



Family Options Change Form

Subscriber Name: Last	First	MI	Social Security #:
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Employer:	Date of Birth: MM/DD/YY
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Dependent Add Information									
Add*	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#

*** Adding dependents not currently covered by RMHP on employer group plans with fewer than 51 employees requires a copy of certificate of creditable coverage provided by previous carrier. Otherwise, pre-existing condition limitations apply.**

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

Plan Change — Change coverage for my dependents listed above to: (check one) High Option Low Option

I understand that all of my enrolled dependents will enroll in this option.

Subscriber Signature: _____ Date: _____

Address Change: Street	City	State	Zip	Phone: Home ()	Phone: Work ()
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Stamp
Required

ATTN: MEMBER ENROLLMENT
Rocky Mountain Health Plans
P.O. Box 10600
Grand Junction, CO 81502-5600



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