

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 comercialenrollment@rmhp.org

Section 1 – Subscriber Information							
Last Name:	First Name:	MI:	Date of Birth: / /	Home Phone: ()			
Social Security Number:			Member ID#:				
Reason for Change: <input type="checkbox"/> Name Change / Address Change / Date of Birth Correction / SSN Correction — Complete Section 2 <input type="checkbox"/> Subscriber Change due to: <input type="checkbox"/> Death <input type="checkbox"/> Medicare Eligibility <input type="checkbox"/> Other: _____ — Complete Section 3 <input type="checkbox"/> Policy Split – Complete Section 4 <input type="checkbox"/> 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.) <input type="checkbox"/> 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 policies. 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.

Multi-Language Insert



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 አርዳታ ድርጅቶች፣ በነጻ ሊያገለግሉዎት ተዘጋጅተዋል። ወደ ሚክተለው 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 3464 --643-008-1 (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: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंको 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 3464-643-008-1 (117:YTT) تماس بگیرید.
Ibo/Igbo	Ige nti: O buru na asu lbo asusu, enyemaka diri gi site na call 1-800-346-4643 (TTY: 711).
Kru-Bassa	Dè dɛ nià kɛ dyédé gbo: ɔ jũ ké m̩ [Bàsóò-wùdù-po-nyò] jũ ní, níí, à wuɖu kà kò dò po-poò b̩éin m̩ 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.