ROCKY MOUNTAIN HEALTH PLANS®

1B

# Medicare Short Enrollment/Change Form

| **Member Name:** | | **Member Number:** | |
|---|---|---|---|
| Home Phone Number: (  ) | | | |
| **Permanent Residence Address** (P.O. Box is not allowed) | | | |
| Address: | | | |
| City: | **County:** | State: | Zip Code: |
| **Mailing Address** (only if different from your Permanent Residence Address) | | | |
| Address: | | | |
| City: | | State: | Zip Code: |

**E-mail Address** (optional)**:**_____

**Please include email address if you would like to receive plan information electronically.**

I am currently a Member of the _____ plan in Rocky Mountain Health Plans with a monthly premium of $_____. I would like to change to the following plan in Rocky Mountain Health Plans. I understand that this plan has different health benefits.

Coverage begins on the first day of the month. **Please check which plan you want to change to (if any):**

- ☐ Rocky Mountain Basic Plan (Cost) $10.00*
- ☐ Rocky Mountain Green Plan (Cost) $35.00*
- ☐ Rocky Mountain Thrifty Plan (Cost) $55.00*
- ☐ Rocky Mountain Standard Plan (Cost) $95.00*
- ☐ Rocky Mountain Plus Plan (Cost) $185.00*

**What Effective Date are you applying for? _____**

**Voluntary dental and/or vision may be added to medical coverage (except the Basic plan) only during the Annual Enrollment Period (October 15th – December 7th)**

**UnitedHealthcare Platinum Dental plan $45.00 / month Add☐ Drop☐**

**VSP Vision plan $12.00/month Add☐ Drop☐**

**Please list your Primary Care Physician (PCP) or clinic:**

Clinic: _____

Physician Name (First and Last Name): _____

Physician or Clinic Address: _____

City: _____ State: _____ Zip: _____

**Please check one of the boxes below if you would prefer to receive your information in a language other than English or in an accessible format:**

☐ Braille ☐ Large Print ☐ Spanish

Please contact Rocky Mountain Health Plans at 888-282-1420 if you need information in an

accessible format or language other than what is listed above. Our office hours are 8am - 8pm, 7 days/week, Oct.1–March 31, and 8am - 8pm, M-F, April 1–Sept.30. TTY users should call 771.

RMHP is a Medicare-approved Cost plan. Enrollment in RMHP depends on contract renewal.

**Document Delivery Preferences**

CMS (Medicare) requires RMHP to provide ***every*** Member with certain required plan documents at enrollment and annually thereafter. The Evidence of Coverage (EOC) is available at **www.rmhpMedicare.org**.

**The Annual Notice of Change (ANOC) will be sent to *every Member* by mail unless a different option is selected below:**

☐ **Option 1 – Opt In to Receive Required Documents Electronically**

To view your documents, you must have Internet access and your system must meet minimum system requirements. You will not receive paper copies.

**E-mail address:** _____

☐ **Option 2 - Consent to Receive One Required Document Mailing per Household (if there are multiple RMHP Members in your household)**

The Members of your household can request that only one set of plan documents be sent. Each household Member must sign below.

| Last Name, First Name | Member ID | Date | Signature |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

*Attach a separate sheet if more than four Members reside at the same address.*

**You may change your document delivery preferences or request a paper copy, free of charge, by calling RMHP Customer Service.**

**Please Read and Sign Below**

Rocky Mountain Health Plans is a Medicare health plan that has a contract with the Federal government. I will need to keep my Medicare Part B.

I understand that if I am getting assistance from a sales agent, broker or other individual employed by or contracted with RMHP, he/she may be paid based on my enrollment in RMHP.

**Release of Information:** By joining this Medicare health plan, I acknowledge that RMHP will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that RMHP will release my information to Medicare, who may release it for research and other purposes which follow all applicable Federal statutes and regulations. The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.

ROCKY MOUNTAIN HEALTH PLANS®

I understand that beginning on the date RMHP coverage starts, in order for RMHP to cover my medical services (except for emergency or urgently needed services or out-of-area dialysis services), my health care must be provided by RMHP plan providers or be authorized by RMHP. If I obtain services outside of the RMHP network that have not been authorized, I will be responsible for all Medicare deductibles and coinsurance, as well as any additional charges as prescribed by the Medicare program. I may also be liable for charges not covered by Medicare.

I understand that my signature (or the signature of the person authorized to act on my behalf under the State law where I live) on this application means that I have read and understand the contents of this application. If signed by an authorized individual (as described above), this signature certifies that: 1) this person is authorized under State law to complete this enrollment and 2) documentation of this authority is available upon request by Rocky Mountain Health Plans or by Medicare.

| **Your Signature:** | **Today's Date:** |
|---|---|
| **Print Name:** | |
| **If you and your spouse are on the same RMHP Medicare plan and would like to receive only one paper copy of plan documents to the address provided on this application, initial here:_____** | |
| If you are the authorized representative, you must sign above and provide the following information: | |
| Name: | |
| Address: | |
| Phone Number: | |
| Relationship to Enrollee: | |

**Please return this form to:**

RMHP Medicare Enrollment, PO Box 10600, Grand Junction, CO 81502-5600

Fax: 970-244-7769

If you have questions, please call our Customer Service at 888-282-1420 (TTY dial 711). Hours are 8am - 8pm, 7 days/week, Oct. 1–March 31, and 8am - 8pm, M-F, April 1–Sept.30.

**Office Use Only**

| Name of staff Member/agent/broker (if assisted in enrollment): | | |
|---|---|---|
| Plan ID#: | Effective Date of Coverage: | |
| IEP: | AEP: | SEP (type): |

ROCKY MOUNTAIN HEALTH PLANS®

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# Medicare Payment Options Form

**Member Name:** _____

**Member Number:** _____

**Change to be effective on the first day of (month and year):** _____

**You can pay your monthly plan premium by mail or Electronic Funds Transfer (EFT). You can also choose to pay your premium by automatic deduction from your Social Security or Railroad Retirement Board benefit check each month.**

If you don't select a payment option, you will receive a bill each month.

**Please select a premium payment option:**

☐ **Receive a bill (mailed). Full payment is due upon receipt of invoice.**

☐ **Electronic funds transfer (EFT) from your bank account each month.**
**Please enclose a VOIDED check or provide the following:**

Account holder name (if different)_____

Account holder signature:_____

Bank routing number: _____

Bank account number: _____

Account type: __Checking __Savings

☐ **Automatic deduction from your monthly Social Security/Railroad Retirement Board benefit check.**

**I get monthly benefits from: Social Security RRB**

(The Social Security/Railroad Retirement Board deduction may take two or more months to begin. In most cases, if Social Security/the Railroad Retirement Board accepts your request for automatic deduction, the first deduction from your Social Security/Railroad Retirement Board benefit check will not include all premiums due from your enrollment effective date up to the point withholding begins. We will send you a paper bill for those months before deduction from your Social Security/Railroad Retirement Board check starts. If Social Security/the Railroad Retirement Board does not approve your request for automatic deduction, we will send you a paper bill for your premiums.) If chosen, Dental and Vision plan premiums are not deducted from Social Security or the RRB benefit check and will be billed directly to the Member.)

## 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.

## 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 እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው 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 1-800-346-4643 (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: तपाईले नेपाली बोल्नुहुन्छ भने तपाईको 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 1-800-346-4643 (117:YTT) تماس بگیرید. |
| **Ibo/Igbo** | Ige nti: O buru na asu Ibo asusu, enyemaka diri gi site na call 1-800-346-4643 (TTY: 711). |
| **Kru-Bassa** | Dè ɖɛ nià kɛ dyéɖé gbo: Ɔ jŭ ké m̀ [Ɓàsɔ́ɔ̀-wùɖù-po-nyɔ̀] jŭ ní, nìí, à wuɖu kà kò ɖò po-poɔ̀ ɓɛ́ìn m̀ gbo kpáa. Đá 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). |