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

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

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Employee Disenrollment Form

All covered family members will be disenrolled from the plan.
Complete this form using black ink only.

Subscriber Information

Subscriber Name Last	First	MI	Date of Birth / /	Member #: Social Security # – –
Address	City		State	Zip
Employer:			Effective Date of Disenrollment	

Please Complete for Disenrollment from Plan

Please cancel the coverage above for the following reasons:

Eligibility for Continuation Coverage

1. Type of qualifying event – Please check one only:
   - ☐ **Voluntary loss of employment (JT)**
   - ☐ **Involuntary loss of employment (subsidy eligible) (IS)**
   - ☐ Death of employee
   - ☐ Employee's enrollment in Medicare
   - ☐ Reduction in hours (COBRA only)
   - ☐ Retirement
2. Date of qualifying event: ____________________

- ☐ Unsatisfactory benefits (BN)
- ☐ Rates too high (VR)
- ☐ Unsatisfactory benefits/rates too high (BR)
- ☐ Moving from plan service area (MT)
- ☐ Quality of care (QT)
- ☐ PCP does not participate (NP)
- ☐ Other: ____

Are any dependent children disenrolling from this plan subject to a court order for health coverage? ☐ Yes ☐ No

If yes, please supply written proof that: 1) any such court order is no longer in effect; or 2) any such child is enrolled in a comparable plan through another insurer.

Certification of Option to Enroll in Different Coverage – for involuntary loss of employment only

Under certain conditions, employers offering more than one health benefit plan may decide to allow Assistance Eligible Individuals (as defined in the American Recovery and Reinvestment Act of 2009) who elect continuation coverage the option to enroll in a plan that is different than the plan in which the individual was enrolled at the time of the qualifying event if that plan is of equal or lower price. If the employer permits such an option, this decision applies to all current and future Assistance Eligible Individuals.

I certify that Assistance Eligible Individuals may change to a different health plan at the time they elect continuation coverage.

☐ Yes ☐ No

☐ Not applicable. The employer does not currently offer more than one health benefit plan to active employees

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

I agree that the above information is true, and I authorize Rocky Mountain Health Plans to make the above change. I certify that if the type of qualifying event checked above is "Involuntary loss of employment" that the employee and/or his or her dependents are eligible for the COBRA premium reduction provided for in the American Recovery and Reinvestment Act of 2009.

Subscriber Signature: ____ Date Signed: __________________

Employer 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

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