# 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? | ☐ Yes ☐ No |
| Do you have dependents living outside of Colorado? | ☐ Yes ☐ 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

Division of Insurance

# 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) |
|---|---|---|---|---|---|
| | ☐ M ☐ F | | SPOUSE/PARTNER | | |
| | ☐ M ☐ F | | ☐ CHILD ☐ STEPCHILD | ☐ Yes ☐ No | |
| | ☐ M ☐ F | | ☐ CHILD ☐ STEPCHILD | ☐ Yes ☐ No | |
| | ☐ M ☐ F | | ☐ CHILD ☐ STEPCHILD | ☐ Yes ☐ No | |

| Employee Name: | Employer Name: |
|---|---|

## 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 |
|---|---|---|---|---|
| | ☐ Yes<br>☐ No | ☐ Cigarettes<br>☐ Chewing Tobacco<br>☐ Pipe/Cigars | | |
| | ☐ Yes<br>☐ No | ☐ Cigarettes<br>☐ Chewing Tobacco<br>☐ Pipe/Cigars | | |
| | ☐ Yes<br>☐ No | ☐ Cigarettes<br>☐ Chewing Tobacco<br>☐ Pipe/Cigars | | |
| | ☐ Yes<br>☐ No | ☐ Cigarettes<br>☐ Chewing Tobacco<br>☐ 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 (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: |
|---|---|

## MEDICARE INFORMATION

**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.**

Are you, your spouse/partner or your child(ren) covered by:

Medicare Part A? ☐Yes ☐No Medicare Part B? ☐Yes ☐No Medicare Part D? ☐Yes ☐No

If "Yes," reason for Medicare: ☐ 65+ Eff. Date_____ ☐Disability Eff. Date_____

☐ End-Stage Renal Disease (ESRD) Eff. Date_____ ☐ Disability and ESRD Eff. Date_____

Name of person covered by Medicare:

## CURRENT MEDICAL COVERAGE

**Do you, your spouse/partner, or your dependent child(ren) listed in this application currently have health insurance coverage?** ☐ Yes ☐No

**Is the plan information listed below the same for your spouse/partner and all dependents? If yes, skip to next section.** ☐ Yes ☐No

Your information will help the small employer carrier(s) to coordinate benefits with any other group health coverage you may have.

| Name | Carrier Name<br>Carrier Phone Number | Plan Name<br>Group Number<br>Subscriber ID# | Effective Date of Coverage (MM/DD/YY) | Termination Date of Coverage (MM/DD/YY) | Type of Coverage (See Key Below) |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

**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:_____

## HEALTH PROVIDER OR PRODUCT SELECTION, IF APPLICABLE

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.

| Covered Person's Name | Medical Plan | Primary Care Physician Name: | Primary Care Physician Address: (optional) | Is this your current provider? |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

| Employee Name: | Employer Name: |
|---|---|

## 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.

| Employee Name: | Employer Name: |
|---|---|

This page may be used to provide additional information that was required in the sections above and did not fit in the space provided.

Signature of Employee: _____ Date Signed: _____

# Commercial Tagline for Notices

ROCKY MOUNTAIN HEALTH PLANS®

## English

**There is important information about your coverage or application with Rocky Mountain Health Plans (RMHP) in this notice. Review it carefully. Look for actions you may need to take and deadlines. You have the right to get information in your language at no cost. Call 800-346-4643 for assistance.**

## Spanish

**Hay información importante sobre su cobertura o solicitud de Rocky Mountain Health Plans (RMHP) en este aviso. Revíselo meticulosamente. Tome las acciones necesarias y considere las fechas de vigencia. Usted tiene el derecho a obtener esta información en su idioma sin ningún cargo. Llame al 800-346-4643 para obtener asistencia.**

## Arabic

**في هذه المذكرة هناك معلومات هامة بخصوص التغطية الخاصة بك أو التطبيق الخاص بك مع الخطط الصحية لروكي ماونتن (RMHP). عليك مراجعتها بعناية. وقم بالبحث عن التصرف الذي قد يكون عليك القيام به ومدد المهلة المطلوبة لذلك. إن من حقك الحصول على المعلومات بلغتك بدون مقابل. ويكون عليك الاتصال على الرقم 3464-643-008 للمساعدة.**

## German

**Es gibt wichtige Informationen über Ihre Absicherung oder Anwendung bei Rocky Mountain Health Plans (RMHP) in dieser Mitteilung. Sehen Sie diese sorgfältig durch. Schauen Sie, ob sie Maßnahmen ergreifen oder Termine einhalten müssen. Sie haben das Recht, kostenlos Informationen in Ihrer Sprache zu erhalten. Rufen Sie 800-346-4643 an, wenn Sie Hilfe benötigen.**

## French

**Cette notice comprend des informations importantes sur votre assurance ou votre demande aux régimes de Rocky Mountain Health Plans (RMHP). Veuillez l'examiner attentivement. Voyez quelles actions que vous devez prendre et leurs échéances. Vous avez le droit d'obtenir gratuitement des renseignements dans votre langue. Appelez le 800-346-4643 pour obtenir de l'aide.**

## Japanese

**この通知にはロッキー・マウンテン・ヘルス・プラン (RMHP) の補償範囲と申請に関する重要な情報が掲載されていますので、よくお読みください。行う必要のある手続きおよび締め切り日にご注意ください。お客様には、関連情報を無料で母国語で受け取る権利があります。800-346-4643 までご連絡いただきサポートをご依頼ください。**

## Korean

**이 안내문은 로키 마운틴 의료 보험 (Rocky Mountain Health Plans (RMHP))의 보험 적용 범위 또는 신청서에 대한 중요한 정보를 포함하고 있습니다. 신중하게 검토하시기 바랍니다. 취해야 할 조치와 마감기일에 유의하세요. 고객님의 언어로 된 정보를 무료로 받으실 수 있습니다. 서비스 관련 문의는800-346-4643 로 전화주시기 바랍니다.**

## Nepali

**यो सूचनामा तपाईंको बीमाकृत राशि वा रकी माउन्टेन हेल्थ प्लान्स् (RMHP) लाई तपाईंले पेश गर्नुभएको आवेदनका बारेमा महत्त्वपूर्ण जानकारीहरू छन्। यसलाई ध्यानपूर्वक हेर्नुहोस्। तपाईंले चाल्न आवश्यक हुन सक्ने कदमहरू र समय सीमाबारे थाहा पाउनुहोस्। तपाईंसँग आफ्नो भाषामा निःशुल्क रूपमा जानकारीहरू प्राप्त गर्ने अधिकार छ। सहायताका लागि 800-346-4643 मा फोन गर्नुहोस्।**

## Persian

**در این یادداشت اطلاعات مهمی راجع به درخواست یا پوشش مد نظر شما از سوی Rocky Mountain Health Plans (RMHP) ارائه می شود. با دقت آنرا مطالعه فرمایید. به اقداماتی که باید انجام دهید و مهلت مقرر آنها توجه نمایید. شما حق دارید اطلاعات را به زبان خودتان بدون پرداخت هزینه ای دریافت کنید. برای درخواست کمک به شماره 3464-643-008 زنگ بزنید.**

## Russian

**В данном уведомлении содержится важная информация касательно Вашего страхового покрытия или заявления в организацию Rocky Mountain Health Plans (RMHP). Просим Вас внимательно его изучить. Вам необходимо наметить порядок действий и сроки. У Вас есть право на бесплатное получение информации на родном языке. За помощью обращайтесь по номеру телефона 800-346-4643 .**

## Simplified Chinese

**本通知中包含有**关落矶山健康计划（**RMHP**）范围和应用的重要信息。请仔细阅读。寻找您可能需要采取的措施和最终期限。您有权免费获得以自己的语言提供的信息。请致电 **800-346-4643** 寻求帮助。

## Vietnamese

**Trong thông báo này có thông tin quan trọng về phạm vi bảo hiểm hoặc đơn xin của quý vị với Chương Trình Chăm Sóc Sức Khỏe Rocky Mountain Health Plans (RMHP). Vui lòng xem kỹ thông báo này. Hãy tìm các hành động quý vị cần thực hiện và hạn chót của các hành động đó. Quý vị có quyền nhận thông tin bằng ngôn ngữ của quý vị mà không bị tính phí. Hãy gọi 800-346-4643 để được hỗ trợ.**

## Yoruba

**Ìfitónilétí pàtàkì wà nípa ìdarapò rẹ àbí ìbéèrè rẹ pèlú Àwọn Èto Ìlera Rocky Mountain [RMHP] nínú àfiyèsí yìí. Fi pèlépèlé gbé e yẹwò. Wò àwọn ìgbésè tí o lè gbé àti àwọn àkókò tí ó dópin. O ní ètó láti gbà ìfitónilétí yìí ní èdè rẹ lófèé. Pè 800-346-4643 fún ìrànlówó.**

## Ibo/Igbo

**Enwere ozi dị mkpa gbasara mkpuchi ma ọ bụ akwụkwọ anamachọihe gị na Rocky Mountain Health Plans (RMHP) n'ọkwa a. Gụgharịa ya nke ọma. Chọọ ihe ndị ị ga-eme yana nduzi. Ị nwere ikike ịnweta ozi n'asụsụ gị na akwụghị ụgwọ ọ bụla. Kpọọ 800-346-4643 maka enyemaka.**

## Tagalog

**May mahalagang impormasyon tungkol sa iyong coverage o aplikasyon sa Rocky Mountain Health Plans (RMHP) sa paalalang ito. Suriin ito nang mabuti. Alamin ang mga pagkilos na maaaring kailangan mong gawin at hanggang kailan mo dapat maisagawa ang mga iyon. May karapatan kang humiling ng impormasyon sa iyong wika nang libre. Tumawag sa 800-346-4643 para sa tulong.**

## Amharic

**በዚህ ማስታወቂያ ላይ Rocky Mountain Health Plans (RMHP) ስለሚሰጥዎት ሽፋን ወይም ማመልከቻዎን በተመለከተ ጠቃሚ መረጅ አይገኛል። በጥንቃቄ ይገምግሙት። መውሰድ ሊኖርብዎት ስለሚችሉ እርምጃዎችና የግዜ ገደብ ላይ ያተኩሩ። ያለምንም ክፍያ በቋንቋዎ መረጃ የማግኘት መብት አለዎት። እርዳታ ለማግኘት በ 800-346-4643 ይደውሉ።**

## Cushite — Oromo

**Facaatii yokin iyyanoo kee Rocky Mountain Health Plans (RMHP) walin qabiduu ilalichisee odeeffannoo baribaachisaatu jiraa. Irra deebi'an siriti xiinxalii. Kan itifuxachoo qabidu fi guyyaa itti xumramuu itti hojachofi ilaalii. Kafalitii malle odeeffanno afani ketiinarigachofi miriga qabidaa. Garigarisafi 800-346-4643 lakofisaa kananii bilibili.**

## Kru-Bassa

**Li bihne lini li gwe banga bi niigana. Li bihne lini li gwe banga bi niigana nyu mam ma kolbaha ndjombi yong tole ma teeda mong ngueda Rocky Mountain Health Plans (RMHP). Yeng ma kel ma ngui munu li bihne lini. Bebeg le u nlama bon nguim man nwaale guim di loo i nkwo nyu I teda mateda ma mboo yong tole I bana mi nsombog mi mahola. U gwee Kundei kosna biniiguene bini ni mahola i hop wong nni nsaa wogui wo. Sebel 800-346-4643.**

Aviso de No Discriminación

Rocky Mountain Health Plans (RMHP) cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo, orientación sexual o identidad de género. RMHP no excluye a las personas ni las trata de forma diferente debido a su origen étnico, color, nacionalidad, edad, discapacidad o sexo, orientación sexual o identidad de género.

RMHP toma medidas razonables para asegurar el acceso significativo y se proporciona a tiempo y de forma gratuita una comunicación eficaz:

- Proporciona asistencia y servicios gratuitos a las personas con discapacidades para que se comuniquen de manera eficaz con nosotros, como los siguientes:
  - Intérpretes de lenguaje de señas capacitados.
  - Información escrita en otros formatos (letra grande, audio, formatos electrónicos accesibles, otros formatos).
- Proporciona servicios lingüísticos gratuitos a personas cuya lengua materna no es el inglés, como los siguientes:
  - Intérpretes capacitados.
  - Información escrita en otros idiomas.

Si necesita recibir estos servicios, comuníquese con el RMHP Member Concerns Coordinator at 800-346-4643, 970-243-7050, or TTY 970-248-5019, 800-704-6370, Relay 711.

Si considera que RMHP no le proporcionó estos servicios o lo discriminó de otra manera por motivos de origen étnico, color, nacionalidad, edad, discapacidad o sexo, orientación sexual o identidad de género, puede presentar un reclamo a la siguiente persona: RMHP EEO Officer at 800-346-4643, 970-244-7760, ext. 7883, or TTY 970-248-5019, 800-704-6370, Relay 711; or eeoofficer@rmhp.org. Puede presentar el reclamo en persona o por correo postal, fax o correo electrónico. Si necesita ayuda para hacerlo, el RMHP EEO Officer está a su disposición para brindársela. También puede presentar un reclamo de derechos civiles ante la Office for Civil Rights (Oficina de Derechos Civiles) del Department of Health and Human Services (Departamento de Salud y Servicios Humanos) de EE. UU. de manera electrónica a través de Office for Civil Rights Complaint Portal, disponible en https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, o bien, por correo postal a la siguiente dirección o por teléfono a los números que figuran a continuación: 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).

Puede obtener los formularios de reclamo en el sitio web http://www.hhs.gov/ocr/office/file/index.html.

RMHP es un Plan de costos aprobada por Medicare. La inscripción en RMHP depende de la renovación del contrato.