

SOLO Health Care Plan Change Form

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

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:

Choose Plan Deductible Option: <input type="checkbox"/> SOLO \$500 <input type="checkbox"/> SOLO \$1,500 <input type="checkbox"/> SOLO \$2,500 <input type="checkbox"/> SOLO \$4,000 <input type="checkbox"/> SOLO \$7,500 <input type="checkbox"/> SOLO \$10,000	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <th style="text-align: center; padding: 5px;">Prescription Drug Rider</th> </tr> <tr> <td style="padding: 5px;"> \$15 copay for Generic drugs is included in the plan unless another option is selected. <input type="checkbox"/> Discount Plan – You pay 100% of the RMHP discounted rate for prescription drugs <input type="checkbox"/> Brand Name Drug Rider \$15 / \$40 / \$60 <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"/> Optional Accident Rider </td> </tr> </table>	Prescription Drug Rider	\$15 copay for Generic drugs is included in the plan unless another option is selected. <input type="checkbox"/> Discount Plan – You pay 100% of the RMHP discounted rate for prescription drugs <input type="checkbox"/> Brand Name Drug Rider \$15 / \$40 / \$60 <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"/> Optional Accident Rider
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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

4. Have you or any covered family member 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 and planned treatment: _____

5. At this time, are you or your spouse pregnant, expecting a child, or in the process of adoption? Yes No

6. Rate Tier Review Request (On Anniversary)

Family Member: _____

Please note: A Rate Tier Review may result in a lower rate tier or the same rate tier, subject to medical underwriting criteria. RMHP will consider each family member's history in their decision.

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 may be subject to medical underwriting and is not an automatic change.
- d) I agree that the approved plan change will be effective on my anniversary date or on the first of the month following approval. I agree to continue to pay premium on my current SOLO plan while this plan change request is processed.

Signature: _____ Date Signed: _____

Attn: SOLO Sales – Rocky Mountain Health Plans
 PO Box 10600, Grand Junction, CO 81502-5600
 Fax: 970-244-7992 SOLO_Sales_Team@rmhp.org