

## SOLO Billing Change For Individual/Family Plans

Please print. Be sure to complete all information. Unanswered questions or omitted information will result in the return of this form and delay the change you want.

Section 1						
Subscriber: Last Name	First Name:	MI	Date of Birth: / /	Social Security Number:		Home Phone  (   )
				Member ID#:		
Address		City		State	County	Zip Code  Business Phone (   )
Effective Date of Change:						
Section 2						
Payment Authorization Section						
Choose one of the following payment methods: <b>Monthly</b> — <input type="checkbox"/> Bank Draft (complete authorization below) <b>Quarterly</b> (every three months) — <input type="checkbox"/> Bank Draft (complete authorization below) <input type="checkbox"/> Invoice Via Mail  <b>Authorization for Automatic Withdrawal</b> I hereby authorize Rocky Mountain HealthCare Options, Inc., to initiate debit entries to the account indicated below, and I hereby authorize the depository (DEPOSITORY) named below to debit the same account.  This authority is to remain in full force and effect until RMHCO and DEPOSITORY have received written notification from me of termination in such time and in such manner as to afford RMHCO and DEPOSITORY a reasonable opportunity to act on it. If RMHCO does not receive written notification from me of termination of authority prior to the first day of the month, such termination shall not be effective until the last day of that month. I understand that this information will become part of the application and the policy.  <b>Premiums are due on the 1st day of the month. Drafts on payor's account will be made on approximately the 4th day of the month in which coverage will be in effect. RMHCO reserves the right to cancel any policy for which RMHCO receives a nonpayment notice from the depository. This shall be considered a failure to pay premiums. Any changes to your account must be received in writing no later than the 25th day of the prior month.</b>						

### Account Deduction Authorization

I, \_\_\_\_\_, authorize the monthly deduction of  
 \_\_\_\_\_  
 (Print Name)  
 Rocky Mountain Health Plans premiums from my account \_\_\_\_\_  
 \_\_\_\_\_  
 (Account Number)  
 at \_\_\_\_\_  
 \_\_\_\_\_  
 (Bank Name) \_\_\_\_\_  
 (Routing Number)  
 for \_\_\_\_\_  
 \_\_\_\_\_  
 (Subscriber name, if different)

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

**Fax to:**  
**Attn: Billing**  
**970-244-7769**

Colorado law requires carriers to make available a Colorado Health Benefit 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.**