



## Individual Plan Change Form – Open Enrollment

Subscriber Name: \_\_\_\_\_ Member ID #: \_\_\_\_\_  
 Address: \_\_\_\_\_ County: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Phone Number: \_\_\_\_\_ Email: \_\_\_\_\_

In the chart below, please select your plan choice by checking the box. Please note there can be only one plan selection per family.

<p><b>Monument Health – HMO Individual and Family Plan Options</b>          Regional Network – Offered to Residents in <b>Mesa</b> and <b>Delta</b> Counties          Monument Health HMO is a 2-tiered network.          Tier 1: Access to the Monument Health Network.          Tier 2: Access to other select RMHP providers.</p>	<p><b>Monument One – HMO Individual and Family Plan Options</b>          Regional Network – Offered to Residents in <b>Mesa</b> County          Monument One is a single-tier network with access to the Monument Health Network.</p>
<input type="checkbox"/> HMO Gold 1000/2500 <input type="checkbox"/> HMO Silver HSA 4500/6000 Rx 90 <input type="checkbox"/> HMO Silver 4500/6000 <input type="checkbox"/> HMO Bronze 8000/8500 <input type="checkbox"/> HMO Silver 5000/7000 <input type="checkbox"/> HMO Bronze HSA 6700/6800 Rx 90	<input type="checkbox"/> HMO Gold 2500 <input type="checkbox"/> HMO Bronze HSA 6750 Rx 90 <input type="checkbox"/> HMO Silver HSA 5500 RX 90 <input type="checkbox"/> HMO Bronze 7200 <input type="checkbox"/> HMO Silver 5500

If you need to add or drop a dependent from your plan, please complete the chart below.

Dependent Add						
Last Name	First Name	MI	Date of Birth	Gender: M/F	Social Security #	Relationship to Subscriber
			/ /			
			/ /			
			/ /			
Dependent Drop						
Last Name	First Name	MI	Date of Birth	Gender: M/F	Social Security #	Relationship to Subscriber
			/ /			
			/ /			
			/ /			

The undersigned individually and on behalf of the undersigned's dependents agrees as follows:

- 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.
- I agree and authorize the above changes to my current RMHP policy. I agree to continue to pay the premium on my current RMHP Individual Health Care Plan while this plan change request is processed.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Attn: Individual Sales – Rocky Mountain Health Plans, PO Box 10600, Grand Junction, CO 81502-5600**  
**Phone: 800-453-2981, Option 4      Email: individualsales@rmhp.org      Fax: 970-244-7992**

**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 Rocky Mountain Health Plans 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**



**ROCKY MOUNTAIN**  
**HEALTH PLANS®**

A UnitedHealthcare Company

## 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](mailto: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>.

## 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 LU'U Y:** 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 निः 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: បើសិនជាអ្នកនិយាយភាសាខ្មែរ (Khmer) ឬសំឡេងភាសាខ្មែរ គឺមានសំរាប់អ្នក។ សូមទូរស័ព្ទទៅលេខសមាជិកគេចំពោះចំណុចនេះ។

**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 jíik'eh, bee ná'ahóót'i'. T'áá shqoqdí díí naaltsoos bidáahgi t'áá jíik'eh naaltsoos báha'dít'éhígíí béesh 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.