ROCKY MOUNTAIN HEALTH PLANS®

MESA REGION

Employer **Group Plan Change** Form

BF

Employer Group Name:

RMHP Group Number:

Effective Date of Change:

Plan Selection (List All enrolled Employees and their plan choice in the grid below)

FOR GROUP PLAN CHANGE USE ONLY

CHANGES TO DEPENDENT COVERAGE OR OTHER ENROLLMENT CHANGES - USE THE RMHP CHANGE FORM

Please list all employees, including their SSN or Member ID and check "Waive" or the plan the employee has chosen.

Plan choice will apply to all enrolled dependents. Other changes on dependent coverage or other enrollment details must be provided on the RMHP Change Form.

Employee Name	EE Social Security # or Member ID	WAIVE COVERAGE	**Rocky Mountain Summit** Plan Selections							**Monument Health** Plan Selections							
			Designate your employer plan choice(s) for Summit above, then check the plan designated by each employee below.							Designate your employer plan choice(s) for Monument above, then check the plan designated by each employee below.							

I authorize the plan changes selected for the employees noted above to be effective on our anniversary. _____/_____

MK657B-10012018

Employer/Authorized Signature **Date**