Plans underwritten by Rocky Mountain HMO (RMHMO)

ROCKY MOUNTAIN HEALTH PLANS®

1B

Mail to:
PO Box 10600
Grand Junction, CO 81502-5600
Fax to: 970-263-5507
Email to: commercialenrollment@rmhp.org

Employee Change Form

To terminate an employee from the group plan, please use the Employee Disenrollment Form.

Subscriber Name: Last	First	MI	Social Security #:
			Member ID#:
Employer			Date of Birth: / /

Name Change / Address Change

Name Change: From:			To:		
Address Change: Street	City	State	Zip	Phone: Home ( )	Phone: Work ( )

Plan Change

Change Plan To (Name of Plan):

Dependent Only - Add / Drop Information

Please make change to: (Check all that apply.) *** If you are adding dependents to a dental or vision plan, a separate form is required.**

Add *	Drop	Date of change	Last Name	First Name	MI	Social Security #	Sex M/F	Date of Birth	Relationship to Subscriber	Primary Care Physician Name
☐ Medical	☐ Medical ☐ Dental ☐ Vision							/ /		
☐ Medical	☐ Medical ☐ Dental ☐ Vision							/ /		
☐ Medical	☐ Medical ☐ Dental ☐ Vision							/ /		

Reason for Addition of Dependent

☐ Marriage/Civil Union/ Domestic Partner/Designated Beneficiary — If adding a new spouse/partner, give date of marriage or date of partnership: _____
A separate form is required for Common Law Marriage, Domestic Partnership or Designated Beneficiary.

☐ Newborn child — Give date of birth: _____Newborn's hospital discharge date: _____

☐ Adoption or placement for adoption. Give adoption or placement date and submit adoption documentation:_____

☐ Court ordered coverage for dependent(s) — Give date of court order and submit court order documentation: _____

☐ Employer group open enrollment

☐ Dependent lost prior coverage —
Type of coverage lost: ☐ Employer group ☐ Child Health Plan ☐ Medicaid ☐ Other_____ Date coverage was lost:_____

A request to add a dependent must be received by RMHP within 30 days of the qualifying event, *except* that a request to add a dependent due to loss of Medicaid or Child Health Plan coverage must be received within 90 days of the loss of coverage.

Reason for Drop of Dependent

☐ Dependent no longer meets dependent child eligibility requirements ☐ Death of dependent — death certificate required ☐ Cannot afford coverage
☐ Divorce / Legal Separation; please provide forwarding address ☐ Termination of Domestic Partnership, Civil Union or Designated Beneficiary
☐ Enrolled in other health coverage; please designate: ☐ Group Coverage ☐ Individual Coverage ☐ Other _____

Dependent Address:
Name:_____Street:_____City:_____State:____ Zip:_____

Is this a drop request for a dependent child whose coverage is required by a court or administrative order? ☐ Yes ☐ No If Yes, attach proof of other coverage.
Name of Dependent:

1. 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.
2. I agree that the above information is true, and I authorize the above change.

Subscriber Signature:	**Date:**

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.