ROCKY MOUNTAIN HEALTH PLANS®

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.