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

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

1B

Group Change Form

Complete this form using black ink only.

Please indicate type of action requested: ❑ ***Add*** ❑ ***Change*** ❑ ***Drop***

Fold and mail or fax to 970-263-5507

Subscriber Name: Last	First	MI	Social Security #:
			Member ID#:
Employer:			Date of Birth: / /

Changes to Existing Health Plan

Address Change: Street City	State	Zip	Phone: Home ( )	Phone: Work ( )
Name Change: From	To:			

Plan Change — Change Coverage To:

Coverage Option: ❑ Single ❑ Employee+Spouse ❑ Employee+Child(ren) ❑ Employee+Spouse+Child(ren)

Change Plan To (Name of Plan): Rx Plan: ❑ Brand ❑ Generic Only (N/A with HSA)

Good Health National Access (for any employees/dependents residing outside Colorado) ❑ Add ❑ Drop Effective date:

Dependent Only Add / Drop Information

Add*	Drop	Date	Last Name	First Name	MI	Social Security #	Sex M/F	Date of Birth MM/DD/YY	Relationship to Subscriber	Primary Care Physician Name and / or Physician ID#

*** A request to add a dependent must be received by RMHP within 30 days of the qualifying event, *except* that a request to add a dependent due to loss of Medicaid or Child Health Plan coverage must be received within 90 days of the loss of coverage. Adding dependents age 19 and older on small employer group plans with fewer than 51 employees requires a copy of certificate of creditable coverage provided by previous carrier or other acceptable proof.**

Reason for Addition of Dependent

❑ Marriage — If adding new spouse, give date of marriage: _____

❑ Newborn child — Give date of birth: _____Newborn's hospital discharge date:_____

❑ Adoption or placement for adoption. Give adoption or placement date and submit adoption documentation: _____

❑ Court ordered coverage for dependent(s) — Give date of court order and submit court order documentation:_____

❑ Employer group open enrollment

❑ Dependent lost prior coverage — (Please submit proof of loss of coverage, i.e., HIPAA Certificate of Creditable Coverage, or other acceptable proof)

Type of coverage lost: ❑ Employer group ❑ Child Health Plan ❑ Medicaid ❑ Other_____ Date coverage was lost:_____

Reason for loss of coverage:

❑ Reduction in hours ❑ Termination of employer contribution toward coverage

❑ Involuntary termination of prior coverage ❑ Termination of employment or loss of eligibility ❑ Other:_____

Reason for Drop / Disenrollment of Dependent

❑ Dependent no longer meets dependent child eligibility requirements ❑ Death of dependent — requires copy of death certificate

❑ Enrolled in other health coverage; please designate: ❑ Group Coverage ❑ Individual Coverage ❑ Other _____

❑ Divorce / Legal Separation; please provide forwarding address ❑ Cannot afford coverage

Address of Disenrolled Dependent:

Name:_____Street:_____City:_____State:_____Zip:_____

Is this a drop request for a dependent child whose coverage is required by a court or administrative order? ❑ Yes ❑ No If Yes, attach proof of other coverage.

1. I agree that enrollment, eligibility, coverage, and benefits in my health plan are subject to applicable policies and requirements and to all terms of the applicable contract for my health plan.
2. I agree that the above information is true, and I authorize the above change.

Subscriber Signature	**Date**