ROCKY MOUNTAIN HEALTH PLANS®
A UnitedHealthcare Company

Plans underwritten by Rocky Mountain HMO (RMHMO)

1B

Individual Change Form

*Note: Please complete an **Individual Health Plan Billing Form** if you want to change your premium payment option.*

Complete this form using black ink only.

Fax completed form to 970-263-5507 or Email to commercialenrollment@rmhp.org

Section 1 – Subscriber Information

Last Name:	First Name:	MI:	Date of Birth: / /	Home Phone: ( )
Social Security Number:			Member ID#:	

Reason for Change:

☐ Name Change / Address Change / Date of Birth Correction / SSN Correction — Complete Section 2
☐ Subscriber Change due to: ☐ Death ☐ Medicare Eligibility ☐ Other:_____— Complete Section 3
☐ Policy Split – Complete Section 4
☐ Dependent Term — Complete Section 5 *(RMHP must receive this form at least **14 days** prior to the requested termination date. Retroactive terminations are not permitted.)*
☐ Dependent Add* — Complete Section 6 *(Outside of Open Enrollment, dependents can only be added with a Triggering Event. See Section 6 for details.)*
*You may use this form to combine all family members under one policy.

Section 2 — Name Change / Address Change / Date of Birth Correction / SSN Correction

Complete this section if: (i) someone on the policy changes his or her name; (ii) your address changes; (iii) date of birth needs to be corrected; or, (iv) SSN needs to be corrected.

Name Change From:	To:			
Address Change Street: City:	State:	ZIP:	Home Phone: ( )	
Date of Birth Correction Name:	Correct Date of Birth:			
Social Security Number Correction Name:	Correct SSN:			

Section 3 — Subscriber Change

*Complete this section to terminate coverage of the current subscriber and make another covered family member the subscriber. **The change will be effective the first of the month following receipt by RMHP.***

New Subscriber Last Name:	First Name:	MI:	DOB: / /	SSN:	Home Phone: ( )

Section 4 — Policy Split

*Complete this section if you and your spouse or dependent both want to continue being covered, but on separate polices. **Please also complete an Individual Health Plan Billing Form to set up your new premium payment. The change will be effective the first of the month following receipt by RMHP.***

Subscriber 1 Last Name:	First Name:	MI:	DOB: / /	SSN:	Home Phone: ( )
Address:	City, State:			ZIP:	County:
Effective Date of Change:					

Please list all dependents continuing coverage with Subscriber 1:

Last Name	First Name	MI	Date of Birth	M/F	Social Security Number	Relationship to Subscriber	RMHP USE
			/ /				
			/ /				
			/ /				

Subscriber 2 Last Name:	First Name:	MI:	DOB: / /	SSN:	Home Phone: ( )
Address	City, State:			ZIP:	County:

Please list all dependents continuing coverage with this subscriber:

Last Name	First Name	MI	Date of Birth	M/F	Social Security Number	Relationship to Subscriber	RMHP USE
			/ /				
			/ /				
			/ /				

Section 5 — Dependent Term

Last Name	First Name	MI	Date of Birth	M/F	Social Security Number	Relationship to Subscriber	RMHP USE
			/ /				
			/ /				
			/ /				

Requested Date of Termination:

Section 6 — Dependent Add

Outside of Open Enrollment, dependents can only be added to your policy if you have a Qualifying Life Event (QLE).
Please select your QLE from the attached Special Enrollment Period Guidelines, and submit the required documentation with this form.

Qualifying Life Event: _____ *(See pages 3-7 of this document)*

Date of Event: _____

Requested Date of Dependent Add:_____

Last Name	First Name	MI	Date of Birth	M/F	Social Security Number	Relationship to Subscriber	RMHP USE
			/ /				
			/ /				
			/ /				

Section 7 – Signature

On behalf of myself and any dependents enrolled, I agree as follows:

- Enrollment, eligibility, coverage, and benefits are subject to the policies, requirements and terms of the contract for my health plan.
- **Termination is effective the first day of the next month following the date notice is received by RMHP.**

For subscriber changes in Section 3:

- I wish to terminate enrollment in the RMHP plan under which I am enrolled. By signing below, I am providing notice of termination.
- The new subscriber is presently enrolled as a dependent under my RMHP health plan.
- The new subscriber assumes all duties and obligations under the health plan contract previously entered into by me and which is currently in effect.
- If the dependent who will become the subscriber under the plan is a minor, the person signing below for the minor also agrees to be bound to the terms of this Subscriber Change Form and the applicable health plan contract. The person signing below for the minor must have legal authority to enter this contract on behalf of the minor.

WE ACKNOWLEDGE AND CERTIFY THAT WE HAVE READ THIS CHANGE FORM AND THAT THE FOREGOING INFORMATION IS TRUE, AND WE UNDERSTAND AND AGREE TO ALL MATTERS COVERED IN THIS FORM.

Current Subscriber Signature:	**Date:**
New Subscriber Signature *(Required if Sections 3 or 4 have been Completed):*	**Date:**

Colorado law requires carriers to make available a Colorado Supplement to the Summary of Benefits of Coverage, which is intended to facilitate comparison of health plans. The form must be provided automatically within seven (7)) business days to a potential policyholder who has expressed interest in a particular plan or who has selected the plan as a finalist from which the ultimate selection will be made. The carrier also must provide the form, upon oral or written request, within seven (7) business days to any person who is interested in coverage under or who is covered by a health benefit plan of the carrier.

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.

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*.

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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 LƯU Ý: 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 नि: 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: េបើសិនអ្នកនិយាយភាសាែខ្ម (Khmer) េសវាជំនួយភាសាេដាយឥតគិតៃថ្ល គឺមានសំរាប់អ្នក។ សូមទូរស័ព្ទេទៅេលខសមាជិកឥតគេចញៃថ្ល បានកត់េនៅខាងមុខេនកូនេសៀវេភៅេនះ។

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 yáníłti'go, saad bee áka'anída'awo'ígíí, t'áá jíík'eh, bee ná'ahóót'i'. T'áá shǫǫdí díí naaltsoos bidáahgi t'áá jiik'eh naaltsoos báha'dít'éhígíí béésh bee hane'í biká'ígíí bee hodíilnih.

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.