2775 Crossroads Blvd.
PO Box 10600
Grand Junction, CO 81502-5600

4E

Optional Vision Benefit Enrollment & Status Change Form

(RMHP Medicare Members do not need to enroll in the Discount Vision Program.)

Be sure form is completed in full for accurate enrollment

Please contact Rocky Mountain Health Plans if you need information in another format
(Braille or Large Print)

ENROLLEE INFORMATION (one form must be completed per person)		
Group Name: Rocky Mountain Health Plans	Effective Date (mm/dd/yyyy) / /	
Last Name:	First Name:	
Medicare Number: ______- _______- ___________ ______	Phone: ( )	
Home Address:		
City:	State:	Zip Code:

PLAN SELECTION
Plan: ☐ **Yes**, I choose to elect coverage in the **Optional Vision Benefit** for $12.00 per month.

REASON FOR SUBMISSION (CHECK ONE)		
Enrollment:	**Change Type:**	
☐ New Enrollment	☐ Change Name	☐ Change Address
☐ Cancel Coverage	From ____________________	From ____________________
	To ____________________	To ____________________

______________________________ __________________
Signature of Subscriber **Date**

Other Providers are available in our network.
Medicare has neither reviewed nor endorsed this information.
RMHP is a Medicare-approved Cost plan. Enrollment in RMHP depends on contract renewal.