

SOLO Health Plan Application

Thank you for your interest in the SOLO plan, underwritten by Rocky Mountain HealthCare Options, Inc. (RMHCO). Please read every section carefully and be sure to complete all items. **Unanswered questions or incomplete/omitted information will result in the return of this application to you and will delay your enrollment in this health care plan.** The SOLO plan is medically underwritten. This means that health care coverage is not guaranteed. Applicants **must** complete a health questionnaire that will be considered before an application is accepted or rejected.

Applicants age 50 or older are required to submit with the initial application a current (within the past 12 months) medical history and physical examination record. The physical exam record must include any health screening tests (including mammogram, PAP, or PSA) or procedures and a lipid panel. Newborn infants who are at least two months of age and under six months of age will require medical records from the first and second well-child check along with immunization records. Costs associated with such services will be the responsibility of the applicant.

If you are age 65 or older or you have a disability and qualify for Medicare, this Individual Plan is not available to you. Call 800-346-4643 for information on Medicare benefit options.

If you have questions or need additional information as you complete this application, please call your broker or RMHP at 800-453-2981, option 4.

SOLO Select Plans

Select Plan Deductible Options		Maternity Rider	Brand Prescription Drug Rider* \$10/\$40/\$60
<input type="checkbox"/> SOLO \$500	AND	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> SOLO \$1,000		Not Available	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> SOLO \$1,500		Not Available	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> SOLO \$2,500		Not Available	<input type="checkbox"/> Yes <input type="checkbox"/> No

SOLO Smart Choice Plans

Smart Choice Coverage Options		Accident Rider	Brand Prescription Drug Rider* \$10/\$40/\$60
<input type="checkbox"/> SOLO \$2,800/80		<input type="checkbox"/> Yes <input type="checkbox"/> No	80% covered after deductible <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> SOLO \$2,800/100		<input type="checkbox"/> Yes <input type="checkbox"/> No	100% covered after deductible <input type="checkbox"/> Yes <input type="checkbox"/> No

SOLO Safety Net Plans

Safety Net Deductible Options	Brand Prescription Drug Rider* \$10/\$40/\$60
<input type="checkbox"/> SOLO \$5,000	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> SOLO \$10,000	<input type="checkbox"/> Yes <input type="checkbox"/> No

Tobacco Use
Have you or a family member living in your household used tobacco products in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, give person's name:

* Generic prescription drug coverage is included with the plan if the Brand Prescription Drug Rider is not selected.

APPLICATION MUST BE COMPLETED BY SUBSCRIBER/APPLICANT PRINT ALL INFORMATION CLEARLY IN BLUE OR BLACK INK

Subscriber: Last Name ¹	First Name	MI	Social Security Number ²			Home Phone ()
Address	City	State	County	Zip Code	Business Phone ()	
Date of Birth — Mo/Day/Year _____ Height _____ Weight _____ <input type="checkbox"/> M <input type="checkbox"/> F						
<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Legally separated <input type="checkbox"/> Common law marriage (statement will be required)						

PROVIDE ALL INFORMATION FOR EACH FAMILY MEMBER APPLYING FOR COVERAGE UNDER THIS PLAN.

Last Name	First Name	MI	HT	WT	Social Security Number ²	Sex M/F	Date of Birth Mo/Day/Yr	Relationship to Subscriber	RMHP USE
Spouse									
Dependent									
Dependent									
Dependent									
Dependent									

¹ If a dependent child is applying as an individual rather than as part of a family, list the child as the subscriber. If more than one dependent child is applying as an individual, complete an application for each child subscriber.

² Supply social security numbers if known. Missing numbers will be requested after enrollment.

Health Questionnaire

All questions must be answered completely for each person applying for coverage on this application or the application will be returned.

Any knowing misrepresentation as to the presence or severity of any health condition, impairment, or disease could result in retroactive termination of coverage. Any failure to notify RMHP of any medical condition, impairment, disease, or change in any applicant's health status that occurs or is diagnosed between the date of application and the later of the effective date of coverage or the date coverage is approved could also result in retroactive termination of coverage. RMHP shall have the right to request and review additional information regarding health history and any change in health status that occurs between the date of application and the effective date of coverage. This additional information may be used to determine if RMHP will accept or decline your application prior to the effective date of coverage. No notice of acceptance related to your application can bind RMHP to coverage until the effective date of coverage, and failure to provide additional requested information could result in your application not being accepted.

1. In the past five years, have you or any family member listed on this application ever had, been treated for, been diagnosed with, or had any indication of any of the following conditions, diseases, or disorders? **Mark EACH condition/disease/disorder either YES or NO.**

CONDITION/DISEASE/DISORDER	YES	NO
Abdominal /Bowel Problem (including colitis, diverticulosis, ulcers, regional enteritis, or hernias)		
Alcohol/Drug/Substance Abuse		
Arthritis, Rheumatoid/Osteoarthritis (Please specify type)		
Asthma/Bronchitis/Emphysema or Other Lung/Breathing Disorder (including sleep apnea, tuberculosis)		
Back/Spine/Bone Problems (including fractures, joint disease/injury, scoliosis/osteochondrosis/osteoporosis)		
Birth Abnormality/Defect/Congenital Problem		
Bleeding Disorder/Anemia		
Brain/Nervous System Disorder (including disabling headaches, epilepsy/seizures, paralysis, stroke, Multiple Sclerosis or Parkinson's Disease)		
Cancer/Malignant Condition (including leukemia, Hodgkin's Disease)		
Cardiovascular/Heart Disorder (including chest pain, heart attack/murmur, valve problems, hypertension, elevated cholesterol)		
Cataract or Other Eye Disorders		
Chronic Fatigue Syndrome/Fibromyalgia		
Diabetes or high blood sugar		
HIV/AIDS Virus (including positive test result for the HIV/AIDS virus)		
Kidney/Bladder/Urinary Disorder (including stones, tumor, renal failure, dialysis, prostate problem)		
Liver/Pancreas Disorder (including pancreatitis, cirrhosis, hepatitis)		
Male/Female Genital/Reproductive Disorders (including STDs, infertility)		
Mental Disorders (including anxiety, attention deficit, depression, eating disorders, paranoia, or schizophrenia)		
Organ Transplant Recipient or on Waiting List for Transplant		
Skin Disorder (including rash, lesions, Lupus)		
Varicose Veins		

2. Have you or any family member listed on this application received advice for, been diagnosed with, or been treated for any condition(s), disease(s), or disorder(s) not listed in Question #1? Yes No (If yes, explain disease, condition, or disorder.)

Person's name: _____

If you answered yes to any of the conditions, diseases, or disorders in Question #1, complete the chart below. Add and label another page if necessary.

FamilyMember	Condition/Disease/Disorder	Date of Last Treatment	Date of Last Hospitalization	Doctor's Name and Address

3. Are you or any family member listed on this application planning any hospitalization or medical/surgical treatment in the next 12 months? Yes No (If yes, please explain.) Person's name: _____

4. Have you or any family member listed on this application been advised to have medical or surgical treatment that has not yet been performed?
 Yes No (If yes, please explain.) Person's name: _____
-
5. Have you, your spouse, or any dependents listed on this application incurred medical/surgical and/or hospital expenses of \$5,000 or more within the last 12 months? Yes No (If yes, please explain.) Person's name: _____
6. Have you or any family member listed on this application seen a provider for **any** reason in the past 12 months (**including physical, mammogram, Pap smear, and prostate screening**)?
 Yes No If yes, complete the chart below. Add and label another page if necessary.

Family Member	Reason for Treatment	Date of Last Treatment	Doctor's Name and Address

7. Have you or any family member listed on this application taken any prescription medications in the last 12 months?
 Yes No If yes, complete the chart below. Add and label another page if necessary.

Family Member	Medication Name	Quantity/ Dosage Taken	Prescribing Physician	Illness for Which Medication Prescribed	Date Prescription Last Received

8. In the chart below, list all surgical procedures, operations, and hospitalizations within the last five years for you or any family member listed on this application. If none, check here: None

Family Member	Operation/Procedure	Date	Reason for Operation/Procedure	Surgeon and Hospital Name and Address

9. Do you or any family member drink alcohol? Yes No
 If yes, person's name: _____ How much daily? _____ How much weekly? _____

10. At this time, is any family member pregnant (**whether or not applying for coverage**)?
 Yes If yes, give person's name and relationship to subscriber: _____
 No **If no, give person's name and date of her last menstrual period:**
 Name: _____ Month _____ Day _____ Year _____
 Name: _____ Month _____ Day _____ Year _____
 If any member's initial menstrual cycle has not yet begun, give her name: _____
11. Are you in the process of adopting? Yes No
12. Have you or any female listed on this application ever had any abnormality of the female organs, abnormal menstrual periods, or any unexplained vaginal bleeding? Yes No If yes, explain: _____
 Name: _____
13. Have you or any family member listed on this application ever had an
 abnormal Pap smear? Yes No
 abnormal mammogram? Yes No
 abnormal PSA? Yes No
 If yes, explain: _____
 Name: _____
14. Please disclose your and/or your spouse's occupation and type of work you and/or your spouse do:

15. Please disclose all hobbies all applicants participate in:

16. Have you or any family member listed on this application had a weight change during the past year? Yes No If yes, give people's names:
 Increased by 10 lbs. or more: _____
 Decreased by 10 lbs. or more: _____
 Reason for each person's weight change: _____
17. If any family member listed on the application is six months of age or younger, fill in below and **submit medical records from date of birth to present (including records from the 1st and 2nd well-child check and immunization records).**
 Birth weight: _____ lbs. _____ oz.
 Current weight: _____ lbs. _____ oz.
 Date of last well-baby check: _____
 As a newborn: a) was the baby kept in an incubator? Yes No
 b) did the baby require oxygen? Yes No
18. Have all applicants under the age of 18 years had all recommended immunizations? Yes No
 If no, list person's name: _____

Qualification for Coverage Through CoverColorado

Have you ended a COBRA or State Continuation of Benefit Plan within the past 62 days in which you have **exhausted ALL** eligible coverage (18 months or 36 months)? Yes No

If you answered "YES," you may qualify for health coverage with no medical screening through CoverColorado*. For information about CoverColorado benefits, exclusions, enrollment, and premium subsidies, contact CoverColorado at:

425 S. Cherry St., Suite 160
Glendale, CO 80246
303-863-1960
www.covercolorado.org

**You do not qualify if (a) you are eligible for a group health benefit plan, Medicare, Medicaid, or have other health benefit plan coverage; (b) your most recent coverage was terminated as a result of nonpayment of premiums or fraud; or (c) you turned down an offer of continuation coverage or did not exhaust such coverage.*

Determining if This Is an Employer-Sponsored Plan

Rocky Mountain Health Plans does not market or sell individual plans to eligible employees of an employer-sponsored plan or to self-employed Business Groups of One. An individual plan is available to noneligible employees and all dependents in an employer-sponsored plan.

Answer the following questions so RMHP can determine if you are eligible for individual medical coverage or if, due to the premium arrangement for the coverage, you are subject to the Colorado small employer group health insurance reform laws.

I pay the **ENTIRE** premium for the coverage out of my own **PERSONAL** funds. Yes No

My employer or my business will be paying **ALL OR A PORTION** of the benefit or premium for coverage. Yes No

My employer or my business will be reimbursing me or any of my dependents for **ALL OR A PORTION** of the premium through wage adjustment or any other way. Yes No

ALL OR ANY PORTION of the premium for the coverage will be deducted from my salary/wages. Yes No

My employer or I will take a tax deduction for the premiums for this coverage. Yes No

If YES, is the premium paid through a Section 125 (cafeteria) plan? Yes No

If YES, my employer:

a) will contribute to the cafeteria plan, OR Yes No

b) will pay for **ALL OR ANY PORTION** of the premium, OR Yes No

c) has other health coverage for employees Yes No

I, _____, certify that the answers to these questions are true and correct.

Printed Name of Applicant

Signature of Applicant

X _____

Date _____

If you are a Business Group of One (BG1), you may apply for a BG1 Plan. A BG1 is a sole proprietor, single full-time employee of a business, or a household employee who works at least 24 hours a week on a permanent basis and who has carried on significant business activity for a period of at least one year prior to application, which generated enough gross income to pay the annual premium and that provided at least a substantial part of such individual's income for one year out of the most recent consecutive 3-year period.

If you: 1) are self-employed, 2) believe you may be a BG1, and 3) intend this plan to be an employer-sponsored plan, you cannot file this application, and you must contact RMHP for an application for a BG1 plan.

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.

**If you've had insurance coverage before,
you must provide the information asked for in this chart.**

List Each Family Member	Name, Address, and Telephone Number of Health Plan or Insurance Company	Effective Date of Coverage	RMHP USE
Policyholder's Name: Policy #: Group Name: S.S. Number:		From: To:	
Policyholder's Name: Policy #: Group Name: S.S. Number:		From: To:	
Policyholder's Name: Policy #: Group Name: S.S. Number:		From: To:	
Policyholder's Name: Policy #: Group Name: S.S. Number:		From: To:	
Policyholder's Name: Policy #: Group Name: S.S. Number:		From: To:	

Pre-Existing Condition Limitation Period

A pre-existing condition is an injury, sickness, or pregnancy for which the Member has, during the 12 consecutive months immediately preceding the Member's effective date of coverage under the plan applicable, either: (a) incurred charges, (b) received medical treatment, (c) consulted a health care professional, or (d) taken prescription drugs. Rocky Mountain Health Plans will not pay for services related to a preexisting condition for 12 consecutive months after the Member's original membership Effective Date. (This is the pre-existing condition limitation period.)

Upon approval of your application, the length of the Pre-Existing Condition Limitation Period will be reduced or eliminated for you and each family member who has creditable coverage. The creditable coverage must have ended within 90 days prior to your enrollment in RMHP. Creditable coverage includes health care coverage provided under: (a) Medicare or Medicaid; (b) an employee welfare benefit plan, group health insurance, or group health benefit plan; (c) an individual health benefit plan; or (d) a state health benefits risk pool (including but not limited to the Cover Colorado Uninsurable Health Insurance Plan and CHP+).

Such creditable coverage reduces the Pre-Existing Condition Limitation Period by one day for each day of creditable coverage. For example: If you had creditable coverage for three months before enrolling in the SOLO plan and such creditable coverage ended less than 90 days prior to your enrollment date, then your Pre-Existing Condition Limitation Period will be reduced from 12 months to nine months. If the creditable coverage ended more than 90 days prior to your enrollment date, then the full 12-month Pre-Existing Condition Limitation Period will apply.

The insurance company or health plan that provided your previous health care coverage should have given you a certificate stating that you had creditable coverage and specifying the time period of such creditable coverage. If you are still covered under another health care plan or you do not have a certificate evidencing your prior creditable coverage, you can ask RMHP to help you obtain proof of creditable coverage. Contact RMHP at 970-244-7800 or 800-453-2981, option 4.

Complete the chart above for yourself and each family member listed on this application. List all current health care coverage policies and/or all previous health care coverage policies in effect during the last 12 months. Add and label additional pages if necessary. **You must include proof of creditable coverage for every family member listed on this application who has had health care coverage within the last 12 months.**

Please Tell Us How You Heard About Us

- Family member
 Broker
 Friend
 Newspaper/radio
 Health plan member
 Website
 Other _____

For RMHP USE

Signature and Certification

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

1. We offer to enter into the health care plan contract for the plan designated in this enrollment application. Upon receipt of all information required for enrollment, approval thereof by Rocky Mountain Health Plans (RMHP) and receipt of the first premium, we shall have a contract with RMHP, the terms of which are set forth in the applicable contract, which contract may be amended from time to time by RMHP in accordance with applicable law.
2. We 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 RMHP such records and information and supplement such records and information as RMHP requests. This authorization shall include all medical records and medical information. Such records and information may be used by RMHP or made available by RMHP to others for treatment, payment, or health care operations purposes, including but not limited to any quality assurance programs conducted by RMHP or its designated agents or contractors. A copy of this authorization shall be as valid as the original until contract is terminated.
3. We consent to RMHP performing case management.
4. The contract contains provisions for the arbitration of disagreements and disputes. We agree to arbitrate such disagreements and disputes as set forth in the applicable contract.
5. RMHP has the right to terminate coverage and deny benefits if any information on this enrollment application, or as otherwise provided by the undersigned to RMHP for enrollment purposes, is knowingly false, incomplete, or misleading in any material respect. RMHP has the right to deny coverage if any outstanding premiums or other payments are owed to RMHP by the undersigned.
6. All information and answers provided in this application are true and correct.
7. The enrollment process will not be completed and coverage will not be effective until a Certificate of Creditable Coverage (if applying for a guaranteed issue plan) for each family member is received by RMHP.
8. Any fraud or intentional misrepresentation as to the presence of any health condition, impairment, disease, or disorder will result in retroactive termination of coverage. As a result, RMHP will not be responsible for payment of any claims for services received up to and including the date of retroactive termination of coverage. RMHP shall have the right to request and review additional information regarding health history. RMHP retains the right to accept or deny an application until the effective date of coverage, regardless of any prior notice of acceptance or receipt of premium. Any additional information regarding your health history or change in health status that occurs between the date of application and the later of the effective date of coverage or the date a coverage decision is made may be used to determine if RMHP will accept or decline your application, or revoke a prior notice of acceptance related to your application. No notice of acceptance related to your application can bind RMHP to coverage until the effective date of coverage.
9. We understand that the policy applied for will not pay for services unless they are medically necessary as determined by RMHP.
10. We understand that a plan change request must be made 31 days prior to my anniversary to be effective on my anniversary date, subject to medical underwriting.
11. We further understand that the policy applied for will not pay benefits for any loss incurred during the first 12 months after the issue date because of any pre-existing condition unless superceded by a Certificate of Creditable Coverage as described herein.
12. We understand that any information regarding this application may be shared with our broker, if applicable.

The above provisions will remain in effect for the entire duration of RMHP membership of the undersigned and the undersigned's dependents.

We acknowledge that we have read this application and that the foregoing answers are true, and we certify that we understand and agree to all matters covered in the application.

APPLICANT/SUBSCRIBER'S SIGNATURE

(If signing for minor, so indicate.)

Date _____

SIGNATURE OF SPOUSE APPLICANT (If applying for family membership)

Date _____

— BROKER COMPLETE — PLEASE PRINT CLEARLY —

Broker/Agent MUST complete the following for application processing:

Broker Name: _____ Address: _____

Broker License #: _____ Broker Agency: _____

Broker Fax #: _____ Broker Phone #: _____

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, hospitals, 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.