ROCKY MOUNTAIN HEALTH PLANS®
Good health. That's the plan.

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

| RMHP USE ONLY |
|---|
| Plan |
| Group |
| Mail |
| Rec'd |
| Processed |

1C

# Disenrollment Form

*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 Coverage | Individual Coverage | Effective Date of Disenrollment |
|---|---|---|

## Please Complete for Disenrollment from Plan

Will you be uninsured after leaving RMHP? ☐ Yes ☐ No

Please cancel the coverage above for the following reasons:

- ☐ Unsatisfactory benefits (BN)
- ☐ Rates too high (VR)
- ☐ Unsatisfactory benefits/rates too high (BR)
- ☐ Loss of employment (JT)
- ☐ Reduction in hours (RH)
- ☐ Moving from plan service area (MT)
- ☐ Other (please indicate)
  - ☐ Could not get help when I called plan with questions or problems (AI)
  - ☐ My claims/bills were not paid (AI)
  - ☐ Did not realize that I joined this plan (still needed?)
  - ☐ Told by plan doctors or staff that I should disenroll (PR)
  - ☐ Prefer Original Medicare program (OM)
  - ☐ Found plan to be too confusing (TC)
- ☐ Death — requires a copy of the death certificate
- ☐ Quality of care (QT)
- ☐ PCP does not participate (NP)
- ☐ PCP problem (PI)
  - ☐ Had limited or no choice of specialist (CS)
  - ☐ Had limited or no choice of primary doctor (CP)
  - ☐ Treated discourteously by doctor/nurse/staff (DS)
  - ☐ Doctor couldn't improve my condition (DC)
- ☐ Provider Access (PA)
  - ☐ Difficulty reaching plan doctor by phone (DP)
  - ☐ Cannot travel to plan doctors because of poor health (TH)
  - ☐ Plan medical group was located too far away (GF)

Are you changing insurance carriers? ☐ Yes ☐ No If yes, please indicate:

- ☐ Changing to spouse's coverage
  - ☐ Individual coverage (IS) ☐ Group coverage (GS) ☐ Medicare
- ☐ New Carrier
  - ☐ Anthem BC/BS
  - ☐ CIGNA
  - ☐ Humana
  - ☐ PacificCare
  - ☐ Rocky Mountain Health Plans
  - ☐ Other: ____________________
- ☐ I am changing to:
  - ☐ Individual coverage (NI) ☐ Group (NG)
- ☐ New Carrier
  - ☐ Anthem BC/BS
  - ☐ CIGNA
  - ☐ Humana
  - ☐ PacificCare
  - ☐ Rocky Mountain Health Plans
  - ☐ 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.

***Your comments regarding the benefits and services provided by Rocky Mountain Health Plans are appreciated.***

1. Were you satisfied with the level of benefits covered by your plan? ☐ Very Satisfied ☐ Satisfied ☐ Dissatisfied
   Comments: ____________________
2. Were you satisfied with the level of service provided by RMHP? ☐ Very Satisfied ☐ Satisfied ☐ Dissatisfied
   Comments: ____________________
3. Would you enroll in another RMHP plan if an opportunity arose? ☐ Yes ☐ No
4. Is your employer paying for an individual policy for you? ☐ Yes ☐ No

***The undersigned individually and 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: (if applicable) ____________________ Date Signed: __________

**EMPLOYER: Please complete continuation of coverage authorization form on back if applicable**

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# Notice to Rocky Mountain Health Plans of Qualifying Event for Continuation of Coverage

***Complete this form using black ink only.***

## Employee Information

| Employee Name Last | First | MI | Date of Birth / / | Member #: |
|---|---|---|---|---|
| | | | | Social Security # – – |

| Employer Name | Address |
|---|---|
| | |

| City | State | Zip | Phone ( ) |
|---|---|---|---|
| | | | |

1. Type of qualifying event: Please check ONE only.
   - ☐ Termination of employment
   - ☐ Death of employee
   - ☐ Child — loss of dependent status (COBRA only)
   - ☐ Divorce or legal separation
   - ☐ Employee's eligibility for Medicare
   - ☐ Other
   - ☐ Reduction in hours (COBRA only)
   - ☐ Retirement
2. Date of qualifying event:______________________

***Names, social security numbers, and current addresses of all Rocky Mountain Health Plans members to be extended continuation of coverage.***

| Name | Employee Social Security # | Address | | | |
|---|---|---|---|---|---|
| | | Street | City | State | Zip |
| Employee | – – | | | | |
| Spouse | | | | | |
| Dependent | | | | | |
| Dependent | | | | | |
| Dependent | | | | | |
| Dependent | | | | | |

**Send this form to:**

Membership Enrollment
Rocky Mountain Health Plans
PO Box 10600
Grand Junction, CO 81502-5600

**Or fax to:**

Attn: Enrollment
970-263-5507