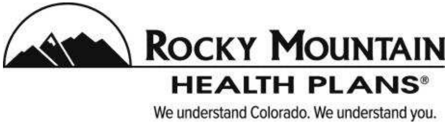
Plans underwritten by Rocky Mountain HMO (RMHMO)
or Rocky Mountain HealthCare Options, Inc. (RMHCO)

1C



Individual Health Care Plan Disenrollment Form

All covered family members will be disenrolled from the plan. To retain coverage for a covered family member, use the Individual Change Form.

Subscriber Information

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

Please Complete for Disenrollment from Plan

Requested termination date:____________________________

RMHP must receive this form prior to the requested termination date. Retroactive terminations are not permitted.

Cancel coverage for myself and my covered family members for: (please check all that apply)

☐ All plans **OR** ☐ Medical Plan
☐ Dental Plan (if applicable)

Please cancel the coverage for the following reasons:

☐ Unsatisfactory benefits (BN)
☐ Rates too high (VR)
☐ Unsatisfactory benefits/rates too high (BR)
☐ Unable to afford coverage (AC)
☐ Limited payment options (PO)
☐ Moving from plan service area (MT)
☐ Service unsatisfactory (SN)
☐ Death — requires a copy of the death certificate (DE)
☐ Quality of care (QT)
☐ PCP does not participate (PN)
☐ Provider Access (PA)

If you have obtained new coverage, please indicate below:

☐ Changing to spouse's coverage
☐ Individual coverage (SI) ☐ Group coverage (SG)

☐ I am changing to:
☐ Individual coverage (IC) ☐ Group (IG) ☐Medicare (MC)

☐ New Carrier
☐ Anthem BC/BS (OA)
☐ CIGNA (OC)
☐ United Healthcare (OU)
☐ Rocky Mountain Health Plans (OR)
☐ Colorado HealthOP (CH)

☐ Other:____

I agree that the above information is true, and I authorize Rocky Mountain Health Plans to make the above change.

Subscriber Signature:____ Date Signed:________________

Mail this form to:
Membership Enrollment
Rocky Mountain Health Plans
PO Box 10600
Grand Junction, CO 81502-5600
Email to: commercialenrollment@rmhp.org

Fax to: 970-263-5507