ROCKY MOUNTAIN HEALTH PLANS®
Good health. That's the plan.

6E

SOLO Health Plan Application

Thank you for your interest in the SOLO plan, underwritten by Rocky Mountain HealthCare Options, Inc. (RMHCO). Read every section carefully and be sure to complete all items. **Unanswered questions or incomplete/omitted information will result in the return of this application to you and will delay your enrollment in this health care plan.** The SOLO plan is medically underwritten. This means that health care coverage is not guaranteed. Applicants **must** complete a health questionnaire that will be considered before an application is accepted or rejected.

Applicants age 50 or older are required to submit with the initial application a current (within the past 12 months) medical history and physical examination record. The physical exam record must include any health screening tests (including mammogram, PAP, or PSA) or procedures and a lipid panel. **Infants** who are at least two months of age and under six months of age will require medical records from their two and/or four month well-child check along with immunization records. Costs associated with such services will be the responsibility of the applicant.

If you are age 65 or older or you have a disability and qualify for Medicare, this Individual Plan is not available to you. Call 800-346-4643 for information on Medicare benefit options.

If you have questions or need additional information as you complete this application, call your broker or RMHP at 866-414-7656.

SOLO Select Plans

Select Plan Deductible Options		Maternity Rider	Brand Prescription Drug Rider* $10/$40/$60
☐ SOLO $500	AND	☐ Yes ☐ No	☐ Yes ☐ No
☐ SOLO $1,000		Not Available	☐ Yes ☐ No
☐ SOLO $1,500		Not Available	☐ Yes ☐ No
☐ SOLO $2,500		Not Available	☐ Yes ☐ No

SOLO Smart Choice Plans

Smart Choice Coverage Options		Accident Rider	Brand Prescription Drug Rider*
☐ SOLO $2,800/80		☐ Yes ☐ No	80% covered after deductible ☐ Yes ☐ No
☐ SOLO $2,800/100		☐ Yes ☐ No	100% covered after deductible ☐ Yes ☐ No

SOLO Safety Net Plans

Safety Net Deductible Options	Brand Prescription Drug Rider* $10/$40/$60
☐ SOLO $5,000	☐ Yes ☐ No
☐ SOLO $10,000	☐ Yes ☐ No

* Generic prescription drug coverage is included with the plan if the Brand Prescription Drug Rider is not selected.

Tobacco Use
Has any person listed on this application used tobacco products in the past 12 months? ☐ Yes ☐ No If yes, give person's name:

Effective Date

The effective date of coverage is the first of the month following the application approval date unless a later effective date is requested.

☐ First of the month following application approval date

☐ First of _____ (write month here)

Please Tell Us How You Heard About Us

☐ Family member ☐ Broker ☐ Friend ☐ Newspaper/radio ☐ Health plan member ☐ Website

☐ Other_____

APPLICATION MUST BE COMPLETED BY SUBSCRIBER/APPLICANT
PRINT ALL INFORMATION CLEARLY IN BLACK INK

Are you adding a dependent to your existing SOLO Health Plan policy? ☐ Yes ☐ No						
Subscriber: Last Name[1]	First Name	MI	Social Security Number [2]			Home Phone ( )
Address	City		State	County	Zip Code	Business Phone ( )
Date of Birth — Mo/Day/Year_____ Height_____Weight_____ ☐ M ☐ F						
☐ Single ☐ Married ☐ Divorced ☐ Legally separated ☐ Common law marriage (statement will be required)						

(continued on page 2)

For RMHP USE

PROVIDE ALL INFORMATION FOR EACH FAMILY MEMBER APPLYING FOR COVERAGE UNDER THIS PLAN.							
Last Name First Name MI	**HT**	**WT**	**Social Security Number [2]**	**Sex M/F**	**Date of Birth Mo/Day/Yr**	**Relationship to Subscriber**	**RMHP USE**
Spouse							
Dependent							
Dependent over age 19 and under 25: ☐ Full time student ☐ Financially dependent or same household as the subscriber							
Dependent							
Dependent over age 19 and under 25: ☐ Full time student ☐ Financially dependent or same household as the subscriber							
Dependent							
Dependent over age 19 and under 25: ☐ Full time student ☐ Financially dependent or same household as the subscriber							
Dependent							
Dependent over age 19 and under 25: ☐ Full time student ☐ Financially dependent or same household as the subscriber							

[1] If a dependent child is applying as an individual rather than as part of a family, list the child as the subscriber. If more than one dependent child is applying as an individual, complete an application for each child subscriber.

[2] Supply social security numbers if known. Missing numbers will be requested after enrollment.

If you have had insurance coverage in the last 12 months, provide the information requested below.

List Each Policyholder's Covered Family Member	Name, Address, and Telephone Number of Health Plan or Insurance Company	Effective Date of Coverage	RMHP USE
Policyholder's Name: _____ Policy #: _____ Group Name: _____ S.S. Number: _____ Others on policy: _____		From: To:	
Policyholder's Name: _____ Policy #: _____ Group Name: _____ S.S. Number: _____ Others on policy: _____		From: To:	

Pre-Existing Condition Limitation Period

A pre-existing condition is an injury, sickness, or pregnancy for which the Member has, during the 12 consecutive months immediately preceding the Member's effective date of coverage under the plan applicable, either: (a) incurred charges, (b) received medical treatment, (c) consulted a health care professional, or (d) taken prescription drugs. Rocky Mountain Health Plans will not pay for services related to a preexisting condition for 12 consecutive months after the Member's original membership Effective Date. (This is the pre-existing condition limitation period.)

Upon approval of your application, the length of the Pre-Existing Condition Limitation Period will be reduced or eliminated for you and each family member who has creditable coverage. The creditable coverage must have ended within 90 days prior to your enrollment in RMHP. Creditable coverage includes health care coverage provided under: (a) Medicare or Medicaid; (b) an employee welfare benefit plan, group health insurance, or group health benefit plan; (c) an individual health benefit plan; or (d) a state health benefits risk pool (including but not limited to the Cover Colorado Uninsurable Health Insurance Plan and CHP+). **You must provide proof of creditable coverage for every family member listed on this application who has had health care coverage within the last 12 months.**

Such creditable coverage reduces the Pre-Existing Condition Limitation Period by one day for each day of creditable coverage. For example: If you had creditable coverage for three months before enrolling in the SOLO plan and such creditable coverage ended less than 90 days prior to your enrollment date, then your Pre-Existing Condition Limitation Period will be reduced from 12 months to nine months. If the creditable coverage ended more than 90 days prior to your enrollment date, then the full 12-month Pre-Existing Condition Limitation Period will apply.

The insurance company or health plan that provided your previous health care coverage should have given you a certificate stating that you had creditable coverage and specifying the time period of such creditable coverage. If you are still covered under another health care plan or you do not have a certificate evidencing your prior creditable coverage, you can ask RMHP to help you obtain proof of creditable coverage. Contact RMHP at 970-244-7800 or 800-453-2981, option 4.

Complete the chart above for yourself and each family member listed on this application. List all current health care coverage policies and/or all previous health care coverage policies in effect during the last 12 months. Add and label additional pages if necessary.

For RMHP USE

Health Questionnaire

All questions must be answered completely for each person applying for coverage on this application or the application will be returned.

Any knowing misrepresentation as to the presence or severity of any health condition, impairment, or disease could result in retroactive termination of coverage. Any failure to notify RMHP of any medical condition, impairment, disease, or change in any applicant's health status that occurs or is diagnosed between the date of application and the later of the effective date of coverage or the date coverage is approved could also result in retroactive termination of coverage. RMHP shall have the right to request and review additional information regarding health history and any change in health status that occurs between the date of application and the effective date of coverage. This additional information may be used to determine if RMHP will accept or decline your application prior to the effective date of coverage. No notice of acceptance related to your application can bind RMHP to coverage until the effective date of coverage, and failure to provide additional requested information could result in your application not being accepted.

1. In the past five years, have you or any family member listed on this application ever had, been treated for, been diagnosed with, or had any indication of any of the following conditions, diseases, or disorders? **Mark EACH condition/disease/disorder either YES or NO.**

CONDITION/DISEASE/DISORDER	YES	NO
Abdominal /Bowel Problem (including colitis, diverticulosis,ulcers, regional enteritis, or hernias)		
Alcohol/Drug/Substance Abuse		
Arthritis, Rheumatoid/Osteoarthritis (specify type)		
Asthma/Bronchitis/Emphysema or Other Lung/Breathing Disorder (including sleep apnea, tuberculosis)		
Back/Spine/Bone Problems (including fractures, joint disease/injury, scoliosis/osteochondrosis/osteoporosis)		
Birth Abnormality/Defect/Congenital Problem		
Bleeding Disorder/Anemia		
Brain/Nervous System Disorder (including disabling headaches, epilepsy/seizures, paralysis, stroke, Multiple Sclerosis or Parkinson's Disease)		
Cancer/Malignant Condition (including leukemia, Hodgkin's Disease)		
Cardiovascular/Heart Disorder (including chest pain, heart attack/murmur, valve problems, hypertension, elevated cholesterol)		
Cataract or Other Eye Disorders		
Chronic Fatigue Syndrome/Fibromyalgia		
Diabetes or high blood sugar		
HIV/AIDS Virus (including positive test result for the HIV/AIDS virus)		
Kidney/Bladder/Urinary Disorder (including stones, tumor, renal failure, dialysis, prostate problem)		
Liver/Pancreas Disorder (including pancreatitis, cirrhosis, hepatitis)		
Male/Female Genital/Reproductive Disorders (including STDs, infertility)		
Mental Disorders (including anxiety, attention deficit, depression, eating disorders, paranoia, or schizophrenia)		
Organ Transplant Recipient or on Waiting List for Transplant		
Skin Disorder (including rash, lesions, Lupus)		
Varicose Veins		

If you answered yes to any of the conditions, diseases, or disorders in Question #1, complete the chart below. Add and label another page if necessary.

FamilyMember	Condition/Disease/Disorder	Date of Last Treatment	Date of Last Hospitalization	Doctor's Name and Address

2. Have you or any family member listed on this application received advice for, been diagnosed with, or been treated for any condition(s), disease(s), or disorder(s) not listed in Question #1? ❑ Yes ❑ No (If yes, explain disease, condition, or disorder.)

Person's name: _____

_____

For RMHP USE

3. Have you or any family member listed on this application been advised or are planning to have medical or surgical treatment that has not yet been performed?
❑ Yes ❑ No (If yes, please explain.) Person's name:_____

_____

4. Have you, your spouse, or any dependents listed on this application incurred medical/surgical and/or hospital expenses of $5,000 or more within the last 12 months? ❑ Yes ❑ No (If yes, please explain.) Person's name:_____

5. Have you or any family member listed on this application seen a provider for **ANY** reason in the past 12 months **(including sick visit, physical, mammogram, Pap smear, and prostate screening)**?
❑ Yes ❑ No If yes, complete the chart below. Add and label another page if necessary.

Family Member	Reason for Treatment	Date of Last Treatment	Doctor's Name and Address

6. Have you or any family member listed on this application taken any prescription medications in the last 12 months?
❑ Yes ❑ No If yes, complete the chart below. Add and label another page if necessary.

Family Member	Medication Name	Quantity/ Dosage Taken	Prescribing Physician	Illness for Which Medication Prescribed	Date Prescription Last Received

7. In the chart below, list all surgical procedures, operations, and hospitalizations within the last five years for you or any family member listed on this application. If none, check here: ❑ None

Family Member	Operation/Procedure	Date	Reason for Operation/Procedure	Surgeon and Hospital Name and Address

8. Does anyone listed on this application drink alcohol? ❑ Yes ❑ No
If yes, person's name:_____How much daily?_____How much weekly?_____

For RMHP USE

9. At this time, is any family member pregnant (**whether or not applying for coverage**)?

❑ Yes *If yes, give person's name and relationship to subscriber:_____

❑ No **If no, list female family members and dates of their last menstrual period:**

Name: _____Month _____ Day _____ Year _____

Name: _____Month _____ Day _____ Year _____

If any member's initial menstrual cycle has not yet begun, give her name:_____

* If you or your spouse are pregnant, this plan is not available to you.

10. Are you in the process of adopting? ❑ Yes ❑ No

11. Have you or any female listed on this application ever had any abnormality of the female organs, abnormal menstrual periods, or any unexplained vaginal bleeding? ❑ Yes ❑ No If yes, explain:_____

Name: _____

12. Have you or any family member listed on this application ever had an

abnormal Pap smear?	❑ Yes	❑ No
abnormal mammogram?	❑ Yes	❑ No
abnormal PSA?	❑ Yes	❑ No

If yes, explain: _____

Name: _____

* If you answered "Yes", provide the results from your last two screenings with your application.

13. Disclose occupation and type of work all applicants do:

_____

14. Disclose all hobbies all applicants participate in:

_____

15. Have you or any family member listed on this application had a weight change during the past year? ❑ Yes ❑ No If yes, provide name(s):

❑ Increased by 10 lbs. or more: _____

❑ Decreased by 10 lbs. or more:_____

Reason for each person's weight change:_____

16. If any family member listed on the application is six months of age or younger, fill in below and **submit medical records from the two and/or four month well-child check along with immunization records).**

Birth weight:_____ lbs. _____ oz.

Current weight:_____ lbs. _____ oz.

Date of last well-baby check:_____

As a newborn: a) was the baby kept in an incubator? ❑ Yes ❑ No

b) did the baby require oxygen? ❑ Yes ❑ No

17. Have all applicants under the age of 18 years had all recommended immunizations? ❑ Yes ❑ No

If no, list person's name: _____

For RMHP USE

Qualification for Coverage Through CoverColorado

If you ended a COBRA or State Continuation of Benefit Plan within the past 62 days in which you have **exhausted ALL** eligible coverage (18 months or 36 months, you may qualify for health coverage with no medical screening through CoverColorado*. For information about CoverColorado benefits, exclusions, enrollment, and premium subsidies, contact CoverColorado at:

425 S. Cherry St., Suite 160
Glendale, CO 80246
303-863-1960
www.covercolorado.org

You do not qualify if (a) you are eligible for a group health benefit plan, Medicare, Medicaid, or have other health benefit plan coverage; (b) your most recent coverage was terminated as a result of nonpayment of premiums or fraud; or (c) you turned down an offer of continuation coverage or did not exhaust such coverage.

Determining if This Is an Employer-Sponsored Plan

Rocky Mountain Health Plans does not market or sell individual plans to eligible employees of an employer-sponsored plan or to self-employed Business Groups of One. An individual plan is available to noneligible employees and all dependents in an employer-sponsored plan.

Answer the following questions so RMHP can determine if you are eligible for individual medical coverage or if, due to the premium arrangement for the coverage, you are subject to the Colorado small employer group health insurance reform laws.

I pay the **ENTIRE** premium for the coverage out of my own **PERSONAL** funds.	❑ Yes	❑ No
My employer or my business will be paying **ALL OR A PORTION** of the benefit or premium for coverage.	❑ Yes	❑ No
My employer or my business will be reimbursing me or any of my dependents for **ALL OR A PORTION** of the premium through wage adjustment or any other way.	❑ Yes	❑ No
ALL OR ANY PORTION of the premium for the coverage will be deducted from my salary/wages.	❑ Yes	❑ No
My employer or I will take a tax deduction for the premiums for this coverage.	❑ Yes	❑ No
If YES, is the premium paid through a Section 125 (cafeteria) plan?	❑ Yes	❑ No
If YES, my employer:		
a) will contribute to the cafeteria plan, OR	❑ Yes	❑ No
b) will pay for ALL OR ANY PORTION of the premium, OR	❑ Yes	❑ No
c) has other health coverage for employees	❑ Yes	❑ No

I,_____, certify that the answers to these questions are true and correct.
Printed Name of Applicant

Signature of Applicant
X _____ **Date** _____

If you are a Business Group of One (BG1), you may apply for a BG1 Plan. A BG1 is a sole proprietor, single full-time employee of a business, or a household employee who works at least 24 hours a week on a permanent basis and who has carried on significant business activity for a period of at least one year prior to application, which generated enough gross income to pay the annual premium and that provided at least a substantial part of such individual's income for one year out of the most recent consecutive 3-year period.

If you: 1) believe you may be a BG1, and/or 2) intend this plan to be an employer-sponsored plan, you cannot file this application, and you must contact RMHP for an application for a BG1 plan.

COLORADO INSURANCE LAW REQUIRES ALL CARRIERS IN THE SMALL GROUP MARKET TO ISSUE ANY HEALTH BENEFIT PLAN IT MARKETS IN COLORADO TO SMALL EMPLOYERS OF 2-50 EMPLOYEES, INCLUDING A BASIC OR STANDARD HEALTH BENEFIT PLAN, UPON THE REQUEST OF A SMALL EMPLOYER TO THE ENTIRE SMALL GROUP, REGARDLESS OF THE HEALTH STATUS OF ANY OF THE INDIVIDUALS IN THE GROUP. BUSINESS GROUPS OF ONE CANNOT BE REJECTED UNDER A BASIC OR STANDARD HEALTH BENEFIT PLAN DURING OPEN ENROLLMENT PERIODS AS SPECIFIED BY LAW.

For RMHP USE

SOLO Payment Options

Rocky Mountain Health Plans (RMHP) offers three different options for your SOLO premium payment. Check the box for the payment plan you wish to use:

- ❑ **Monthly Bank Draft.** RMHP can withdraw your monthly premiums directly from your bank account. With this option, no invoice is mailed and you do not have to worry about mailing your payment in time. *Simply complete the Account Deduction Authorization form (below) and attach a voided check.* RMHP will draft your first premium on the 4th of the month after you are approved.
- ❑ **Monthly Credit Card Automation.** RMHP can automatically request monthly payment from your credit card company. With this option, there is no invoice sent and you do not have to worry about mailing your payment in time. As an added convenience, **you only need to give us your Credit Card information and approval one time**. *Simply complete the Credit Card Authorization form (below) and check the box for* ***reoccurring billing***. RMHP will take your first premium on the 4th of the month after you are approved.
- ❑ **Quarterly Invoice Billing.** RMHP will mail you a quarterly premium billing invoice. This option requires pre-payment for the entire quarter. Quarterly payments are due the first business day of the month and the amount due is for the full three months.

Thank you for your Membership with Rocky Mountain Health Plans.

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)

I understand that if the bank fails to remit my premium, my membership will not be terminated until I have been given the opportunity to pay the amount due.

Signature _____ Date _____

✔ **Attach a voided check from your bank account.**

Credit Card Authorization for Automatic Recurring Billing

Use this form to pay the accompanying invoice with either VISA, DISCOVER, or MASTERCARD. Simply fill in the information requested. Then sign where indicated before returning this form with your invoice.

Member Name: _____

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

CREDIT CARD: ❑ VISA ❑ DISCOVER ❑ MASTERCARD

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

X _____ Date: _____
Signature of Account Holder

PO Box 10600, Grand Junction, CO 81502-5600 — 866-414-7656
Fax: 970-244-7992
If you are hearing impaired and use TTY equipment, call 800-704-6370

For RMHP USE

Signature and Certification

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

1. Upon approval of application, coverage will begin on the first of the month following the date of approval.
2. First premium will be due and collected on the 4th day of the month in which your coverage begins.
3. We offer to enter into the health care plan contract for the plan designated in this enrollment application. Upon receipt of all information required for enrollment, approval thereof by Rocky Mountain Health Plans (RMHP) and RMHP acceptance of the first premium, we shall have a contract with RMHP, the terms of which are set forth in the applicable contract, which contract may be amended from time to time by RMHP in accordance with applicable law.
4. We authorize any physician, health care provider, hospital or other medical facility, insurance company, or other entity or person that now or hereafter has records or knowledge of the health of any person proposed for coverage, to give RMHP such records and information and supplement such records and information as RMHP requests. This authorization shall include all medical records and medical information. Such records and information may be used by RMHP or made available by RMHP to others for treatment, payment, or health care operations purposes, including but not limited to any quality assurance programs conducted by RMHP or its designated agents or contractors. A copy of this authorization shall be as valid as the original until contract is terminated.
5. We consent to RMHP performing case management.
6. The contract contains provisions for the arbitration of disagreements and disputes. We agree to arbitrate such disagreements and disputes as set forth in the applicable contract.
7. RMHP has the right to terminate coverage and deny benefits if any information on this enrollment application, or as otherwise provided by the undersigned to RMHP for enrollment purposes, is knowingly false, incomplete, or misleading in any material respect. RMHP has the right to deny coverage if any outstanding premiums or other payments are owed to RMHP by the undersigned.
8. All information and answers provided in this application are true and correct.
9. This application will remain valid for 90 days from date of applicant's signature below.
10. Any fraud or intentional misrepresentation as to the presence of any health condition, impairment, disease, or disorder will result in retroactive termination of coverage. As a result, RMHP will not be responsible for payment of any claims for services received up to and including the date of retroactive termination of coverage. RMHP shall have the right to request and review additional information regarding health history. RMHP retains the right to accept or deny an application until the effective date of coverage, regardless of any prior notice of acceptance or receipt of premium. Any additional information regarding your health history or change in health status that occurs between the date of application and the later of the effective date of coverage or the date a coverage decision is made may be used to determine if RMHP will accept or decline your application, or revoke a prior notice of acceptance related to your application. No notice of acceptance related to your application can bind RMHP to coverage until the effective date of coverage.
11. We understand that the policy applied for will not pay for services unless they are medically necessary as determined by RMHP.
12. We understand that a plan change request must be made 31 days prior to my anniversary to be effective on my anniversary date, subject to medical underwriting.
13. We further understand that the policy applied for will not pay benefits for any loss incurred during the first 12 months after the issue date because of any pre-existing condition unless superceded by a Certificate of Creditable Coverage as described herein.
14. We understand that any information regarding this application, including associated medical records, may be shared with our broker, if applicable.

The above provisions will remain in effect for the entire duration of RMHP membership of the undersigned and the undersigned's dependents.

We acknowledge that we have read this application and that the foregoing answers are true, and we certify that we understand and agree to all matters covered in the application.

APPLICANT SIGNATURE

(If signing for minor, so indicate.) X _____ Date _____

*This application will expire 90 days from date of signature.

SIGNATURE OF SPOUSE APPLICANT (If applying for family membership)

X _____ Date _____

—BROKER COMPLETE —PRINT CLEARLY —

Broker/Agent MUST complete the following for application processing:

Broker Name:	HOWARD INSURANCE AGENCY, INC.	Address:	Littleton, Colorado
Broker License #:	68-0583632	Broker Agency:	HOWARD INSURANCE AGENCY, INC.
Broker Fax #:	303-660-1877	Broker Phone #:	303-660-8809 or 1-800-234-3391

Colorado law requires carriers to make available a Colorado Health 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.

MK14R0108Þ

For RMHP USE

ROCKY MOUNTAIN HEALTH PLANS®
Good health. That's the plan.

SOLO Health Plan Application Checklist

Unanswered questions or incomplete/omitted information will result in the return of your application. Please make sure the following are complete **BEFORE** you mail your application.

- ❑ Fill in every applicable blank in the application, including details and explanations if asked for.
- ❑ Include copies of required medical records (if age 50 or older and for any child between two and six months of age). See the next page for details of required medical records.
- ❑ Child-only applicants are listed as the subscriber. Complete a separate application for each child who is applying.
- ❑ Attach and write the applicant's name on additional pages if applicable.
- ❑ If you or any family member applying for coverage was previously covered by health insurance, complete the chart on page 6.
- ❑ If paying by automatic bank draft each month, attach a voided check. Write VOID on the signature line of the blank check. (See example on page 7.)
- ❑ Sign in each applicable place, by the **X** on pages 5, 7, and 8.

Note: If your application is approved, your coverage will automatically begin on the first of the month following the date of approval. Your first premium will be due and collected on the 4th day of the month in which your coverage begins.

If you want to withdraw your application for any reason, please contact the SOLO Sales Team immediately at 800-453-2981, option 4, or email to SOLO_Sales_Team@rmhp.org.

ROCKY MOUNTAIN HEALTH PLANS®
Good health. That's the plan.

Rocky Mountain Health Plans (RMHP)
Medical Record Requirements

PLEASE NOTE: In order to complete your RMHP application, the following must be submitted within 30 days. If you have not had these required physical exams, please schedule an appointment with your doctor to do so. Your application cannot be processed without these requirements.

ADULTS

To enroll in an RMHP health plan, adults 50 years of age or older must have:

- History and physical within the last 12 months
- Pap test (unless documented hysterectomy) and mammogram within the last 12 months
- PSA within the last 12 months
- Lipid panel within the last 12 months
- Liver function tests, within the last 12 months, if on statins
- Results from any other tests recommended during your physical exam

CHILDREN

To enroll in an RMHP health plan, children must have:

- 2-month Well Child check to include immunizations (babies less than 2 months of age are deferred until 2-month Well Child check)
- Last Well Child check (for children less than 6 months)
- Recommended immunizations (for children up to age 18)

Rocky Mountain Health Plans accepts children for enrollment any time after their 2-month Well Child check.

Please have your doctor submit this information to us within 30 days of your enrollment application date.

Information should be mailed or faxed to:

Rocky Mountain Health Plans
Attention: SOLO Sales
2775 Crossroads Boulevard, PO Box 10600, Grand Junction, CO 81502
Fax: 970-244-7992

If you have any questions about these enrollment requirements, please call the RMHP SOLO Sales Department at 866-414-7656, or 970-244-7800, ext. 4.

RMHP reserves the right to request additional information, as needed, by our medical underwriters.