Rocky Mountain Health Plans
Individual Application

Please complete using black ink only. We cannot process incomplete forms.

Thank you for choosing Rocky Mountain Health Plans (RMHP) for your health care coverage. Here are some tips for completing the application.

- In the chart below:
  - **Select your plan choice by checking the box.**
  - Note there can be only one plan selection per family.

- RMHP offers all our Medical plans with a pediatric dental option. You can elect a medical plan with pediatric dental and it will apply to all family members. You can also elect to purchase a stand-alone pediatric dental plan for your children through Connect for Health Colorado.

- You will also need to:
  - **Complete the payment authorization** on the back of this form.
  - **Complete the Colorado Uniform Individual Application** for Major Medical Health Benefit Plans (attached).

- To ensure your enrollment is processed for your requested effective date, make sure all questions are answered and all information is complete.

Select one plan below:

Rocky Mountain View Individual and Family Plan Options			
☐ Gold $500/$35	☐ Silver $1500/$40 ☐ Silver $2500/$40 ☐ Silver $3000/$40 ☐ Silver HSA $2500/100%	☐ Bronze $4500/$55 ☐ Bronze $5500/$60 ☐ Bronze HSA $6300/100%	☐ PPO $6350/100%

Include Pediatric Dental? ☐ Yes ☐ No

I authorize the above plan selection.

_____ _____

Signature **Date**

To receive a personalized quote, help completing your application,
or to answer any questions, please contact our Individual Sales Team at:
Phone# 800-453-2981, option 4

Email: individualsales@rmhp.org

Individual Health Care Plan Billing Information

Payment Authorization

Choose one of the following monthly payment methods:

☐ **Bank Draft** (complete authorization below)
☐ **Credit Card (**complete authorization below)

Authorization for Automatic Withdrawal

I hereby authorize Rocky Mountain Health Plans (RMHP), to initiate debit entries to the account indicated below, and I hereby authorize the depository (DEPOSITORY) named below to debit the same account.

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. Rocky Mountain Health Plans (RMHP) reserves the right to cancel any policy for which RMHP 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.

Bank Draft Authorization

I, _____, authorize the monthly deduction of
(Print Name)

RMHP premiums from my account _____
(Account Number)

at _____ _____
(Bank Name) (Routing Number)

for _____.
(Subscriber name, if different)

☐ Checking ☐ Savings

RMHP has the authority to draft funds from my bank account. This authority will remain in effect until I change or cancel it in writing and will comply with all U.S. laws that apply. If I decide to terminate RMHP's authority to draft my premium, I understand I must send written notice to RMHP at least 10 days before the date of termination. Written notice can be an e-mail to billingreps@rmhp.org or mailed to Rocky Mountain Health Plans, PO Box 10600, Grand Junction, CO 81502. I understand my monthly premium may be billed from my bank account if 10 days prior notice is not given. RMHP is not responsible for bank fees that occur due to late notification. I understand this statement will become part of my policy if I am issued one.

Signature_____ Date _____

Credit Card Authorization

Member Name: _____

Name of Account Holder (if different from member name):_____

CREDIT CARD: ☐ VISA ☐ DISCOVER ☐ MASTERCARD

Credit Card Number: _____ Expiration Date: Mo. _____ Yr. _____

_____ Date: _____
Signature of Account Holder

Division of Insurance

COLORADO UNIFORM INDIVIDUAL APPLICATION FOR MAJOR MEDICAL HEALTH BENEFIT PLANS

This form is designed for an individual's initial application for coverage. Please contact your carrier with questions regarding this form.

Federal financial assistance may be available for coverage purchased through Connect for Health Colorado. If purchasing coverage through Connect for Health Colorado, you will need to provide additional information for determination of eligibility for federal financial assistance. Further information may be found at www.connectforhealthco.com.

COVERAGE INFORMATION

Application Type:	☐ New Coverage ☐ Change/Modification to Existing Coverage ☐ Open Enrollment ☐ Special Enrollment*
Requested Effective Date:	_____/_____/_____ (MM/DD/YYYY)

* Proof of eligibility for special enrollment will be required – information on eligibility for special enrollment periods is available at: www.dora.colorado.gov/DOI/HealthApp

PRIMARY APPLICANT/INSURED INFORMATION

Instructions: Please type or print using black or blue ink. Please fill out the entire application for each person for whom coverage is being sought. If a person is currently enrolled in Medicare, this application should not be completed for that enrolled individual. If additional pages are needed to fully complete this application please attach, sign, and date each page.

First Name:		Middle Initial:		Last Name:	
Social Security #:		Date of Birth:	/ /	Current Age:	Sex: ☐ M F ☐
Physical Address:				City:	
County:		State:		Zip:	
Mailing Address (If different):				City:	
County:		State:		Zip:	
Home Phone:		Alternate Phone:		Email:	

Are you (check one): ☐ Single ☐ Married ☐ Common Law* ☐ Civil Union* ☐ Legally Separated ☐ Divorced ☐ Under 21

Are you or is anyone in your family American Indian or Alaskan Native? ☐ Yes ☐ No

* A common law, civil union, or designated beneficiary certification may be required by the carrier

Employer Name and Address:		Work Phone:	

ADDITIONAL APPLICANTS

Complete ONLY if your spouse/partner, and/or child(ren) under the age of 26(older if medically disabled) are applying for coverage. If a dependent child is applying an as individual rather than as part of a family list the child as the primary applicant. If there is not enough space provided, please attach additional family information. **Please sign and date the additional sheet.**

*Social Security Numbers (or document numbers for any legal immigrants) are needed for anyone applying for health insurance, missing numbers will be requested after enrollment

Name (First, MI, Last)	Sex	Social Security #	Relationship	Disabled	Birth Date (MM/DD/YY)	Employer Name and Position
	☐ M ☐ F		SPOUSE/PARTNER			
	☐ M ☐ F		☐ CHILD ☐ STEPCHILD	☐ Yes ☐ No		
	☐ M ☐ F		☐ CHILD ☐ STEPCHILD	☐ Yes ☐ No		
	☐ M ☐ F		☐ CHILD ☐ STEPCHILD	☐ Yes ☐ No		

Do(es) the child(ren) named within the application live with you at the same physical address shown above? ☐ Yes ☐ No (if no, complete below)

Child(ren)'s Name:			Mailing Address (If different):				
City:		County:		State:		Zip:	
Home Phone:		Alternate Phone:		Email:			

Primary Applicant Name:

Name of the Legal Guardian or Parent responsible for carrying health insurance for the child:							
If the primary applicant is under the age of 21 if different from above, provide the name and mailing address of the legal guardian or custodial parent:							
Legal Guardian or Custodial Parent's Name:		Mailing Address (If different):					
City:		County:		State:		Zip:	
Home Phone:		Alternate Phone:		Email:			

TOBACCO USE

Please answer the following questions to the best of your knowledge. 45 CFR 147.102(a)(1)(iv) "For purposes of this section, tobacco use means use of tobacco on average four or more times per week within no longer than the past 6 months. This includes all tobacco products, except that tobacco use does not include religious or ceremonial use of tobacco. Further, tobacco use must be defined in terms of when a tobacco product was last used."

Has anyone named in this application used tobacco or smokeless tobacco during the past 6 months? If yes, provide the information requested below.

Name of Person	Used Tobacco Products	If Yes, check all that apply	Duration	Frequency
	☐ Yes ☐ No	☐ Cigarettes ☐ Chewing Tobacco ☐ Pipe/Cigars		
	☐ Yes ☐ No	☐ Cigarettes ☐ Chewing Tobacco ☐ Pipe/Cigars		
	☐ Yes ☐ No	☐ Cigarettes ☐ Chewing Tobacco ☐ Pipe/Cigars		
	☐ Yes ☐ No	☐ Cigarettes ☐ Chewing Tobacco ☐ Pipe/Cigars		

MEDICARE/MEDICAID INFORMATION

Is any applicant enrolled in Medicare? ☐Yes ☐No

Name of person covered by Medicare: _____. For this applicant, please stop here, this insurance may duplicate existing Medicare coverage.

Is any applicant enrolled in Medicaid, CHIP+, or other governmental health program? ☐Yes ☐No

Name of person covered by Medicaid or other governmental health program: _____. For this applicant, please be aware that obtaining individual health insurance may affect this individual's Medicaid status.

CURRENT MEDICAL COVERAGE

Do you, your spouse/partner, or your dependent child(ren) listed in this application currently have health insurance? ☐Yes ☐No

(Dental Coverage in next Section)

Name	Carrier Name	Effective Date of Coverage (MM/DD/YY)	Termination Date of Coverage (MM/DD/YY)	Coverage Type

If any applicant has current health coverage, will that applicant cancel current coverage if this applicant is accepted? ☐ Yes ☐ No

Type of Coverage Key: **G** = Group Comprehensive Major Medical; **I** = Individual Comprehensive Major Medical; **MS** = Medicare Supplement; **H** = Hospital Coverage Only; **V** = Vision Coverage Only **O**=Other, please explain:_____

Primary Applicant Name:

CERTIFICATION OF DENTAL INSURANCE COVERAGE (Certification of dental insurance coverage is not required when purchasing coverage through Connect for Health Colorado)	
Pediatric dental coverage is a required essential health benefit. The plan you select may not include pediatric dental coverage. Do you have pediatric dental coverage under another plan?	☐ Yes ☐ No Note: you may be required to provide proof that you have obtained coverage before this policy will be approved

TERMS AND CONDITIONS

I acknowledge that I have read all sections of this Application, and I certify on behalf of my eligible family dependents and myself that the answers contained in this Application are complete and accurate to the best of my knowledge.

I understand that my answers, together with any supplements or additional pages, are the basis for the certificate or policy that is issued. I agree that no insurance will be effective until the date specified by the carrier on the certificate or policy.

I understand that my signature constitutes an attestation that I have obtained the required pediatric dental coverage under a separate policy, and may be required to provide proof of this pediatric dental policy prior to this policy being issued and approved. (Certification of dental insurance coverage is not required when purchasing coverage through Connect for Health Colorado)

I understand that any intentional misrepresentation relied upon by the carrier may be used to deny a claim. I further understand that this contract can be voided if, within the first 24 months from the date of the policy or certificate, it is determined that I or a family member made an intentional misrepresentation in this application.

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance carrier for the purpose of defrauding or attempting to defraud the carrier. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance carrier or agent of an insurance carrier 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.

I understand that I may request a copy of this Application. I agree that a photographic copy of this Application shall be as valid as the original. A legible facsimile signature shall have the same force and effectiveness as the original. This document, or the information contained herein, will become a part of the contract when coverage is approved and issued.

I would like to receive all policy notices, premium notices, and other notices relating to this policy through the supplied email address above. ☐Yes ☐No

I understand I can change this designation at a later date by contacting my carrier directly, and understand it is my responsibility to notify my carrier of any changes to my email address.

Signature of Primary Applicant/Parent or Legal Guardian for Child-Only Plans	Date Signed:

Complete this section if someone assisted you in the completion of this Application	
The following person assisted me in completing the Application:	Please explain the assistant's relationship to you and your family:

Primary Applicant Name:

AGENT/PRODUCER INFORMATION	
This section is to be completed by Agent or Producer.	
Agent / Agency of Record: (for commissions and correspondence)	Writing Agent / Producer:
Name (print): ColoradoHealth.com, Inc.	Name (print):
Agent ID # (NPR): 841485637	Agent ID #(NPR):
Agent replacement questions: Will this policy replace any existing accident and sickness insurance policy(s)? ☐Yes ☐No As the Writing Agent/Producer, I acknowledge that I am responsible to personally interact with the primary applicant submitting this application in order to fully and accurately represent the terms and conditions of the plans and services of the offering or insuring entity, or one of its subsidiaries. These provisions are available to me and the primary applicant in the benefits summary document or other plan literature.	
Writing Agent Signature	**Date**

DISCLOSURES

This document is a publication of the Colorado Division of Insurance. If you have questions about the content of this document please contact our offices at 303-894-7499 or visit our website at http://www.dora.colorado.gov/insurance. For questions regarding coverage or enrollment please see your carrier.

This section may be used to provide additional information that was required in the sections above and did not fit in the space provided.

Signature of Primary Applicant: _____ **Date Signed:** _____