ROCKY MOUNTAIN HEALTH PLANS®

Plans underwritten by Rocky Mountain HMO (RMHMO)

OE

Application for Health Benefits For Large Employers

Please complete all sections on front and back using black ink only. We cannot process incomplete forms.

Section 1 – Company Information

Company Name		Type of entity: Corporation ☐ LLC ☐ Sole Proprietor ☐ Other _____		
Phone ( )	Fax ( )	E-Mail		
Physical Address	City	State	Zip	PO Box
Mailing Address	City	State	Zip	PO Box
Contact Person		Title		
President/CEO/Owner (Name)		Federal Tax ID Number (TIN / EIN)		
Proposed Effective Date	Industry or Type of Business	Industry Code (SIC)	Is your business a church group health plan that is not subject to ERISA? ☐ Yes ☐ No	

Does the company or owners applying for coverage share ownership in any other business(es)? ☐ Yes ☐ No If yes, give:

Name of business(es): _____

Name of all owners: _____

Total number of all employees on payroll who work 30 hours per regular work week for all businesses:# _____

Eligible employees must have a regular work week of the required number of hours a week and must satisfy any applicable waiting period.

Section 2 – Employee Eligibility

1. a. Number of employees on payroll who work 30 hours or more per week during the immediately preceding calendar year: #____ b. Number of Full Time Equivalents (FTE) during same time frame as "a"*: #____ *The FTE is the sum of all part time employee hours each month divided by 120.	10. Waiting Period Waived at Initial Open Enrollment ☐ Yes ☐ No
2. Number of employees eligible for health benefits coverage: #_____	11. Employer Contribution Medical (50% minimum) Employee _____% Family_____%
3. Average number of **all** employees (full-time, part-time, seasonal, etc.) employed on all business days during the prior calendar year. _____	12. Classes Excluded (If any, please describe.)
4. Number of employees in Colorado: #_____ Number of employees outside Colorado: #_____	13. Number of employees, former employees, or employees currently covered by or eligible for a Colorado or COBRA Continuation of Coverage plan: #_____
5. Number of eligible employees enrolling: #_____ Number of eligible employees waiving: #_____	14. Do you administer your own COBRA? ☐ Yes ☐ No
6. Number of full-time or part-time employees who were employed for 20 weeks or more this year or last year: # _____	15. Do you want RMHP to assist in continuation of coverage administration? ☐ Yes ☐ No
7. Number of full-time or part-time employees who worked at least 50% of your working days in the preceding calendar year: # _____	16. Does your company's eligibility include anyone who is not a company employee; for example, a person who is an independent contractor? ☐ Yes ☐ No
8. Hours Worked Requirement:	17. Are your employees leased from a leasing company or a professional employer organization? ☐ Yes ☐ No
9. Waiting Period for New Hires: ☐ Date of hire **OR** First of month following: ☐ Date of hire ☐ 1 Month ☐ 2 Months ☐ Other _____ Does any class have a different waiting period? (Cannot exceed 90 days) ☐ Yes ☐ No If yes, please describe:	18. Has your group had health coverage during the last 90 days? ☐ Yes ☐ No If yes, name of your current medical carrier: _____ 19. In the last 12 months, was coverage through a MEWA? ☐ Yes ☐ No Self-Funded? ☐ Yes ☐ No 20. Do you allow for dependent coverage? ☐ Yes ☐ No

Section 3 – Desired Coverage

Medical Plan 1:

Medical Plan 2:

Medical Plan 3:

Vision Plan:	EAP Plan:	Dental Plan:	Chiro Plan:	☐ Out-of-state employees ☐ Out-of-state dependents

I understand that my group's coverage will not be effective until all required enrollment information is received and approved by RMHMO I understand RMHMO has the right to terminate coverage and deny benefits if any information provided by the undersigned is knowingly false, incomplete, or misleading in any material respect.

Any fraud or intentional misrepresentation of a material fact will result in termination of coverage. I understand that I must tell RMHP of any change in responses between the date of application and the effective date of coverage. RMHP has the right to verify information provided and request additional information if necessary.

Employer/Authorized Signature:	Title:	Date:

Broker Signature: Producer license #/Tax ID:	Name of Agency:_____ Broker Name: _____ Alternate Contact: _____ Phone #: _____ Email: _____

Read important information below:

An access plan is available for each managed care network offered by RMHP 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 shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.