



**ROCKY MOUNTAIN
HEALTH PLANS®**

We understand Colorado. We understand you.

2775 Crossroads Blvd.
PO Box 10600
Grand Junction, CO 81502-5600



OPTIONAL VISION BENEFIT ENROLLMENT & STATUS CHANGE FORM

(RMHP Medicare Members do not need to enroll in the Discount Vision Program.)

Be sure form is completed in full for accurate enrollment

Please contact Rocky Mountain Health Plans if you need information in another format (Braille or Large Print)

ENROLLEE INFORMATION (one form must be completed per person)		
Group Name: Rocky Mountain Health Plans	Effective Date (mm/dd/yyyy) / /	
Last Name:	First Name:	
Medicare Number: ____ - ____ - _____	Phone: ()	
Home Address:		
City:	State:	Zip Code:
PLAN SELECTION		
Plan: <input type="checkbox"/> Yes, I choose to elect coverage in the Optional Vision Benefit for \$12.00 per month.		
REASON FOR SUBMISSION (CHECK ONE)		
Enrollment: <input type="checkbox"/> New Enrollment <input type="checkbox"/> Cancel Coverage	Change Type: <input type="checkbox"/> Change Name <input type="checkbox"/> Change Address From _____ From _____ To _____ To _____	
_____ Signature of Subscriber		_____ Date