

New Group Checklist

Account Information			
Group Size <i>(Application must be submitted to local RMHP office by this day prior to requested effective date)</i>			
<input type="checkbox"/> BG-1 (5 th of month)	<input type="checkbox"/> 2-50 (15 th of month)	<input type="checkbox"/> 51+ (15 th of month)	
Group Name			
Producer Name		E-Mail Address	RMHP Account Executive/Manager
Producer Agency		Producer (Payee) License #/Tax ID	
Prior Carrier		Date Received by Marketing	Requested Effective Date
Check Amount Submitted			
Medical Plan 1: Rx Plan: <input type="checkbox"/> Brand <input type="checkbox"/> Generic Only (N/A for HSA) <input type="checkbox"/> Both Rx Plans (employee will select one) Accident Rider: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A (HMO Classic Plans)			
Medical Plan 2: Rx Plan: <input type="checkbox"/> Brand <input type="checkbox"/> Generic Only (N/A for HSA) <input type="checkbox"/> Both Rx Plans (employee will select one) Accident Rider: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A (HMO Classic Plans)			
Medical Plan 3: Rx Plan: <input type="checkbox"/> Brand <input type="checkbox"/> Generic Only (N/A for HSA) <input type="checkbox"/> Both Rx Plans (employee will select one) Accident Rider: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A (HMO Classic Plans)			
Chiropractic Plan		Dental/Vision Plan	
Application Document Checklist			
<i>(All boxes and lines must be completed or indicated not applicable)</i>			
Business Groups of 1		Groups of 2 or More	
<input type="checkbox"/> Uniform Application including completed Health Questionnaire		<input type="checkbox"/> Group Application	
<input type="checkbox"/> 1st Month's Premium		<input type="checkbox"/> 1st Month's Premium	
<input type="checkbox"/> Current Physical Exam Records <i>(within the past 12 months)</i> for applicants 45 years or older ❶ ❺		<input type="checkbox"/> Proof of Creditable Coverage <i>(most recent detailed premium statement listing employee names or Certificates of Creditable Coverage are required)</i> ❶ ❷	
<input type="checkbox"/> Attestation for BG-1		<input type="checkbox"/> Tax & Wage Documentation <i>(see Tax & Wage Requirements)</i> ❷ ❸ ❹	
<input type="checkbox"/> Proof of Creditable Coverage <i>(most recent detailed premium statement listing names or Certificates of Creditable Coverage are required)</i> ❶		Required Enrollment Documents — Indicate # of Forms Attached	
<input type="checkbox"/> Tax & Wage Documentation <i>(see requirements on page 2)</i> ❸		# of Enrollment Forms (51+) or Uniform Applications (2-50)	
<input type="checkbox"/> Waiver Form <i>(for eligible dependent declining coverage)</i>		# of Previous Health Insurance Information <i>(should be same as enrollment #)</i>	
<input type="checkbox"/> Previous Health Insurance Information ❶		# of Waivers	
<input type="checkbox"/> Open Enrollment Certification Form <i>(Basic & Standard Plans)</i>		# of Dependent Waivers <i>(include spouse waiver if both are employed by same company and enrolling separately)</i>	
<input type="checkbox"/> Common Law Spouse Form		# of Certification of Dependent Status Forms <i>(age 19 and older in 51+ group)</i>	
<input type="checkbox"/> Disenrollment Form <i>(for employee cancelling other RMHP coverage)</i>		# of Common Law Spouse Forms	
		# of Domestic Partner forms	
		# of Disenrollment Forms <i>(for employee cancelling other RMHP Coverage)</i>	
		# of COBRA/Continuation of Coverage Forms <i>(all participants have been notified of the plan change)</i>	
		Good Health National Access <i>(for any employees/dependents residing outside Colorado)</i>	
		<input type="checkbox"/> Yes <input type="checkbox"/> No	
		<input type="checkbox"/> List of eligible employees and dependents for groups 2 – 50	

Tax & Wage Document Checklist for 2-50 ② ③

UITR: Groups of 2-50 Eligible Employees

Most recent Unemployment Insurance Tax Report (UITR) and supporting Quarterly Report of Worker Wages. (If only one individual is enrolling in the plan, the two most recent UITRs must be submitted.) The number of hours worked per week for each employee listed **must be written** on the UITR, regardless of eligibility. If the group is not required to file a UITR, please see ④.

Please note: Each eligible employee enrolling must appear on the UITR and show income sufficient to verify the required hours worked. If any of the employees enrolling or waiving (including owners of the business) **do not appear** on the UITR, the following documents will be required, listed in order of priority:

Owner:

- W2 form** — if not available, RMHP will accept:
- Owner tax schedule that applies** (i.e., C, E, F, or SE) — if not available, RMHP will accept:
- Copy of owner draws** (cancelled checks for previous 3 months)
- If none of the above items are available, RMHP will require a copy of the **Articles of Incorporation** and other documentation to substantiate eligibility for group coverage. Please contact your RMHP Account Executive to determine the specific documentation that should be submitted with your application.

Employees:

- W4 form and current payroll documents**

Additional Basic and Standard Plan Materials Needed

Groups enrolling in the Rocky Mountain HealthCare Options PPO Standard Health Benefit Plan for Colorado and choosing supplemental coverage for Alcoholism Rehabilitation at an additional charge of 1.8%.

Supplemental coverage for alcoholism rehabilitation? Yes No

If yes, Signed Acceptance of Supplemental Alcoholism Rehabilitation Form. (This form only required when accepting coverage.)

Tax & Wage Document Checklist for BG-1 ⑤ All tax documents that apply are required.

<input type="checkbox"/> If C Corp	<input type="checkbox"/> Company Form 1120 <input type="checkbox"/> Owner Form 1040, pages 1&2 <input type="checkbox"/> Owner Schedule E	<input type="checkbox"/> If Sole Proprietorship	<input type="checkbox"/> Owner Form 1040, pages 1&2 <input type="checkbox"/> Owner Schedule C <input type="checkbox"/> Schedule SE
<input type="checkbox"/> If S Corp	<input type="checkbox"/> Company Form 1120S <input type="checkbox"/> Company Schedule K1 <input type="checkbox"/> Owner Form 1040, pages 1&2 <input type="checkbox"/> Owner Schedule E	<input type="checkbox"/> If Nonprofit	<input type="checkbox"/> Organization Articles of Incorporation <input type="checkbox"/> Organization Form 990 <input type="checkbox"/> W2s or paystub with deductions for each employee (most current three months)
<input type="checkbox"/> If Partnership or LLC	<input type="checkbox"/> Company Form 1065 <input type="checkbox"/> Company Schedule K1 <input type="checkbox"/> Owner Form 1040, pages 1&2 <input type="checkbox"/> Owner Schedule E <input type="checkbox"/> Owner Schedule SE	<input type="checkbox"/> If Farm	<input type="checkbox"/> Company Form 943 <input type="checkbox"/> Owner Form 1040, pages 1&2 <input type="checkbox"/> Owner Schedule F <input type="checkbox"/> W2s or paystub with deductions for each employee (most current three months)

- ① Does not apply to *Rocky Mountain HMO* HMO Standard Health Benefit Plan for Colorado and *Rocky Mountain HMO* HMO Basic Limited Mandate Health Benefit Plan for Colorado
- ② Does not initially apply to groups with 51+ employees
- ③ RMHP reserves the right to require additional documentation for any group size to substantiate eligibility
- ④ If company is not required to file a UITR, it must submit a completed employee census and most recent 3 months of payroll documents
- ⑤ Does not apply to *Rocky Mountain HCO* PPO Standard Health Benefit Plan for Colorado and *Rocky Mountain HCO* PPO Basic Limited Mandate Health Benefit Plan for Colorado

RMHP Marketing Use Only

Group Name		Requested Effective Date	
<input type="checkbox"/> Rate Sheet (Groups of 10+ rerun composite rates)	Enrollment _____ # Subscribers/Brand _____ # Subscribers/Generic _____ # Members	Commission	
<input type="checkbox"/> 1st Month's Premium for COBRA/CCOC apps is included		<input type="checkbox"/> 1 to 50	
<input type="checkbox"/> Contact Sheet Attached		<input type="checkbox"/> 50+	
<input type="checkbox"/> Termed Group Database Checked			

Date: _____ **Comments** _____ **Initial:** _____

Notes:



RMHP USE ONLY
RMHP Rec'd: _____
UW Rec'd: _____
Status: _____

Application for Health Benefits For Groups with 2 or More Employees

Please complete all information on front and back using black ink only. We cannot process incomplete applications.

Section 1 – Company Information				
Company Name				
Phone ()	Fax ()	E-Mail		
Physical Address	City	State	Zip	PO Box
Mailing Address	City	State	Zip	PO Box
Contact Person			Title	
President/CEO/Owner (Name)		Federal Tax ID Number (TIN / EIN)		
Proposed Effective Date	Industry or Type of Business	Industry Code (SIC)		
Does the company or owners applying for coverage share ownership in any other business(es)? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, give: Name of business(es): _____ Name of all owners: _____ Total number of all employees on payroll who work 24 hours per regular work week for all businesses: _____ Employers with 50 or fewer eligible employees are required to attach a list of eligible employees and dependents.				
Eligible employees must have a regular work week of the required number of hours a week and must satisfy any applicable eligibility waiting period.				
Section 2 – Employee Eligibility				
1. Number of employees on payroll who work 24 hours or more per week: #		2. Number of employees eligible for health benefits coverage: #		
3. Number of employees in Colorado: # _____ Number of employees outside of Colorado: # _____		4. Total number of eligible employees enrolling in group plan: # _____ Total number of eligible employees waiving: # _____		
5. Number of full-time or part-time employees who were employed for 20 weeks or more this year or last year: # _____		6. Number of full-time or part-time employees who worked at least 50% of your working days in the preceding calendar year: # _____		
7. Are your employees leased from a leasing company or a professional employer organization? <input type="checkbox"/> Yes <input type="checkbox"/> No		8. Hours Worked Requirement:		
9. Waiting Period for New Hires: <input type="checkbox"/> Date of hire OR First of month following: <input type="checkbox"/> Date of hire <input type="checkbox"/> 1 Month <input type="checkbox"/> 3 Months <input type="checkbox"/> 6 Months <input type="checkbox"/> 9 Months <input type="checkbox"/> Other _____ Does any class have a different waiting period? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please describe:			10. Waiting Period Waived at Initial/ Open Enrollment <input type="checkbox"/> Yes <input type="checkbox"/> No	
11. Employer Contribution Medical (50% minimum of employee) Employee _____% Family _____%		12. Classes Excluded (If applicable, please describe.)		
13. Number of employees, former employees, or employees' dependents currently covered by or eligible for a Colorado or COBRA continuation of coverage plan: # _____			14. Does group administer its own COBRA? <input type="checkbox"/> Yes <input type="checkbox"/> No	
15. Number of eligible employees <u>only</u> <u>literate</u> in the same non-English language. _____ Identify the language:				
16. Do you want RMHP to assist in continuation of coverage administration? <input type="checkbox"/> Yes <input type="checkbox"/> No				
17. Does your company's eligibility include anyone who is not a company employee; for example, a person who is an independent contractor? <input type="checkbox"/> Yes <input type="checkbox"/> No				
18. Has your group been insured with health insurance during the past 90 days? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, name of current medical carrier:				
19. Was coverage through a MEWA? <input type="checkbox"/> Yes <input type="checkbox"/> No Self-Funded? <input type="checkbox"/> Yes <input type="checkbox"/> No				
20. Was coverage terminated due to: Nonpayment of Premium: <input type="checkbox"/> Yes <input type="checkbox"/> No Fraud: <input type="checkbox"/> Yes <input type="checkbox"/> No				

Section 3 – Desired Coverage

Small employers that employ between 10 and 50 eligible employees have a choice of composite rates or four-tier family age-banded rates and can request both to compare the two rating approaches. In either case, the total monthly premium to the employer is identical.

Age-banded rates means that you will be billed different premiums based on employees' ages. For example, the premium for a 60-year-old employee would be substantially higher than for a 20-year-old employee. Age-banded rates are always billed in four-tier monthly premiums: employee; employee and spouse; employee and child (or children); and employee, spouse, and child (or children). **Composite rates** do not vary because of age of the employee. In the example given above, both the 60- and 20-year-old employees would have the same monthly premium rate. Composite rates are available in four-tier (employee, employee and spouse, employee plus child or children, and employee plus family).

New group rate sheet attached. Rates presented shall be Composite Age-Banded (Mandatory for groups size 2 – 9 employees)
 COVERAGE SELECTED:

Medical Plan 1: Rx Plan: Brand Generic Only Both Rx plans (employees will select one) Accident Rider: Yes No N/A (VISTA & HMO Classic Plans)

Medical Plan 2: Rx Plan: Brand Generic Only Both Rx plans (employees will select one) Accident Rider: Yes No N/A (VISTA & HMO Classic Plans)

Medical Plan 3: Rx Plan: Brand Generic Only Both Rx plans (employees will select one) Accident Rider: Yes No N/A (VISTA & HMO Classic Plans)

Vision Plan:	EAP Plan:	Dental Plan:	Chiro Plan:	Good Health National Access (GHNA) available. Check desired access: <input type="checkbox"/> Out-of-state employees <input type="checkbox"/> Out-of-state dependents
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I understand that my group's coverage will not be made effective until all enrollment information given here or is otherwise provided to or obtained by Rocky Mountain HMO (RMHMO) or Rocky Mountain HealthCare Options, Inc. (RMHCO), is evaluated and approved by RMHMO or RMHCO.

I understand RMHMO or RMHCO has the right to terminate coverage and deny benefits if any information on this enrollment application or as otherwise provided by the undersigned for enrollment purposes is knowingly false, incomplete, or misleading in any material respect.

Any misrepresentation or failure to notify Rocky Mountain Health Plans of any change in responses between the date of application and the effective date of coverage could result in termination of coverage. Rocky Mountain Health Plans has the right to verify information provided and request additional information if necessary.

Employer/Authorized Signature:	Title:	Date:
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Broker Signature:	Name of Agency: <u>Roper Insurance</u>
	Broker Name: <u>Steven J. Roper</u>
	Alternate Contact: <u>Laura Buckingham</u>
Producer license #/Tax ID: 10561 - 841590836	Phone #: <u>303-721-1145</u>
	Email: <u>uw@roperinsurance.com</u>

Plans underwritten by Rocky Mountain HMO (RMHMO)	Plans underwritten by Rocky Mountain HealthCare Options (RMHCO)
Good Health Savings Plans HSA HMO Rocky Mountain VISTA HMO RMHMO HMO Standard Health Benefit Plan for Colorado RMHMO HMO Basic Limited Mandate Health Benefit Plan for Colorado	Rocky Mountain Good Health HMO Good Health Savings Plans HSA PPO Rocky Mountain Core Plus Hospital RMHCO PPO Standard Health Benefit Plan for Colorado RMHCO PPO Basic Limited Mandate Health Benefit Plan for Colorado

Read important information below:

Colorado law requires carriers to make available a Colorado Health Benefit 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.

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 small employer groups, see the enclosed Disclosure Notice for Small Employer Groups, which is incorporated into this document by reference.

