ROCKY MOUNTAIN HEALTH PLANS®
We understand Colorado. We understand you.

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

1B

SOLO Change Form

Note: Please complete a SOLO Billing Change Form if you want to change your premium payment option.

Complete this form using black ink only.

Fax completed form to 970-244-7992

Section 1

Subscriber Name: Last Name	First Name	MI	Date of Birth / /	Home Phone ( )
Social Security Number:			Member ID#:	

Reason for the change:
- ☐ Name / Address Change — Complete Section 2
- ☐ Death ☐ Medicare eligibility ☐ Other, explain:__________— Complete Section 3
- ☐ Divorce — Complete Section 3 or 4 as appropriate
- ☐ Dependent Term — Complete Section 5
- ☐ Dependent Add* — Complete Section 6

*If your dependent(s) is already covered on a SOLO health plan that is the same plan design as your plan, you may use this form to get all family members together under one policy. If your dependent is ***not*** currently covered on a SOLO health plan, please complete the SOLO Health Plan Application.

Section 2 — Name Change / Address Change

Complete this section if someone on the policy changes his/her name or if your address has changed

Address Change: Street	City	State	Zip	Phone: Home ( )	Phone: Work ( )
Name change from:		To:			

Section 3 — Subscriber Change

Complete this section to terminate coverage of the current subscriber and make another covered family member the subscriber. If only children remain on the plan, each child will be the subscriber on his/her own policy and the premium will change to child-only rates.

Change to Subscriber: Last Name	First Name	MI	Date of Birth / /	Social Security Number	Home Phone ( )

The change will be effective the first of the month following receipt by RMHP.

Please list all dependents continuing coverage through the new subscriber:

Last Name	First Name	MI	Date of Birth / /	Sex M/F	Social Security Number		Relationship to Subscriber	RMHP USE
Dependent								
Dependent								
Dependent								

Section 4 — Policy Split

Complete this section if the subscriber and covered spouse are legally separated or divorced and both want to keep the coverage. **Please also complete a SOLO Billing Change form to set up your premium payment.** The change will be effective the first of the month following receipt by RMHP.

Subscriber 1: Last Name	First Name	MI	Date of Birth / /	Social Security Number			Home Phone ( )
Address	City			State	Zip Code	County	Business Phone ( )

Effective date of change:

Please list all dependents continuing coverage with this subscriber:

Last Name	First Name	MI	Date of Birth / /	Sex M/F	Social Security Number		Relationship to Subscriber	RMHP USE
Dependent								
Dependent								
Dependent								

Subscriber 2: Last Name	First Name	MI	Date of Birth / /	Social Security Number			Home Phone ( )
Address	City			State	Zip Code	County	Business Phone ( )

Please list all dependents continuing coverage with this subscriber:

Last Name	First Name	MI	Date of Birth / /	Sex M/F	Social Security Number		Relationship to Subscriber	RMHP USE
Dependent								
Dependent								
Dependent								

Section 5 — Dependent Term

Last Name	First Name	MI	Date of Birth / /	Sex M/F	Social Security Number		Relationship to Subscriber	RMHP USE
Dependent								
Dependent								
Dependent								
Effective date of termination:								

Section 6 — Dependent Add

Complete this section to add dependents who are already covered on a SOLO Health Care Plan to combine all family members under the same policy or to add a child who was born or adopted within the past 31 days. The new premium rate will be based on the rating period in effect for the subscriber's policy.

Last Name	First Name	MI	Date of Birth / /	Sex M/F	Social Security Number		Relationship to Subscriber	RMHP USE
Dependent								
Dependent								
Dependent								
Effective date of add:								

Section 7

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

1. I agree that enrollment, eligibility, coverage, and benefits in my health plan are subject to applicable policies and requirements and to all terms of the applicable contract for my health plan.
2. **Termination by a subscriber or other dependent member is effective the first day of the next month following the effective date of the notice of termination, unless the subscriber requests a different date and such different date of termination is accepted by RMHCO/RMHMO.**

For subscriber changes:

1. The current subscriber wishes to terminate enrollment in the RMHCO/RMHMO plan under which she/he is enrolled. By signing below, the current subscriber is providing notice of termination.
2. The undersigned new subscriber is presently enrolled as a dependent under the current subscriber's RMHCO/RMHMO health plan.
3. The current subscriber and new subscriber wish to retain enrollment under the current subscriber's RMHCO/RMHMO health plan for dependent(s) already enrolled in such plan.
4. The new subscriber will replace the current subscriber in the health plan contract with RMHCO/RMHMO, the terms of which contract are set forth in the applicable contract, which may be amended from time to time by RMHCO/RMHMO in accordance with applicable law.
5. The new subscriber assumes all duties and obligations under the health plan contract previously entered into by the current subscriber and which is presently in effect.
6. If the dependent who is to become the new subscriber under the plan is a minor, the person signing below for the minor dependent also agrees to be bound to the terms of this Subscriber Change Form and the applicable health plan contract, and further warrants that they have legal authority to enter this contract on behalf of the minor dependent.

WE ACKNOWLEGE AND CERTIFY THAT WE HAVE READ THIS SOLO CHANGE FORM AND THAT THE FOREGOING INFORMATION IS TRUE, AND WE UNDERSTAND AND AGREE TO ALL MATTERS COVERED IN THIS FORM.

New Subscriber Signature:	**Date:**
Current Subscriber Signature:	**Date:**

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.