



## SOLO Individual Disenrollment Form

All covered family members will be disenrolled from the plan. To retain coverage for a covered family member, use the SOLO Change 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
Please Complete for Disenrollment from Plan					
Requested termination date: _____					
RMHP must receive this form prior to the requested termination date. Retroactive terminations are not permitted.					
Will you be uninsured after leaving RMHP? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Please cancel the coverage above for the following reasons:					
<input type="checkbox"/> Unsatisfactory benefits (BN) <input type="checkbox"/> Rates too high (VR) <input type="checkbox"/> Unsatisfactory benefits/rates too high (BR) <input type="checkbox"/> Loss of employment (JT) <input type="checkbox"/> Reduction in hours (RH) <input type="checkbox"/> Moving from plan service area (MT) <input type="checkbox"/> Other (please indicate) <input type="checkbox"/> Could not get help when I called plan with questions or problems (AI) <input type="checkbox"/> My claims/bills were not paid (AI) <input type="checkbox"/> Did not realize that I joined this plan (still needed?) <input type="checkbox"/> Told by plan doctors or staff that I should disenroll (PR) <input type="checkbox"/> Prefer Original Medicare program (OM) <input type="checkbox"/> Found plan to be too confusing (TC)			<input type="checkbox"/> Death — requires a copy of the death certificate <input type="checkbox"/> Quality of care (QT) <input type="checkbox"/> PCP does not participate (NP) <input type="checkbox"/> PCP problem (PI) <input type="checkbox"/> Had limited or no choice of specialist (CS) <input type="checkbox"/> Had limited or no choice of primary doctor (CP) <input type="checkbox"/> Treated discourteously by doctor/nurse/staff (DS) <input type="checkbox"/> Doctor couldn't improve my condition (DC) <input type="checkbox"/> Provider Access (PA) <input type="checkbox"/> Difficulty reaching plan doctor by phone (DP) <input type="checkbox"/> Cannot travel to plan doctors because of poor health (TH) <input type="checkbox"/> Plan medical group was located too far away (GF)		
Are you changing insurance carriers? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please indicate:					
<input type="checkbox"/> Changing to spouse's coverage <input type="checkbox"/> Individual coverage (IS) <input type="checkbox"/> Group coverage (GS) <input type="checkbox"/> Medicare  <input type="checkbox"/> I am changing to: <input type="checkbox"/> Individual coverage (NI) <input type="checkbox"/> Group (NG)			<input type="checkbox"/> New Carrier <input type="checkbox"/> Anthem BC/BS <input type="checkbox"/> Aetna <input type="checkbox"/> CIGNA <input type="checkbox"/> UnitedHealthcare <input type="checkbox"/> Rocky Mountain Health Plans <input type="checkbox"/> Other: _____		
<b>The undersigned individually and on behalf of the undersigned's dependents agrees as follows:</b>					
I agree that the above information is true, and I authorize Rocky Mountain Health Plans to make the above change.					
Subscriber Signature: _____				Date Signed: _____	

**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