Rocky Mountain Health Plans®

Plans underwritten by Rocky Mountain HMO (RMHMO)

Enrollment Form
(for Employer Groups with 101 or more employees)

In order to expedite employee's enrollment, please make certain Sections 1, 2, 3, 4, and 5 are completed fully. Please use black ink only.

Section 1 – Employee Information

Employer Name		Date of Employment		Job/Occupation	Hours Worked per Week
Employee Last Name	First Name	MI	Social Security #*	Home Phone	Business Phone
Address (include PO Box)		City	State	Zip Code	County of Residence

Section 2 – Plan Selection / Desired Coverage

Name of health plan selected by your employer	☐ Brand Rx ☐ Generic Only Rx Optional Rx for Grandfathered Plans	Will you be working and residing out of state? ☐ Yes ☐ No Are you enrolling dependents who live out of state? ☐ Yes ☐ No If Yes, please note below in Section 4.
Desired coverage: ☐ Single ☐ Double ☐ Family ☐ EE & Child(ren) ☐ COBRA/CCOC – Qualifying event date:________________	Marital Status: ☐ Single ☐ Married ☐ Common Law* ☐ Civil Union ☐ Domestic Partner* ☐ Designated Beneficiary* ☐ Widowed/Divorced ☐ Legally Separated *Form Required	

Section 3 – Other Health Coverage

While covered under this plan, will you or any family members applying for coverage have other active health insurance? ☐ Yes ☐ No

If yes, please provide name of other insurance: ______________________ Policy Holder: ______________________	Phone #:	Plan # :______________________ or Social Security #*: ______________________

Have you or any family member ever been treated for a serious accident or injury within the last 5 years? ☐ Yes ☐ No

If yes, please indicate: ☐ Auto ☐ Workers' Compensation Other: ______________________

Section 4 – Persons Enrolling in the Plan

Last Name	First Name	MI	Social Security #*	Sex M/F	Birthdate MM/DD/YY	Relationship to Subscriber	Primary Care Physician Name and/or Physician ID#
Self:							
Spouse/Partner:							
				Spouse reside in Colorado? ☐ Yes ☐ No			
Dependent:							
Disabled age 26 and older? ☐ Yes ☐ No	If yes, please complete disabled dependent form.			Dependent reside in Colorado? ☐ Yes ☐ No			
Dependent:							
Disabled age 26 and older? ☐ Yes ☐ No	If yes, please complete disabled dependent form.			Dependent reside in Colorado? ☐ Yes ☐ No			
Dependent:							
Disabled age 26 and older? ☐ Yes ☐ No	If yes, please complete disabled dependent form.			Dependent reside in Colorado? ☐ Yes ☐ No			
Dependent:							
Disabled age 26 and older? ☐ Yes ☐ No	If yes, please complete disabled dependent form.			Dependent reside in Colorado? ☐ Yes ☐ No			

* Please supply social security numbers if known. Missing numbers will be requested after enrollment.

Signature required on back of this form.
RMHP Fax 970-263-5507

Section 5 – Agreement – SIGNATURE REQUIRED | 2A

The undersigned, individually ("I") and on behalf of my dependents ("We"), state as follows:

1. I enter into and agree to the terms of the contract for the health plan designated in this application and any RMHMO health plan that replaces the health plan designated (herein the "Evidence of Coverage" or "EOC"). We will have a contract with RMHMO upon (1) receipt of all information required for enrollment, (2) approval by RMHMO and (3) receipt of the first premium. If the fully completed application is received by RMHMO between the first and the fifteenth day of the month, the first effective day of the health plan will be no later than the first day of the following month. If the fully completed application is received by RMHMO between the sixteenth and the last day of the month, the first effective day of the health plan will be no later than the first day of the second following month. The terms of the contract are set forth in the EOC. The terms may be amended from time to time by RMHMO as applicable.
2. I understand and acknowledge that RMHMO, or their designated agents/contractors may obtain, use, and disclose information or records related to the health of any person proposed for coverage. This information includes the treatment, payment, and health care operations functions of RMHMO. For example, the information could be used for processing of claims, in quality assurance programs, or to involve me or my dependent(s) in case management. Such information or records may come from any physician, health care provider, hospital, clinic, other medical facility, insurance company, or other entity. All information is subject to confidentiality laws. I 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 the health plan such information as requested.
3. I understand that if I decline coverage for myself or my dependents (including my spouse) for whatever reason, I may, in the future, be limited in my ability to enroll myself or my dependents (if I am already enrolled) in this plan. I understand that my ability to enroll in the future will be limited to: (1) future open enrollment periods; or (2) experiencing a qualifying event which entitles me to a special enrollment period. To enroll after a qualifying event I must request enrollment within thirty (30) days after the qualifying event occurs. If the qualifying event is losing coverage under the "Colorado Medical Assistance Act," becoming eligible for premium assistance under the "Colorado Medical Assistance Act" or the Children's Basic Health Plan, or a dependent dis-enrolling or becoming ineligible for the Children's Basic Health Plan, I must request enrollment within sixty (60) days.
4. I agree to the applicable EOC provisions for the resolution of disagreements and disputes, including arbitration when required. We agree to resolve such disagreements and disputes as set forth in the EOC.
5. I agree that RMHMO will have the right to terminate coverage and deny benefits if any information on this application or as otherwise provided by me for enrollment purposes is knowingly false, misleading, or inaccurate in any material respect.
6. I agree that the above provisions will remain in effect for me and my dependents for the entire duration of coverage. The provisions will continue to the extent of any continuing rights or obligations under the EOC.
7. I have read the information on the back of this enrollment form.

Subscriber Signature:	**Date:**

Plans underwritten by Rocky Mountain HMO (RMHMO)

Colorado law requires carriers to make available a Colorado Supplement to the Summary of Benefits of Coverage, which is intended to facilitate comparison of health plans. The form must be provided automatically within seven (7) 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 seven (7) 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 will be reported to the Colorado Division of Insurance.

Multi-Language Insert

ROCKY MOUNTAIN HEALTH PLANS®

English	ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-800-346-4643 (TTY: 711).
Spanish	ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-346-4643 (TTY: 711).
Vietnamese	CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-346-4643 (TTY: 711).
Chinese	注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-346-4643 (TTY: 711)。
Korean	주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-346-4643 (TTY: 711)번으로 전화해 주십시오.
Russian	ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-346-4643 (телетайп: 711).
Amharic	ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-800-346-4643 (መስማት ለተሳናቸው: 711).
Arabic	ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-643-008-- 3464(رقم هاتف الصم والبكم: 117).
German	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-346-4643 (TTY: 711).
French	ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-346-4643 (ATS : 711).
Nepali	ध्यान दिनुहोस्: तपाईले नेपाली बोल्नुहुन्छ भने तपाईको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् 1-800-346-4643 (टिटिवाइ: 711) ।
Tagalog	PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-346-4643 (TTY: 711).
Japanese	注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-346-4643（TTY:711）まで、お電話にてご連絡ください。
Cushite/Oromo	XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-800-346-4643 (TTY: 711).
Persian	**توجه**: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-800-643-008-1 3464 (117:YTT) تماس بگیرید.
Ibo/Igbo	Ige nti: O buru na asu Ibo asusu, enyemaka diri gi site na call 1-800-346-4643 (TTY: 711).
Kru-Bassa	Dè ɖɛ nìà kɛ dyéɖé gbo: Ɔ jŭ ké m̀ [Ɓàsɔ́ɔ̀-wùɖù-po-nyɔ̀] jŭ ní, nìí, à wuɖu kà kò ɖò po-poɔ̀ ɓɛ́ìn m̀ gbo kpáa. Ɖá 1-800-346-4643 (TTY: 711)
Yoruba	AKIYESI: Ti o ba nso ede Yoruba ofe ni iranlowo lori ede wa fun yin o. E pe ero ibanisoro yi 1-800-346-4643 (TTY: 711).

Notice of Nondiscrimination

Rocky Mountain Health Plans (RMHP) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex, sexual orientation, or gender identity. RMHP does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex, sexual orientation, or gender identity.

RMHP takes reasonable steps to ensure meaningful access and effective communication is provided timely and free of charge:

- Provides free auxiliary aids and services to people with disabilities to communicate effectively with us, such as:
    - Qualified sign language interpreters (remote interpreting service or on-site appearance)
    - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language assistance services to people whose primary language is not English, such as:
    - Qualified interpreters (remote or on-site)
    - Information written in other languages

If you need these services, contact the RMHP Member Concerns Coordinator at 800-346-4643, 970-243-7050, or TTY 970-248-5019, 800-704-6370, Relay 711; para asistencia en español llame al 800-346-4643.

If you believe that RMHP has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, sexual orientation, or gender identity , you can file a grievance with: the RMHP EEO Officer at 800-346-4643, 970-244-7760, ext. 7883, or TTY 970-248-5019, 800-704-6370, Relay 711; para asistencia en español llame al 800-346-4643, or eeoofficer@rmhp.org. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the RMHP EEO Officer is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf*, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD).

Complaint forms are available at *http://www.hhs.gov/ocr/office/file/index.html*.

RMHP is a Medicare-approved Cost plan. Enrollment in RMHP depends on contract renewal.

Patient Protection and Affordable Care Act Group Notices for Rocky Mountain Health Plans ("Your Plan")

Your Plan may require the designation of a primary care provider (PCP). A Member has the right to designate any PCP who participates in RMHP's network and who is available to accept the Member as a patient. If required, until a Member makes this designation, a PCP will be designated for the Member. For information on how to select a PCP, and for a list of the participating PCPs, contact customer service at 970-243-7050 or 800-346-4643. For children, a pediatrician may be designated as the PCP. A Member does not need prior authorization in order to obtain access to obstetrical or gynecological care from a health care professional in RMHP's network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact customer service at 970-243-7050 or 800-346-4643.

Collection, Use, and Disclosure of Medical Information

As your health plan, RMHP must ask for and use personal information in the administration of your health care benefits. You have the right to have this personal information kept private. Your personal health care information is protected in the following ways:

1) All employees of Rocky Mountain Health Maintenance Organization agree to follow procedures for safeguarding the privacy of our Members' personal health information.

2) RMHP does not keep complete medical records about our Members. Members can review their medical records by asking their primary care physician or other health care provider.

3) Some employers may request information about their employees' care. Unless it is allowed by law or your specific written permission is first obtained, data is only provided to employers when it can be presented as a data group and cannot be connected to specific health plan Members.