

## Enrollment/Change Form

**Please complete the information below if your employer is offering Vision coverage with your Rocky Mountain Health Plans medical coverage.**

<b>Name of Employer Group:</b>								
<b>Employee Information</b>								
Last Name:				First Name:				
Date of Birth: / /		Gender: <input type="checkbox"/> M <input type="checkbox"/> F		Are you married? <input type="checkbox"/> Yes <input type="checkbox"/> No		Social Security Number:		
Home Address:				City, State:			Zipcode:	
<b>Enrollment</b>								
<input type="checkbox"/> Yes, I am enrolling in Vision coverage, in addition to the medical plan. <input type="checkbox"/> Yes, I am enrolling in Vision coverage and waiving enrollment in the medical plan. Coverage requested for: <input type="checkbox"/> Employee Only <input type="checkbox"/> Employee + Spouse <input type="checkbox"/> Employee + Child(ren) <input type="checkbox"/> Employee + Family <input type="checkbox"/> I have listed dependents enrolling in the Vision Plan below.								
<b>Spouse Name</b>			<b>Gender</b>	<b>Birthdate</b>		<b>Social Security Number</b>		
				/ /				
<b>Dependent Name</b>			<b>Gender</b>	<b>Birthdate</b>		<b>Relationship to Employee</b>		
				/ /				
				/ /				
				/ /				
<b>Waiver</b>								
<input type="checkbox"/> I am waiving vision coverage. I understand I am also waiving vision coverage for any eligible dependents and my next opportunity to enroll in the vision plan will be Open Enrollment.								
<b>Add/Drop Information</b>								
I understand that if I drop vision coverage for myself, all covered family members will be disenrolled.								
Reason for addition of dependent:								
<input type="checkbox"/> Marriage <input type="checkbox"/> Newborn or adopted child <input type="checkbox"/> Employer group open enrollment <input type="checkbox"/> Dependent lost other vision coverage								
<b>Add</b>	<b>Drop</b>	<b>Date</b>	<b>Last Name</b>	<b>First Name</b>	<b>MI</b>	<b>Sex M/F</b>	<b>Date of Birth mm/dd/yyyy</b>	<b>Relationship to Subscriber</b>
I agree that enrollment, eligibility, coverage and benefits of the vision plan are subject to applicable policies and to all terms of the applicable coverage policy.								
<b>Signature:</b>						<b>Date:</b>		