

## SOLO Health Care Plan Change Form

Subscriber Name: \_\_\_\_\_ Member ID #: \_\_\_\_\_  
 Address: \_\_\_\_\_ County: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Phone Number: \_\_\_\_\_ Email: \_\_\_\_\_

Please indicate the benefit change requested:

1. Have you or any covered family member used tobacco in the last 12 months?  Yes  No  
 If Yes, give person's name: \_\_\_\_\_

2.  **Change plan** — Please choose from among the following plan options:

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"/> <b>Discount Plan</b> – You pay 100% of the RMHP discounted rate for prescription drugs <input type="checkbox"/> <b>Brand Name Drug Rider</b> \$15 / \$40 / \$60 <input type="checkbox"/> <b>Brand Name with \$250 Deductible Rider</b> \$15 Generic copay (no deductible) \$40 / \$60 Brand Name copay after \$250 deductible
<input type="checkbox"/> SOLO \$500 w/ Maternity rider	
<input type="checkbox"/> SOLO \$1,500	
<input type="checkbox"/> SOLO \$2,500	
<input type="checkbox"/> SOLO \$4,000	
<b>Optional Accident Rider</b>	
	<input type="checkbox"/> <b>Optional Accident Rider</b> \$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"/> <b>Brand Name Drug Rider</b> Generic and Brand Name prescription drugs are covered at 100% after deductible.
<input type="checkbox"/> SOLO HSA \$3,250/100	
<input type="checkbox"/> SOLO HSA \$5,000/100	
<b>Optional Accident Rider</b>	
	<input type="checkbox"/> <b>Optional Accident Rider</b> \$1 to \$1,000 covered in full for each accident, then deductible and coinsurance apply.
<b>Additional Information:</b>	

3. Have you or any covered family member 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

**Maternity**

Add maternity rider (available only with SOLO View \$500).  Drop maternity rider.  
 Is any female member pregnant at this time?  Yes  No If yes, give person's name: \_\_\_\_\_  
 If no, list covered females name and dates of their last menstrual period(s):  
 Name: \_\_\_\_\_ Date: \_\_\_\_\_ Name: \_\_\_\_\_ Date: \_\_\_\_\_

The undersigned individually and on behalf of the undersigned's dependents agrees as follows:

- a) I agree that enrollment, eligibility, coverage, and benefits in my health plan are subject to applicable policies and requirements and to all terms of the applicable contract for my health plan.
- b) I agree that the above information is true, and I authorize the above change.
- c) I understand that the above-requested benefit change is subject to medical underwriting and is not an automatic change.
- d) I agree that the approved benefit change will be effective on my anniversary date as described in my rate change notification correspondence.

Signature: \_\_\_\_\_ Date Signed: \_\_\_\_\_

Attn: Individual SOLO Sales  
 Rocky Mountain Health Plans  
 PO Box 10600, Grand Junction, CO 81502-5600  
 Fax: 970-244-7992