Plans underwritten by Rocky Mountain HMO (RMHMO)
or Rocky Mountain HealthCare Options, Inc. (RMHCO)

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ROCKY MOUNTAIN HEALTH PLANS®
We understand Colorado. We understand you.

Employee Disenrollment Form

All covered family members will be disenrolled from the plan.

Complete this form using black ink only.

Subscriber Information

Subscriber Name: Last	First:	MI:	Date of Birth: / /	Member #:
				Social Security # – –
Address:	City:			State: Zip:
Employer:				Effective Date of Disenrollment:

Cancel Coverage

Cancel all plans coverage for myself and my covered family members for:
☐ All

Or ⟶

Cancel coverage for myself and my covered family members for one or more of these:
- ☐ Medical Plan
- ☐ Dental Plan (if applicable)
- ☐ Vision Plan (if applicable)

If you do not want to cancel coverage for all family members, please use the Group Change Form.

Please Complete for Disenrollment from Plan

Please cancel the coverage above for the following reasons:

Eligibility for Continuation Coverage
1. Type of qualifying event – Please check one only:
   - ☐ Loss of employment (JT)
   - ☐ Death of employee
   - ☐ Employee's enrollment in Medicare
   - ☐ Gross Misconduct
   - ☐ Reduction in hours (COBRA only)
   - ☐ Retirement
2. Date of qualifying event: _____

Please check any that apply:
- ☐ No longer eligible for benefits (LB)
- ☐ Unsatisfactory benefits (BN)
- ☐ Rates too high (VR)
- ☐ Unsatisfactory benefits/rates too high (BR)
- ☐ Moving from plan service area (MT)
- ☐ Quality of care (QT)
- ☐ PCP does not participate (NP)
- ☐ Other: _____

Are any dependent children disenrolling from this plan subject to a court order for health coverage? ☐ Yes ☐ No
If yes, please supply written proof that: 1) any such court order is no longer in effect; or 2) any such child is enrolled in a comparable plan through another insurer.

The undersigned individually or on behalf of the undersigned's dependents agrees as follows:
I agree that the above information is true, and I authorize Rocky Mountain Health Plans to make the above change.

Subscriber Signature: _____ **Date Signed:** _____

Employer Signature: _____ **Date Signed:** _____

Only one signature required, Employee or Employer.

Send this form to:
Membership Enrollment
Rocky Mountain Health Plans
PO Box 10600
Grand Junction, CO 81502-5600
Email: commercialenrollment@rmhp.org

Or fax to: Attn: Enrollment 970-263-5507