ROCKY MOUNTAIN HEALTH PLANS®
A UnitedHealthcare Company

1C

Plans underwritten by Rocky Mountain HMO (RMHMO)

Individual Health Care Plan Disenrollment Form

By submitting this disenrollment form, all covered family members will be disenrolled from the health plan. To retain coverage for a covered family member, please use the RMHP Individual Change Form.

Last Name:	First Name:	MI:	Date of Birth: / /	Member ID:
				SSN:
Address:	City:		State:	Zip:

Requested termination date: _____

Retroactive terminations are not permitted. Termination will be effective on the last day of the month in which we receive the disenrollment notice.

Please terminate my coverage for the following reason:

- ☐ Unsatisfactory benefits (BN)
- ☐ Rates too high (VR)
- ☐ Unsatisfactory benefits/rates too high (BR)
- ☐ Unable to afford coverage (AC)
- ☐ Limited payment options (PO)
- ☐ Moving from plan service area (MT)
- ☐ Service unsatisfactory (SN)
- ☐ Death — requires a copy of the death certificate (DE)
- ☐ Quality of care (QT)
- ☐ PCP does not participate (PN)
- ☐ Provider access (PA)

If you have obtained new coverage, please complete the following section:

- ☐ Changing to spouse's coverage
  - ☐ Individual coverage (SI) ☐ Group coverage (SG)
- ☐ Changing to other coverage
  - ☐ Individual coverage (IC) ☐ Group coverage (IG) ☐Medicare (MC)
- ☐ New carrier
  - ☐ Anthem BC/BS (OA)
  - ☐ Bright Health (BH)
  - ☐ Cigna (OC)
  - ☐ Kaiser Permanente (KP)
  - ☐ Friday Health (FH)
  - ☐ Other: _____

I agree that the above information is true, and I authorize Rocky Mountain Health Plans to terminate my coverage.

Subscriber Signature: _____ Date Signed:_____

Mail this form to:
Membership Enrollment
Rocky Mountain Health Plans
PO Box 10600
Grand Junction, CO 81502-5600

Email to: commercialenrollment@rmhp.org

Fax to: 970-263-5507