give date of birth: ____Newborn's hospital discharge date: ______________________

☐ Adoption or placement for adoption. Give adoption or placement date and submit adoption documentation: ______________________________________

☐ Court ordered coverage for dependent(s) — Give date of court order and submit court order documentation: ____________________________________

☐ Child lost prior coverage — (Please submit proof of loss of coverage, i.e., HIPAA Certificate of Creditable Coverage, or other acceptable proof)

Type of coverage lost: ☐ Employer group ☐ Child Health Plan ☐ Medicaid ☐ Other__________________________ Date coverage was lost: _____

For RMHP Use ____

Prior Health Insurance Coverage

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 or until we receive evidence establishing creditable coverage. Applicants under age 19 do not need to provide a certificate of creditable coverage.

Policyholder's Name:____

Name of Insurance Company:____

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

Please note: If you currently have coverage on an RMHP employer group health plan, you will need to complete a form to disenroll from that plan. Do not disenroll until you are approved for and accept SOLO health care coverage. RMHP cannot disenroll you from your group coverage without your signature on the form. Please contact us and we will provide you the form you need to cancel your group health care coverage.

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. Except as set forth below, 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, Medicaid, or the children's basic health plan; (b) an employee welfare benefit plan or group health insurance or health benefit plan; (c) an individual health benefit plan; (d) a state health benefits risk pool (including but not limited to CoverColorado or (e) other federal coverage under title 10, chapter 55 of the U.S. code, a medical care program of the federal Indian health service or of a tribal organization, a health benefit plan offered under title 5, chapter 89 of the U.S. code, a public health plan, or a health benefit plan under section 5(e) of the federal Peace Corps Act. **Except as set forth below, 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 90 days or less 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.

The Pre-Existing Condition Limitation Period, including the requirement to provide proof of creditable coverage, will not apply to you, or any family member, if you or the family member is under 19 years of age at the time of application. This exception to the Pre-Existing Condition Limitation Period is applied on an individual basis, and each individual must separately qualify for this exception.

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 ____________________________________

Health Questionnaire

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

1. In the last 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, neck pain)		
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, high blood pressure, 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)		
Behavioral Health 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:____

   ____

For RMHP Use ____________________________________

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 a hospital stay of three nights 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 had a well (annual) exam, mammogram, pap smear, prostate screening, colon cancer screening, or childhood immunizations in the last two years? ☐ Yes ☐ No If yes, complete the chart below for each visit. Add and label another page if necessary.

Family Member	Date of Exam	Doctor's Name and Address

6. Have you or any family member listed on this application seen a provider for **ANY** reason in the last 12 months (sick visit, counseling, therapy, consultation, etc.)?
☐ Yes ☐No If yes, complete the chart below for each visit in the last 12 months. Add and label another page if necessary.

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

7. 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

8. 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

For RMHP Use ____________________

9. Has any applicant consumed any alcoholic beverage in the last 6 months? (Amount: A drink is 12 oz. of beer, 6 oz. of wine, or 1 oz. of liquor) ☐ Yes ☐No If yes, please complete below.

Applicant Name:________________________________ Amount:___________ drinks per week

Applicant Name:________________________________ Amount:___________ drinks per week

10. At this time, are you or any family member pregnant, expecting a child, or in the process of adoption or surrogacy with anyone (**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 the last menstrual period. Include female family members listed on this application **and** female family members who are not applying for coverage.

Name:____ Month: ____ Day:_____ Year:______

☐ N/A due to hysterectomy

☐ N/A due to menopause

Name:____ Month: ____ Day:_____ Year:______

☐ N/A due to hysterectomy

☐ N/A due to menopause

* If you or your spouse is pregnant, or if you are expecting to be the parent of a baby, or you are in the process of adoption or surrogacy, this plan is not available to you, regardless of whether or not the pregnant person is applying for coverage.

11. In the last five years, have you or any female listed on this application had any abnormality of the female organs, abnormal menstrual periods, or any unexplained vaginal bleeding? ☐ Yes ☐ No If yes, explain: ________________________________

Name:____

12. In the last five years, have you or any family member listed on this application 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 all applicants under the age of 18 years had all recommended immunizations? ☐ Yes ☐ No

If no, list child's name and explain:____

<u>Any knowing misrepresentation as to the presence or severity of any health condition, impairment, or disease could result in retroactive termination of coverage.</u> 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, decline, or adjust the premium of 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. Please do not supply genetic information.

For RMHP Use ____

Qualification for Coverage Through CoverColorado

If you ended a COBRA or State Continuation of Benefit Plan within the past 63 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, Phone: 303-863-1960 Website: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.

Permissible Employer Reimbursement through Wage Adjustment or HRA

1. ☐ Yes ☐ No Will an employer of fifty (50) or fewer eligible employees be paying for or reimbursing an employee through wage adjustment or a health reimbursement arrangement for any portion of the premium on the policy being applied for?

If you answered “yes”, please continue. If you answered “no”, you may stop.

2. ☐ Yes ☐ No Did the employer have a small group health benefit plan providing coverage to any employee in the twelve months prior to the date of this application?

NOTE:
If the answer to both questions 1 and 2 is “yes,” the applicant may not be issued an individual policy with the premiums, or portion thereof, paid or reimbursed by the employer.

If the answer to question 1 is “yes” and the answer to question 2 is “no,” the applicant must submit a signed affidavit from the employer certifying that the employer has not had a small group health benefit plan providing coverage to any employee in the previous twelve (12) months. The affidavit form to be executed by the employer is located at www.rmhp.org\Individuals-Families. You may also get a copy of the form by contacting the SOLO Sales Team or your broker.

The submission of this affidavit does not guarantee that the individual policy you are applying for will be issued by RMHP.

Determining if This Is a Small Employer-Sponsored Plan

RMHCO does not market or sell individual plans if the plan would be a small employer-sponsored plan or a self-employed Business Group of One plan. Please review and complete the following certification so RMHCO can determine if you are eligible for individual plan coverage or if, due to the premium payment arrangement for the coverage, you are subject to the Colorado small employer group health coverage laws.

I, the undersigned applicant hereby certify the following:

1. The premium or benefits for this health coverage plan **WILL NOT** be paid in whole or in part by my employer or my business, except that reimbursement through wage adjustment or a health reimbursement arrangement through my employer is permitted if the employer does not have, and has not had in the previous twelve months, an employer-sponsored small group health benefit plan.

2. Except as permitted by C.R.S. 10-16-105.2 (1.5) regarding employer reimbursement through wage adjustment or a health reimbursement arrangements when my employer does not have, and has not had in the previous twelve months, an employer-sponsored small group health benefit plan, no person or entity, including me, my dependents, nor my employer will take a tax deduction or receive a tax benefit for the premiums for this coverage or treat it as a plan or program under Section 106 of the federal Internal Revenue Code of 1986 (IRC), or under Section 162 of the IRC.

3. If any portion of the premium for this health coverage plan is going to be paid through a plan or program under Section 125 of the IRC, my employer: will not contribute to the plan or program; does not have in place an employer sponsored health benefit plan for employees; and does not pay for any portion of the premium or benefit.

By signing below, I ____, certify that the statements above 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) are 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.

Authorization by Enrollee

Authorization to Obtain Records: I the Proposed Enrollee, authorize any physician, medical professional, hospital, clinic, pharmacy related services organization, pharmacy benefit manager, health plan, or insurance company to disclose to Rocky Mountain Health Maintenance Organization, Inc., Rocky Mountain HealthCare Options, Inc., and its affiliates and subsidiaries, collectively referred to below as "Companies" my protected health information, including copies of records concerning physical or mental illness, advice, diagnosis, prognosis, prescription information, care or treatment provided to me, including without limitation, information relating to autoimmune deficiency syndrome (AIDS), human immunodeficiency virus (HIV), or the use of drugs or alcohol. I understand that my authorization is required for the Companies to consider my application and to determine whether or not an offer of coverage will be made. I understand information obtained with my authorization may be re-disclosed by the Companies as permitted or required by law and may no longer be protected by the federal privacy laws. I understand that I or any authorized representative will receive a copy of this authorization upon request. I authorize the Companies to use or disclose the information I provide in this application (or that the Companies has or receives from third parties) for purposes of administering my health insurance benefits. This authorization is valid for 2 years from the date signed unless revoked by me in writing (which I may do at any time by contacting the Companies).

Signature of Proposed Enrollee: **X** ______________________________ Date: ______________

(Applicant signing on behalf of all children listed on the application who are applying for health care coverage)

Signature of Spouse Applicant: **X** ______________________________ Date: ______________

Signature of all dependents applying who are age 18 or older: **X**______________________ Date: ______________

______________________________ Date: ______________

______________________________ Date: ______________

For RMHP Use ______________________________

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 or the fifteenth of the month following the date of approval or later date as agreed by you and RMHP.
2. Premium will be due and collected upon enrollment in accordance with the SOLO Payment Options described in this application.
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. You may request a copy of the contract from RMHP at any time.
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, adjust the premium, 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 at least 15 days prior to my enrollment anniversary to be effective on my anniversary date, subject to medical underwriting.
13. We further understand that, except for any enrollee who is under 19 years of age at the time of application, 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. <u>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.</u>

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.) **X** ______________________________ **Date** __________

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

SIGNATURE OF SPOUSE APPLICANT (If applying for family membership)

X ______________________________ **Date** __________

SIGNATURE OF ALL DEPENDENTS APPLYING WHO ARE AGE 18 OR OLDER

X ______________________________ **Date** __________

For RMHP Use ______________________________

SOLO Payment Options

Rocky Mountain Health Plans (RMHP) offers different options for your SOLO premium payment. Check the box for the payment plan you wish to use. Please note the options are different for initial and ongoing payment.

Initial Payment Option

Please select the option for the first month's premium payment.

☐ **Bank Account Deduction Authorization.** Complete the form below. Only your first month's premium will be deducted **unless** you also choose this as your Ongoing Payment Option. (If your coverage is effective the 15th of the month, the first month's premium will be prorated.)

☐ **Credit/Debit Card Authorization.** Complete the form below. Only your first month's premium will be deducted. (If your coverage is effective the 15th of the month, the first month's premium will be prorated.) You must select an ongoing payment option of either monthly or quarterly bank draft or quarterly invoice billing in the section below.

☐ **Pay by check.** You may include a check for the first month's premium with your application.

Ongoing Payment Option

☐ **Monthly Bank Draft.** RMHP will draft your monthly premium on the 4th of each month after you are approved.

☐ **Quarterly Bank Draft.** RMHP will draft your premium for the calendar quarter on the 4th of January, April, July and October after you are approved.

RMHP can withdraw your premiums directly from your bank account. With either of the options above, no invoice is mailed and you do not have to worry about mailing your payment in time. *Simply complete the Account Deduction Authorization (below).*

☐ **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.

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)

Signature ____________________ Date ____________________

Credit Card Authorization for Initial Payment Option Only

Member Name: ____________________

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

CREDIT CARD: ☐ VISA ☐ DISCOVER ☐ MASTERCARD

Credit Card Number: ____________________ Expiration Date: Mo. __________ Yr. ______

____________________ 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

For RMHP Use ____________________

ROCKY MOUNTAIN
HEALTH PLANS®
We understand Colorado. We understand you.

Rocky Mountain Health Plans (RMHP)
Medical Record Requirements

PLEASE NOTE: In order to complete your RMHP application, the following must be submitted within 30 days. If you have not had these required physical exams, please schedule an appointment with your doctor to do so. Your application cannot be processed without these required medical records.

ADULTS

To enroll in an RMHP health plan, adults 50 years of age or older must have medical records from:

- History and physical within the last 12 months
- Pap test (unless documented hysterectomy) and mammogram within the last 12 months
- PSA within the last 12 months
- Lipid panel within the last 12 months
- Fasting blood glucose test results within the last 12 months
- The most recent colorectal cancer screening
- Liver function tests, within the last 12 months, if on statins
- Results from any other tests recommended during your physical exam

CHILDREN

To enroll in an RMHP health plan, children under 6 months of age must have medical records from:

- The most recent Well Child check to include immunizations
- If the mother is applying within 2 months of a child's birth, please provide the record from the 6-week post-partum check-up. We will also need the date of the mother's last menstrual cycle within the last 28 days. If the mother has not had a cycle within the last 28 days, she will need to provide the results from a blood serum pregnancy test.

Please have your doctor submit this information to us within 30 days of your enrollment application date.

Information should be mailed, faxed or emailed to:

Rocky Mountain Health Plans
Attention: SOLO Sales
2775 Crossroads Boulevard, PO Box 10600, Grand Junction, CO 81502
Fax: 970-244-7992
Email: SOLO_Sales_Team@rmhp.org

If you have any questions about these enrollment requirements, please call the RMHP SOLO Sales Team at 800-453-2981, option 4, or 970-244-7800, option 4.

RMHP reserves the right to request additional information, as needed, by our medical underwriters.

This prescreening questionnaire is required by Colorado law.

It is not necessary for child-only applications.

You may complete this form and submit it to any Colorado health insurance carrier prior to completing the full-length application.

Rocky Mountain Health Plans will not offer you coverage based on this questionnaire. A full-length application must be completed in order to apply for and be offered coverage.

If you would like to return this questionnaire to Rocky Mountain Health Plans, please return it to:
Rocky Mountain Health Plans
PO Box 10600
Grand Junction, CO 81502-5600

Email: SOLO_Sales_Team@RMHP.org

Fax: 970-244-7992

If you have questions about this form, please call the SOLO Sales Team at 800-453-2981, option 4. Please be sure to write your or your broker's contact information on the form so that we may reply to you.

Prescreening Questionnaire

DO NOT COMPLETE THIS QUESTIONNAIRE IF YOU ARE APPLYING FOR A CHILD-ONLY POLICY.

APPLICANT INFORMATION							
Last Name:		First Name:				Middle Initial:	
Current address:							
City:		State:		ZIP Code:		County:	
Phone:		Email Address:					
☐ Single ☐ Married ☐ Divorced ☐ Legally Separated ☐ Common Law Marriage							
CARRIER RESPONSES SHOULD BE EMAILED OR FAXED TO:							
INFORMATION FOR EACH FAMILY MEMBER INTERESTED IN COVERAGE							
Spouse Information:							
Last Name:		First Name:				Middle Initial:	
Dependent Information: Please complete for dependents from age 19 up to age 26.							
Last Name:		First Name:				Middle Initial:	
Last Name:		First Name:				Middle Initial:	
Last Name:		First Name:				Middle Initial:	
Last Name:		First Name:				Middle Initial:	
Last Name:		First Name:				Middle Initial:	
Last Name:		First Name:				Middle Initial:	

PRESCREENING QUESTIONS: INDIVIDUAL HEALTH BENEFIT PLANS

Children under 19 years of age cannot be denied coverage based on a pre-existing condition. If a private health insurance carrier denies you or a family member over the age of 19 coverage based on this form, YOU MAY STILL BE ELIGIBLE FOR COVERAGE WITH COVERCOLORADO and the denial may serve as a denial for purposes of eligibility for coverage through CoverColorado.

Has any applicant (which includes the individual completing form, spouse and dependents) ever been diagnosed with any of the following conditions?

Condition/Disease/Disorder:	Yes:	No:	Condition/Disease/Disorder:	Yes:	No:
AIDS/HIV+			**Malignant Tumor, last 4 years**		
Alzheimer's Disease			**Multiple or Disseminated Sclerosis**		

Bipolar Disorder			**Muscular Dystrophy**		
Cirrhosis of the Liver			**Myasthenia Gravis**		
Cystic Fibrosis			**Paraplegia or Quadriplegia**		
Hemophilia			**Parkinson's Disease**		
Hepatitis, Chronic			**Primary Polycythemia**		
Hodgkin's Disease			**Schizoaffective Disorder**		
Huntington's Disease			**Schizophrenia**		
Lou Gehrig's Disease			**Stroke**		
Lupus Erythematosus Disseminate					

If you or any family member age 19 or older checked "Yes", please clearly indicate which family member checked yes for which condition: ____

____

____

Determining Your Coverage Options: PLEASE READ CAREFULLY

If you or any family member age 19 or older checked "Yes" to any condition on the above list: Please DO NOT proceed with a full-length application for any private health insurance carrier. Please submit this prescreening questionnaire to the insurance carrier of your choice and that insurance carrier will decide to issue coverage, ask you for additional information, or decide to deny coverage. If you receive a denial from a carrier based on your answers to this form, that denial may serve as your CoverColorado medical eligibility form. If you have medical documentation of the condition marked "Yes" on the list, you may also submit to CoverColorado a letter, on your doctor's letterhead, or a prescription form from your doctor reflecting your doctor's name, address, and phone number for purposes of eligibility in CoverColorado. The letter or prescription form must state the applicant's name and exact diagnosis, and must be signed and dated by your doctor and must accompany your CoverColorado application. The letter or prescription form will serve as your proof of medical eligibility, so a denial letter from a private health insurance carrier will not be necessary. Other eligibility requirements for CoverColorado may apply.

If neither you nor anyone in your family checked "Yes" to any condition on the list above: You should proceed directly to a full-length application for any private health insurance carrier with which you may want coverage and submit ONLY the full-length application. Please DO NOT submit this Prescreening Questionnaire.

Applicant Signature:		Date:	
Spouse Signature:		Date:	
Dependent Signature:		Date:	
Dependent Signature:		Date:	
Dependent Signature:		Date:	
Dependent Signature:		Date:	

Contact Information for CoverColorado:			
The individuals with medical conditions on the list above are medically eligible for healthcare coverage through CoverColorado. If you want additional information on CoverColorado please contact an enrollment specialist at the CoverColorado Administration Office at 303-863-1960 or 1-866-787-9129 (8 am – 5 pm MST, M-F), or at: CoverColorado, 425 South Cherry Street, Suite 160, Glendale, CO 80246, or website www.covercolorado.org.			
Producer Name (if appropriate)		Date:	
Agency Name:			
Telephone:		Fax:	

Health Insurance Carrier Response:

(Completed by the health insurance carrier for those applicants submitting the Prescreening Questionnaire)

☐ Prescreening Questionnaire Accepted

Approval for health care coverage is not guaranteed and is based on medical history and health status. You will be contacted with a full-length insurance application packet. Please do not cancel other current health insurance coverage until written notification is received indicating that your full-length application has been approved.

Name of Accepted Applicant: ______________________________

Name of Accepted Spouse: ______________________________

Name of Accepted Dependent: ______________________________

Name of Accepted Dependent: ______________________________

Name of Accepted Dependent: ______________________________

Name of Accepted Dependent: ______________________________

☐ Prescreening Questionnaire Denied

Name of Denied Applicant: ______________________________

Reason for Denial: ______________________________

Name of Denied Applicant: ______________________________

Reason for Denial: ______________________________

Name of Denied Applicant: ______________________________

Reason for Denial: ______________________________

Carrier Name:		Phone Number:	
Carrier Signature:		Date:	