



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):			
<input type="checkbox"/> Rocky Mountain Basic Plan (Cost) \$10.00* <input type="checkbox"/> Rocky Mountain Green Plan (Cost) \$35.00* <input type="checkbox"/> Rocky Mountain Thrifty Plan (Cost) \$59.00* <input type="checkbox"/> Rocky Mountain Standard Plan (Cost) \$99.00* <input type="checkbox"/> Rocky Mountain Plus Plan (Cost) \$189.00*			
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. I understand that people with Medicare aren't covered under Medicare while out of the country except for limited coverage near the U.S. border.

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. Please refer to the Evidence of Coverage document (also known as a member contract or subscriber agreement) for services that will be covered under RMHP.

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):

OD

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.)