

# Enrollment Form – Group Coverage

*In order to expedite employee's enrollment, please make certain Sections 1, 2, 3, 4, and 5 are completed fully using black ink only.*

Section 1 – Employee Information							
Employer Name				Date of Employment / /		Job/Occupation	Hours Worked per Week
Employee Last Name		First Name		MI	Social Security #* - -		Home Phone ( )
Address (include PO Box)			City		State	Zip Code	County of Residence
If you prefer to receive member newsletters or announcements from RMHP via e-mail, please provide your e-mail address:							
Section 2 – Plan Selection / Desired Coverage							
Name of health plan selected by your employer (see back of form for plan names)				Complete only if your employer group offers the Family Options Plan: Are your dependents enrolling in a different Plan than you? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Desired coverage: <input type="checkbox"/> Single <input type="checkbox"/> Double <input type="checkbox"/> Family <input type="checkbox"/> EE & Child(ren) <input type="checkbox"/> COBRA/CCOC – Qualifying event date _____				Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Common Law (statement requested) <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Legally Separated			
Section 3 – Other Health Coverage							
While covered under this plan, will you or any family members applying for coverage have other active health insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No							
If yes, please provide name of other insurance: Policy Holder:				Phone # ( )		Plan # or Social Security #* - -	
Have you or any family member ever been treated for a serious accident or injury within the last 5 years? <input type="checkbox"/> Yes <input type="checkbox"/> No							
If yes, please indicate: <input type="checkbox"/> Auto <input type="checkbox"/> Workers' Compensation Other:							
<b>Complete the waiver form on page 3 if you are not enrolling or you are not enrolling your spouse or dependents. Waiver must be completed for future special enrollment on this plan.</b>							
Section 4 – Eligible Enrolling Persons							
Last Name		First Name	MI	Social Security #*	Sex M/F	Birthdate MM/DD/YY	Relationship to Subscriber
Primary Care Physician Name and/or Physician ID#							
Self							
Spouse							
Common-Law Spouse? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please complete common-law spouse form.							
Dependent							
Full-Time Student age 19 and older? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, please complete student status form.					
Handicapped age 19 and older? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, please complete handicapped dependent form.					
Dependent							
Full-Time Student age 19 and older? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, please complete student status form.					
Handicapped age 19 and older? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, please complete handicapped dependent form.					
Dependent							
Full-Time Student age 19 and older? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, please complete student status form.					
Handicapped age 19 and older? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, please complete handicapped dependent form.					
Dependent							
Full-Time Student age 19 and older? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, please complete student status form.					
Handicapped age 19 and older? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, please complete handicapped dependent form.					
Dependent							
Full-Time Student age 19 and older? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, please complete student status form.					
Handicapped age 19 and older? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, please complete handicapped dependent form.					
Dependent							
Full-Time Student age 19 and older? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, please complete student status form.					
Handicapped age 19 and older? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, please complete handicapped dependent form.					
Dependent							
* Please supply social security numbers if known. Missing numbers will be requested after enrollment.							

**Pre-Existing Condition Limitation Periods**

Rocky Mountain HMO or Rocky Mountain HealthCare Options, Inc., will apply a limitation period for coverage for pre-existing medical conditions. This limitation period could last up to six months from the day your coverage starts or from the first day of any waiting period imposed by your employer, whichever is earlier. This limitation period could be reduced or eliminated for each family member, including you, who is now or who was previously covered by a health care plan. No pre-existing condition limitation period will be applied to adopted children, children placed for adoption prior to their 18th birthday, to pregnancy, or to any condition relating to pregnancy. For more information on pre-existing condition limitation periods, please refer to disclosure statement on last page. **(Does not apply to RMHMO HMO Basic Health Benefit Plan Without Specified Mandates for Colorado or RMHMO HMO Standard Health Benefit Plan for Colorado or plans with 51 or more employees)**

**Previous Health Insurance Information**

Please list all current health coverage policies and/or all previous health coverage policies in effect in the last 12 months. Complete this section for yourself and each family member listed on this enrollment form. Add additional pages if needed.

**You must attach to this form a copy of proof of creditable coverage for every family member listed on this enrollment form who has had coverage.**

Family Member Name	Name and Telephone Number of Health Plan or Insurance Company	Effective Dates of Coverage MM/DD/YY	RMHP USE
Subscriber Name:	Company Name:	From:	
Plan # or Social Security Number:        -        -	Phone Number: (        )	To:	
Dependent Name:	Company Name:	From:	
Plan # or Social Security Number:        -        -	Phone Number: (        )	To:	
Dependent Name:	Company Name:	From:	
Plan # or Social Security Number:        -        -	Phone Number: (        )	To:	
Dependent Name:	Company Name:	From:	
Plan # or Social Security Number:        -        -	Phone Number: (        )	To:	

**Section 5 – Agreement**

The undersigned, individually and on behalf of the undersigned's dependents ("we"), state as follows:

1. We offer to enter into and agree to the terms of the applicable contract for the health plan designated in this enrollment application and any Rocky Mountain HMO (RMHMO) and/or Rocky Mountain HealthCare Options (RMHCO) health plan that replaces the health plan so designated. We shall have a contract with RMHMO and/or RMHCO upon receipt of all information required for enrollment, approval by RMHMO or RMHCO, and receipt of the first premium. The terms of the contract are set forth in the applicable contract for the health plan and may be amended from time to time by the applicable health plan.
2. We understand and acknowledge that RMHMO or RMHCO or their designated agents/contractors may obtain, use, and disclose information or records related to the health of any person proposed for coverage for the treatment, payment, and health care operations functions of RMHMO or RMHCO. For example, these treatment, payment, and health care operation functions of RMHMO or RMHCO include use of such information for processing and payment of claims, in RMHMO or RMHCO quality assurance programs, or to involve me or my dependent(s) in case management. Such information or records may be obtained from any physician, health care provider, hospital, clinic, other medical facility, insurance company, or other entity. All information is subject to confidentiality laws. I authorize any physician, health care provider, hospital or other medical facility, insurance company, or other entity or person that now or hereafter has records or knowledge of the health of any person proposed for coverage to give the health plan such information and supplement such information as requested.
3. We agree to the applicable contract provisions for the resolution of disagreements and disputes, including arbitration when required. We agree to resolve such disagreements and disputes as set forth in the applicable contract.
4. We agree that RMHMO and RMHCO shall have the right to terminate coverage and deny benefits if any information on this enrollment application or as otherwise provided by the undersigned for enrollment purposes is knowingly false, misleading, or inaccurate in any material respect.
5. We agree that the above provisions will remain in effect for the undersigned and the undersigned's dependents for the entire duration of coverage and shall continue thereafter to the extent of any continuing rights or obligations under such health plans.
6. We have read the information on the back of this enrollment form.

Subscriber Signature

Date

Complete this section **ONLY** if you are not enrolling yourself or your spouse or dependents. Waiver must be completed for future special enrollment on this plan.

**Employee/Dependent Waiver**

Subscriber Name \_\_\_\_\_ Group Name \_\_\_\_\_

Social Security #: \_\_\_\_\_

Date of Employment      /      /

I hereby certify as follows on behalf of myself and each of my dependents:

1. I have been informed of the availability of coverage under a Rocky Mountain HMO or Rocky Mountain HealthCare Options, Inc., health benefit plan(s) as offered by my employer;
2. I have been given an opportunity to enroll in such plan(s).
3. After careful consideration, I have declined to enroll in such plan(s) and decided to waive my opportunity to enroll in such plan(s). I have declined to enroll in such plan(s) for the following coverages (must check appropriate box AND list names in the chart).

- Single coverage for myself.     Coverage for my spouse.     Coverage for my dependent children.

I understand I cannot waive coverage for myself and enroll my dependents.

Last Name	First Name
Self	
Spouse	
Dependent	
Dependent	
Dependent	

4. The reason I have chosen to decline such coverage for myself or my dependents is:

- I am covered under my spouse's group policy.  
 I am covered under my spouse's individual policy.  
 My spouse is covered under another plan.  
 My dependents are covered under another plan.  
 I cannot afford coverage.  
 I wish to continue other coverage obtained through an Individual Plan.

5. **If covered under another health plan, copy of ID card from other carrier is required.**

6. I understand that if I decline coverage for myself or my dependents (including my spouse) because of other insurance coverage, I may, in the future, be able to enroll myself or my dependents (if I am already enrolled) in this plan as required by applicable law, provided I request enrollment within 30 days after other coverage ends. I also understand that if I have a new dependent as a result of marriage, birth, adoption, or placement for adoption, I may be able to enroll myself and my dependents provided that I request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. I understand that if I do not request enrollment within 30 days for the above events, I will not be eligible for enrollment for such coverage until whichever of the following dates occur first (1) the date I enroll for such coverage during an Annual Open Enrollment Period; or (2) the date twelve (12) months following the date I first request such coverage. I also understand that if I do not list a dependent on this form who has other coverage, I can't enroll this dependent until whichever of the following dates occur first (1) the date I enroll for such coverage during an Annual Open Enrollment Period; or (2) the date twelve (12) months following the date I first request such coverage. I also understand that, upon enrollment, I and/or my dependent(s) may be subject to a pre-existing condition limitation period.

Subscriber Signature \_\_\_\_\_ Date \_\_\_\_\_

Plans underwritten by Rocky Mountain HMO (RMHMO)	Plans underwritten by Rocky Mountain HealthCare Options (RMHCO)
C1, C3, C8, C15K, C1000, C5000, NC50 Family Options Good Health Savings Plans HDHP HMO Rocky Mountain Choice HMO Rocky Mountain Direct HMO RMHMO HMO Standard Health Benefit Plan for Colorado RMHMO HMO Basic Health Benefit Plan Without Specified Mandates for Colorado	Family Options Good Health Savings Plans HDHP PPO Indemnity Plans Rocky Mountain Choice PPO Rocky Mountain Direct EPO Rocky Mountain Direct PPO RMHCO PPO Standard Health Benefit Plan for Colorado RMHCO PPO Basic Health Benefit Plan Without Specified Mandates for Colorado

Colorado law requires carriers to make available a Colorado Health Plan Description Form, which is intended to facilitate comparison of health plans. The form must be provided automatically within three (3) business days to a potential policyholder who has expressed interest in a particular plan or who has selected the plan as a finalist from which the ultimate selection will be made. The carrier also must provide the form, upon oral or written request, within three (3) business days to any person who is interested in coverage under or who is covered by a health benefit plan of the carrier.

**An access plan is available for each managed care network offered by Rocky Mountain Health Plans to any interested party upon request. Such access plans contain information on providers, referral and grievance procedures, quality assurance, access for members with special needs, emergency coverage provisions, and other information on how to access services.**

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

**COLORADO INSURANCE LAW REQUIRES ALL CARRIERS IN THE SMALL GROUP MARKET TO ISSUE ANY HEALTH BENEFIT PLAN IT MARKETS IN COLORADO TO SMALL EMPLOYERS OF 2-50 EMPLOYEES, INCLUDING A BASIC OR STANDARD HEALTH BENEFIT PLAN, UPON THE REQUEST OF A SMALL EMPLOYER TO THE ENTIRE SMALL GROUP, REGARDLESS OF THE HEALTH STATUS OF ANY OF THE INDIVIDUALS IN THE GROUP. BUSINESS GROUPS OF ONE CANNOT BE REJECTED UNDER A BASIC OR STANDARD HEALTH BENEFIT PLAN DURING OPEN ENROLLMENT PERIODS AS SPECIFIED BY LAW.**

The pre-existing condition limitation period does not apply to the RMHMO HMO Basic Health Benefit Plan Without Specified Mandates for Colorado and the RMHMO HMO Standard Health Benefit Plan for Colorado. It also does not apply to pregnancy, a newly adopted child, or a child placed for adoption.

RMHP will impose a six-month pre-existing condition limitation period (12-month limitation period for Business Groups of One) for all new enrollees (not including late enrollees) who have a physical or mental condition for which medical advice, diagnosis, care, supplies, prescription drugs, or treatment was recommended or received within six months immediately preceding the date of their enrollment in an RMHP plan or the first day of any employer-imposed waiting period, whichever is earlier. The pre-existing condition limitation period will be reduced by the period of time that a new enrollee was covered by creditable coverage, provided the creditable coverage did not terminate more than 90 days before the earlier of the first day of the waiting period or the effective date of coverage under an RMHP plan.

RMHP will impose an 18-month pre-existing condition limitation period for all late enrollees who have a physical or mental condition for which medical advice, diagnosis, care, supplies, prescription drugs, or treatment was recommended or received within six months immediately preceding the date of their enrollment in an RMHP plan. This 18-month period shall also include a 12-month period of exclusion from coverage that is applicable to late enrollees. The pre-existing condition limitation period for late enrollees will be reduced by the period of time that the late enrollee was covered by creditable coverage, provided the creditable coverage did not terminate more than 90 days before the date of their enrollment under an RMHP plan.

For small employer groups, see the enclosed Disclosure Notice for Small Employer Groups, which is incorporated into this document by reference.