

Rocky Mountain Health Plans Employee Application for Small Employers

- **ENROLL IN HEALTH COVERAGE**

If you are enrolling in health coverage, you must:

- Complete the information below
- Complete the Colorado Uniform Employee Application for Small Group Health Benefit Plans (attached). Social Security numbers are required for all enrolling family members.

This Information Must Be Completed To Enroll	
Employee Name:	
Employer Group Name:	
Medical Plan:	
Do you live outside of Colorado?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have dependents living outside of Colorado?	<input type="checkbox"/> Yes <input type="checkbox"/> No

- **IF YOU ARE NOT ENROLLING IN THE HEALTH COVERAGE**

- Complete page 1 of “Employee Information”
- Complete page 2 of “Employee/Dependent Waiver of Coverage” of the Colorado Uniform Employee Application for Small Group Health Benefit Plans

- **ARE YOU ENROLLING IN DENTAL AND/OR VISION COVERAGE?**

If your Employer offers a Dental and/or Vision plan, you must complete the Dental and/or Vision applications separately. If you do not have these applications, please contact your Employer.

- **ADDITIONAL FORMS YOU MAY NEED**

- Affidavit of Common Law Marriage
- Affidavit of Domestic Partnership
- Request for Enrollment of Designated Beneficiary
- Request for Coverage for a Physically or Mentally Disabled Dependent Child



COLORADO UNIFORM EMPLOYEE APPLICATION FOR SMALL GROUP HEALTH BENEFIT PLANS

This form is designed for an employee's initial application for coverage. Please contact your agent or the carrier to determine if this form should be used in other situations once the group is enrolled with the carrier.

COVERAGE INFORMATION

Application Type: New Coverage Change/Modification to Existing Policy Open Enrollment Special Enrollment*

* Proof of eligibility for special enrollment will be required – information on eligibility for special enrollment periods is available at: www.dora.colorado.gov/DOI/HealthApp

EMPLOYER INFORMATION

Employee Name: _____ Employer Name: _____
Proposed Effective Date: _____ Group Number (if known): _____

EMPLOYEE INFORMATION

Employee Instructions: Please type or print using black or blue ink. Please fill out the entire application for each person for whom coverage is being sought.

First Name: _____ Middle Initial: _____ Last Name: _____
Social Security #: _____ Date of Birth: ____/____/____ Current Age: _____ Sex: M F
Address: _____ City: _____
County: _____ State: _____ Zip: _____
Mailing Address (if different): _____ City: _____
County: _____ State: _____ Zip: _____
Home Phone: _____ Email: _____ Home Work
What is your job title at your current employer? _____ Work Phone: _____
What was your first day of employment? _____ How many hours, on average, do you work each week? _____
Are you (check one): Single Married Common Law* Civil Union*
 Designated Beneficiary* Legally Separated Divorced Widow or Widower
* A common law, civil union, or designated beneficiary certification may be required by the carrier
Are you on COBRA or State Continuation? Yes No Start Date: _____ Stop Date: _____

TYPE OF HEALTH COVERAGE

List all dependents (spouse/partner and child(ren)) applying for coverage. **If you need additional space, please use a separate sheet of paper and attach it to this application (please print your name and sign and date the additional sheet).**
Please select the type of health insurance coverage for which you are applying: Employee Only Employee & Family

DEPENDENT INFORMATION
(list all dependents to be covered)

Name (First, MI, Last)	Sex	Social Security Number	Relationship	Disabled	Birth Date (MM/DD/YY)
	<input type="checkbox"/> M <input type="checkbox"/> F		SPOUSE/PARTNER		
	<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> CHILD <input type="checkbox"/> STEPCHILD	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> CHILD <input type="checkbox"/> STEPCHILD	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> CHILD <input type="checkbox"/> STEPCHILD	<input type="checkbox"/> Yes <input type="checkbox"/> No	

Employee Name:	Employer Name:
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TOBACCO USE

Please answer the following questions to the best of your knowledge. 45 CFR 147.102(a)(1)(iv) "For purposes of this section, tobacco use means use of tobacco on average four or more times per week within no longer than the past 6 months. This includes all tobacco products, except that tobacco use does not include religious or ceremonial use of tobacco. Further, tobacco use must be defined in terms of when a tobacco product was last used."
 Has anyone named in this application used tobacco or smokeless tobacco during the past 6 months? If yes, provide the information requested below.

Name of Person	Used Tobacco Products	If Yes, check all that apply	Duration	Frequency
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Cigarettes <input type="checkbox"/> Chewing Tobacco <input type="checkbox"/> Pipe/Cigars		
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Cigarettes <input type="checkbox"/> Chewing Tobacco <input type="checkbox"/> Pipe/Cigars		
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Cigarettes <input type="checkbox"/> Chewing Tobacco <input type="checkbox"/> Pipe/Cigars		
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Cigarettes <input type="checkbox"/> Chewing Tobacco <input type="checkbox"/> Pipe/Cigars		

EMPLOYEE/DEPENDENT WAIVER OF COVERAGE

Complete this section ONLY if you are not enrolling yourself or your spouse/partner or dependents. Waiver must be completed for all of your dependents to be eligible for enrollment on this plan in the event of changing circumstances. I understand that I am eligible to apply for group health coverage through my employer. I do **NOT** want, and hereby waive, group health coverage for:

Name	Name (Last, First, MI)	Birth Date (Mo/Day/Year)
Employee		
Spouse/Partner		
Dependent 1		
Dependent 2		
Dependent 3		

I am **waiving** group health coverage for myself and/or the dependents listed above because (check all that apply, **copy of ID card may be required**):

I am covered under my spouse/partner's group policy.
 My spouse/partner is covered under another plan (including this plan, if spouse/partner is also an employee).
 My dependents are covered under another plan.
 I wish to continue other coverage obtained through an Individual Plan or Medicare
 Other (Please explain): _____

WAIVER: I certify that I have been given the opportunity to apply for group health coverage and decline to enroll as indicated above, on behalf of myself, my spouse/partner and my dependent child(ren). I understand that by signing this waiver, I, my spouse/partner, and my dependent child(ren) forfeit the right to coverage. I was not pressured, forced or unfairly induced by my employer, the agent or the carrier(s) into waiving or declining the group health coverage. If in the future I apply for coverage, I, my spouse/partner, or any of my dependent child(ren) may be treated as a late enrollee and subject to postponement of coverage for up to 12 months.

I understand that if I am declining enrollment for myself, my spouse/partner, or my dependent child(ren) because of other health coverage, I may, in the future, be able to enroll myself, my spouse/partner, or my dependent child(ren) in this plan, as required by law, provided that I request enrollment within 30 days after my other health coverage ends or a qualifying event occurs. **If I do not request enrollment within 30 days of the above events, I understand that I may not be able to enroll for coverage until my company's Open Enrollment period.** I understand that I can obtain information related to my enrollment eligibility from my employer or small group health carrier.

Signature of Employee: _____ Date Signed: _____

Employee Name:	Employer Name:
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MEDICARE INFORMATION
<p>If you need to complete this section for more than one person, please use a separate sheet of paper and attach it to this application (please sign and date the additional sheet). A copy of your ID card may be required.</p> <p>Are you, your spouse/partner or your child(ren) covered by:</p> <p>Medicare Part A? <input type="checkbox"/> Yes <input type="checkbox"/> No Medicare Part B? <input type="checkbox"/> Yes <input type="checkbox"/> No Medicare Part D? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If "Yes," reason for Medicare: <input type="checkbox"/> 65+ Eff. Date _____ <input type="checkbox"/> Disability Eff. Date _____</p> <p style="padding-left: 100px;"><input type="checkbox"/> End-Stage Renal Disease (ESRD) Eff. Date _____ <input type="checkbox"/> Disability and ESRD Eff. Date _____</p> <p>Name of person covered by Medicare:</p>

CURRENT MEDICAL COVERAGE																																				
<p>Do you, your spouse/partner, or your dependent child(ren) listed in this application currently have health insurance coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Is the plan information listed below the same for your spouse/partner and all dependents? If yes, skip to next section. <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Your information will help the small employer carrier(s) to coordinate benefits with any other group health coverage you may have.</p>																																				
<table border="1" style="width:100%; border-collapse: collapse; text-align: center;"> <thead> <tr style="background-color: #cccccc;"> <th style="width: 16.6%;">Name</th> <th style="width: 16.6%;">Carrier Name Carrier Phone Number</th> <th style="width: 16.6%;">Plan Name Group Number Subscriber ID#</th> <th style="width: 16.6%;">Effective Date of Coverage (MM/DD/YY)</th> <th style="width: 16.6%;">Termination Date of Coverage (MM/DD/YY)</th> <th style="width: 16.6%;">Type of Coverage (See Key Below)</th> </tr> </thead> <tbody> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> </tbody> </table> <p>Type of Coverage Key: G = Group Comprehensive Major Medical; I = Individual Comprehensive Major Medical; MS = Medicare Supplement; H = Hospital Coverage Only; V = Vision Coverage Only O=Other, please explain: _____</p>	Name	Carrier Name Carrier Phone Number	Plan Name Group Number Subscriber ID#	Effective Date of Coverage (MM/DD/YY)	Termination Date of Coverage (MM/DD/YY)	Type of Coverage (See Key Below)																														
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HEALTH PROVIDER OR PRODUCT SELECTION, IF APPLICABLE				
<p>Please select the type of coverage for which you are applying from the plans offered by your employer and issued by the carrier. This section should be completed only if the small employer group insurance for which you are applying requires the selection of a primary care provider. A selection should be made for each individual applying for such coverage and for each carrier from which insurance coverage is being sought. The provider information may be listed in the provider materials that are supplied by each carrier to your employer. Use additional sheets if necessary.</p>				
Covered Person's Name	Medical Plan	Primary Care Physician Name:	Primary Care Physician Address: (optional)	Is this your current provider?

Employee Name:	Employer Name:
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TERMS AND CONDITIONS

I acknowledge that I have read all sections of this Colorado Uniform Employee Application for Small Employer Group Health Coverage (Application), and I certify on behalf of my eligible family dependents and myself that the answers contained in this Application are complete and accurate to the best of my knowledge. I understand and agree that neither my employer nor any insurance agents have any authority to waive my complete answer to any question, agree to insurability, alter any contract, or waive any Colorado small employer carrier's other rights or requirements.

I hereby apply for enrollment for myself and for my eligible family dependents listed. On behalf of my eligible family dependents and myself, I agree to all of the terms and conditions of the group contract(s) with Colorado small employer carrier(s) under which I wish to enroll for coverage. I have indicated in this Application, if required, what product(s) or provider(s) I have selected. **I agree that no coverage will be effective until the date specified by the Colorado small employer carrier(s) with whom I enroll, after this application has been accepted by such carrier(s).**

I understand and agree that any information obtained in connection with this Application will be used by Colorado small employer carrier(s) to determine eligibility for coverage.

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance carrier for the purpose of defrauding or attempting to defraud the carrier. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance carrier or agent of an insurance carrier 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.

When applicable, I authorize my employer to deduct contributions from my earnings to be applied to the cost of coverage.

I agree to any applicable group contract provisions for the resolution of disagreements and disputes, including arbitration when required and as allowed by law. Please refer to any arbitration provisions in the group contract(s).

I understand that I may request a copy of this Application. I agree that a photographic copy of this Application shall be as valid as the original. A legible facsimile signature shall have the same force and effectiveness as the original. This document will become a part of the contract when coverage is approved and issued.

Signature of Employee: _____

Date Signed: _____

DISCLOSURES

COLORADO INSURANCE LAW REQUIRES ALL CARRIERS IN THE SMALL GROUP MARKET TO ISSUE ANY APPLICABLE HEALTH BENEFIT PLAN IT MARKETS IN COLORADO TO ANY SMALL EMPLOYER THAT APPLIES FOR THE PLAN AND AGREES TO MAKE THE REQUIRED PREMIUM PAYMENTS, AND SATISFIES THE OTHER PROVISIONS OF THE HEALTH BENEFIT PLAN.

This document is a publication of the Colorado Division of Insurance. If you have questions about the content of this document please contact our offices at 303-894-7499 or visit our website at <http://dora.colorado.gov/insurance>. For questions regarding coverage or enrollment please see your employer.

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. RMHP does not exclude people or treat them differently because of race, color, national origin, age, disability, 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, sex, sexual orientation, or gender identity, you can file a grievance with: the RMHP EEO Officer. You can file a grievance in person or by phone, mail, fax, or email.

- Phone: 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
- Mail: ATTN: EEO Officer, Rocky Mountain Health Plans, PO Box 10600, Grand Junction, CO 81502-5600
- Fax: ATTN: EEO Officer, 970-244-7909
- Email: eeoofficer@rmhp.org

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>.

Multi-Language Insert



ATENCIÓN: Si habla español (Spanish), hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al número de teléfono gratuito que aparece en la portada de esta guía.

請注意：如果您說中文(Chinese)，我們免費為您提供語言協助服務。請撥打本手冊封面所列的免付費會員電話號碼。

XIN LU'U Y: Nếu quý vị nói tiếng Việt (Vietnamese), quý vị sẽ được cung cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Xin vui lòng gọi số điện thoại miễn phí dành cho hội viên trên trang bìa của tập sách này.

알림: 한국어(Korean)를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다. 이 책자 앞 페이지에 기재된 무료 회원 전화번호로 문의하십시오.

PAUNAWA: Kung nagsasalita ka ng Tagalog (Tagalog), may makukuha kang mga libreng serbisyo ngtulong sa wika. Pakitawagan ang toll-free na numero ng telepono na nakalista sa harapan ng booklet na ito.

ВНИМАНИЕ: бесплатные услуги перевода доступны для людей, чей родной язык является русским (Russian). Позвоните по бесплатному номеру телефона, указанному на лицевой стороне данной брошюры.

تنبيه: إذا كنت تتحدث العربية ، فهناك خدمات مساعدة لغوية مجانية متاحة. اتصل بالرقم المجاني على غلاف هذا الدليل.

ATANSYON: Si w pale Kreyòl ayisyen (Haitian Creole), ou kapab benefisye sèvis ki gratis pou ede w nan lang pa w. Tanpri rele nimewo telefòn gratis pou manm yo ki sou kouvèti ti liv sa a.

ATTENTION : Si vous parlez français (French), des services d'aide linguistique vous sont proposés gratuitement. Veuillez appeler le numéro de téléphone sans frais pour les affiliés figurant au début de ce guide.

UWAGA: Jeżeli mówisz po polsku (Polish), udostępniliśmy darmowe usługi tłumacza. Prosimy zadzwonić pod bezpłatny członkowski numer telefonu podany na okładce tej broszury.

ATENÇÃO: Se você fala português (Portuguese), contate o serviço de assistência de idiomas gratuito. Ligue gratuitamente para o número do membro encontrado na frente deste folheto.

ATTENZIONE: in caso la lingua parlata sia l'italiano (Italian), sono disponibili servizi di assistenza linguistica gratuiti. Si prega di chiamare il numero verde per i membri indicato all'inizio di questo libretto.

ACHTUNG: Falls Sie Deutsch (German) sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Bitte rufen Sie die gebührenfreie Rufnummer für Mitglieder auf der Vorderseite dieser Broschüre an.

注意事項：日本語(Japanese) を話される場合、無料の言語支援サービスをご利用いただけます。本冊子の表紙に記載されているメンバー用フリーダイヤルにお電話ください。

توجه: اگر به فارسی صحبت می کنید ، خدمات کمک به زبان رایگان در دسترس است. با شماره تلفن رایگان روی جلد این راهنما تماس بگیرید.

ध्यान दें: यदि आप हिंदी बोलते हैं, तो निः शुल्क भाषा सहायता सेवाएं उपलब्ध हैं। इस गाइड के कवर पर टोल-फ्री नंबर पर कॉल करें।

CEEB TOOM: Yog koj hais Lus Hmoob (Hmong), muaj kev pab txhais lus pub dawb rau koj. Thov hu tus tswv cuab xov tooj hu dawb teev nyob ntawm sab xub ntiag ntawm phau ntawv no.

ចំណាប់អារម្មណ៍: លើសពីនេះក្រៅពីការប្រើប្រាស់ភាសាខ្មែរ (Khmer) លើសពីនេះក្រៅពីការប្រើប្រាស់ភាសាខ្មែរ គឺមានសំរាប់អ្នក។ សូមទូរស័ព្ទទៅលេខសមាជិកក្នុងក្របខណ្ឌ បានកត់នៅខាងមុខនៃក្របខណ្ឌនេះ។

PAKDAAR: Nu saritaem ti Ilocano (Ilocano), ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Pakitawagan iti miyembro toll-free nga number nga nakasurat iti sango ti libro.

DÍÍ BAA'ÁKONÍNÍZIN: Diné (Navajo) bizaad bee yáníłt'igo, saad bee áka'anída'awo'ígíí, t'áá jíik'eh, bee ná'ahóót'i'. T'áá shqódí díí naaltsoos bidáahgi t'áá jíik'eh naaltsoos báha'dít'éhígíí béésh bee hane'í biká'ígíí bee hodiilnih.

OGOW: Haddii aad ku hadasho Soomaali (Somali), adeegyada taageerada luqadda, oo bilaash ah, ayaad heli kartaa. Fadlan wac lambarka xubinta ee telefonka bilaashka ah ee ku qoran xagga hore ee buugyaraha.