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

6E

SOLO Health Care Plan Application

Thank you for your interest in the SOLO plan, underwritten by Rocky Mountain HealthCare Options, Inc. (RMHCO). Please 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 or procedures and a lipid panel. 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.

You must include a nonrefundable application fee of $25 payable by check or money order made out to Rocky Mountain HealthCare Options, Inc. Application fee will be applied to your first month's premium. Fees **cannot** be accepted from a business account. If you have questions or need additional information as you complete this application, please call your broker or RMHCO at 800-453-2981.

Choose Plan Deductible		Choose Maternity Rider Deductible	Choose Any Rx Rider
❑ SOLO $500	AND	❑ $500 ❑ None	❑ None
❑ SOLO $1,500	AND	❑ $1,500 ❑ None	❑ $10 Generic
❑ SOLO $3,000		None Available	❑ $15/$40/$55 ❑ $250 deductible; $10/$20/$35
OR Choose an HSA-Eligible Plan			
❑ SOLO $2,000 HDHP ❑ SOLO $5,000 HDHP		None Available	None Available

Tobacco Use
Have you or a family member living in your household used tobacco products in the past 12 months? ❑ No ❑ Yes If yes, give person's name:

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

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)

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							
Dependent							
Dependent							

[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. If applying for Child Only, include only one $25 application fee for all dependent children applying at the same time.

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

For RMHP USE

MK14R1105P

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 and/or failure to notify RMHCO 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 effective date of coverage could result in retroactive termination of coverage. RMHCO 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.

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 (Please 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		

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: ______________________________

   ____

   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.

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

3. Are you or any family member listed on this application planning any hospitalization or medical/surgical treatment in the next 12 months?
   ❑ Yes ❑ No (If yes, please explain.) Person's name: ______________________________

   ____

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

   ____

For RMHP USE

5. 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:______________________________

6. Have you or any family member listed on this application seen a provider for **any** reason in the past 12 months **(including 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

7. 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

8. 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

9. Do you or any family member drink alcohol? ❑ Yes ❑ No
If yes, person's name:______________________________How much daily?________How much weekly?________

For RMHP USE

10. 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, give person's name and date of her 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: ______

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

12. 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: ______

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

abnormal Pap smear?	❑ Yes	❑ No
abnormal mammogram?	❑ Yes	❑ No
abnormal prostate screening?	❑ Yes	❑ No

If yes, explain: ______

Name: ______

14. Please disclose your and/or your spouse's occupation and type of work you and/or your spouse do:

______

15. Please disclose all hobbies all applicants participate in:

______

16. Have you or any family member listed on this application had a weight change during the past year? ❑ Yes ❑ No If yes, give people's names:

❑ Increased by 10 lbs. or more: ______

❑ Decreased by 10 lbs. or more: ______

Reason for each person's weight change: ______

17. If any family member listed on the application is six months of age or younger, fill in below and **submit medical records from date of birth to present (including records from the 1st and 2nd well-child check and 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

18. 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

Are you ending a COBRA or State Continuation of Benefits Plan in which you have ***exhausted ALL*** eligible coverage (18 months or 36 months) without a break in coverage of more than 62 days? ❑ **Yes** ❑ **No**

If you answered "YES," you may qualify for health coverage with no medical screening through CoverColorado*. If you need assistance with this process, contact CoverColorado at 303-863-1960 or 800-672-8447.

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 HealthCare Options, Inc., 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 RMHCO 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) are self-employed, 2) believe you may be a BG1, and 3) 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

If you've had insurance coverage before,
you must provide the information asked for in this chart.

List Each 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:		From: To:	
Policyholder's Name: Policy #: Group Name: S.S. Number:		From: To:	
Policyholder's Name: Policy #: Group Name: S.S. Number:		From: To:	
Policyholder's Name: Policy #: Group Name: S.S. Number:		From: To:	
Policyholder's Name: Policy #: Group Name: S.S. Number:		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 HealthCare Options, Inc., 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.)

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 RMHCO. 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+).

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 RMHCO to help you obtain proof of creditable coverage. Contact RMHCO at 970-244-7800 or 800-453-2981.

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. **You must include proof of creditable coverage for every family member listed on this application who has had health care coverage within the last 12 months.**

Please Tell Us How You Heard About Us

❑ Family member ❑ Broker ❑ Friend ❑ Newspaper/radio ❑ Health plan member

❑ Other ______________________________

For RMHP USE

Payment Options

Rocky Mountain HealthCare Options, Inc., offers flexible payment options. Choose one of the following payment methods:

- ☐ **Monthly — automatic bank withdrawal (complete Authorization below)**
- ☐ **Quarterly — cash, check, credit card (every three months)**
- ☐ **Biannual — cash, check, credit card (every six months)**
- ☐ **Annual — cash, check, credit card (every 12 months)**

Authorization for Automatic Withdrawal

I hereby authorize Rocky Mountain HealthCare Options, Inc., to initiate debit entries to the account indicated below, and I hereby authorize the depository (DEPOSITORY) named below to debit the same account.

This authority is to remain in full force and effect until RMHCO and DEPOSITORY have received written notification from me of termination in such time and in such manner as to afford RMHCO and DEPOSITORY a reasonable opportunity to act on it. If RMHCO does not receive written notification from me of termination of authority prior to the first day of the month, such termination shall not be effective until the last day of that month. I understand that this information will become part of the application and the policy.

Payor's Name: ______________________________

(Please Print — payor shall be the person who owns and controls the account)

Payor's Address: ______________________________

City, State, Zip: ______________________________

Depository (payor's financial institution): ______________________________

Account Number ______________________________

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. RMHCO reserves the right to cancel any policy for which RMHCO 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.

Signature of Payor X ______________________________ **Date Signed** ______________

IN THIS SPACE, STAPLE OR TAPE A SAMPLE VOIDED CHECK FROM THE ACCOUNT YOU WANT DEBITED

1234

Pay to the order of ______________________________ $

MEMO ______________ **VOID**

For RMHP USE

Signature and Certification

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

1. 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 HealthCare Options, Inc., (RMHCO) and receipt of the first premium, we shall have a contract with RMHCO, the terms of which are set forth in the applicable contract, which contract may be amended from time to time by RMHCO in accordance with applicable law.
2. 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 RMHCO such records and information and supplement such records and information as RMHCO requests. This authorization shall include all medical records and medical information. Such records and information may be used by RMHCO or made available by RMHCO to others for treatment, payment, or health care operations purposes, including but not limited to any quality assurance programs conducted by RMHCO or its designated agents or contractors. A copy of this authorization shall be as valid as the original until contract is terminated.
3. We consent to RMHCO performing case management.
4. 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.
5. RMHCO has the right to terminate coverage and deny benefits if any information on this enrollment application, or as otherwise provided by the undersigned to RMHCO for enrollment purposes, is knowingly false, incomplete, or misleading in any material respect. RMHCO has the right to deny coverage if any outstanding premiums or other payments are owed to RMHCO by the undersigned.
6. All information and answers provided in this application are true and correct.
7. The enrollment process will not be completed and coverage will not be effective until a Certificate of Creditable Coverage (if applying for a guaranteed issue plan) for each family member is received by RMHCO.
8. Any fraud or intentional misrepresentation as to the presence of any health condition, impairment, disease, or disorder will result in retroactive termination of coverage. RMHCO shall have the right to request and review additional information regarding health history.
9. We understand that the policy applied for will not pay for services unless they are medically necessary as determined by RMHCO.
10. 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.
11. 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.
12. We understand that any information regarding this application may be shared with our broker, if applicable.

The above provisions will remain in effect for the entire duration of RMHCO 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/SUBSCRIBER'S SIGNATURE

(If signing for minor, so indicate.) **X** ________________ **Date** ________

SIGNATURE OF SPOUSE APPLICANT (If applying for family membership)

X ________________ **Date** ________

— BROKER COMPLETE — PLEASE PRINT CLEARLY —

Broker/Agent MUST complete the following for application processing:

Broker Name: Steve Roper
Address: 9777 Mt. Pyramid Ct. # 110 Englewood CO 80112
Broker License #: RPI 10561
Broker Agency: Roper Insurance
Broker Fax #: 303 721-1085
Broker Phone #: 303 721-1145

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.

For RMHP USE