

**EMPLOYEE WAIVER OF ROCKY MOUNTAIN HMO AND HCO PLANS**

Employer Name or Business Name			Date of Active Employment		Employee Social Security Number	
Employee Last Name	First Name	M.I.	Home Phone ( )		Business Phone ( )	
Address (include P.O. Box)		City	State	Zip Code	County of Residence	

I hereby certify as follows on behalf of myself and each of my dependents:

1. I have been informed of the availability of coverage under Rocky Mountain HMO/HCO Health Benefit Plan(s) as offered by my employer;

2. I have been given an opportunity to enroll in such plan(s).

3. After careful consideration, I have declined to enroll in such plan(s) and decided to waive my opportunity to enroll in such plan(s). I have declined to enroll in such plan(s) for the following coverages:

- Single coverage for myself. Names: Spouse \_\_\_\_\_
- Coverage for my spouse. Dependent(s) \_\_\_\_\_
- Coverage for my dependent children. \_\_\_\_\_

I understand I cannot waive coverage for myself and enroll my dependents.

4. The reason I have chosen to decline such coverage is:

- I am covered under my spouse's group policy.
- I am covered under my spouse's individual policy.
- My dependents are covered under another plan.
- I cannot afford coverage.
- I wish to continue other coverage obtained through an Individual Plan.

5. I understand that if I decline coverage for myself or my dependents (including my spouse) because of other insurance coverage, I may, in the future, be able to enroll myself or my dependents (if I am already enrolled) in this plan as required by applicable law, provided I request enrollment within 30 days after my other coverage ends. I also understand that if I have a new dependent as a result of marriage, birth, adoption, or placement for adoption, I may be able to enroll myself and my dependents provided that I request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. I understand that if I do not request enrollment within 30 days for the above events, I will not be eligible for enrollment for such coverage until whichever of the following dates occur first: (1) the date I enroll for such coverage with Rocky Mountain HMO/HCO during an Annual Open Enrollment Period; or (2) the date twelve (12) months following the date I first request such coverage by Rocky Mountain HMO/HCO under a Rocky Mountain HMO/HCO health benefit plan offered by my employer. I also understand that, upon enrollment, I and/or my dependent(s) may be subject to a pre-existing condition limitation period.

6. I understand that before my spouse or dependent children can be enrolled in an Rocky Mountain HMO/HCO health benefit plan offered by my employer as the result of my employment, I must also be enrolled in such plan.

I am executing this document on my behalf and on behalf of my spouse and each of my dependents.

Signature \_\_\_\_\_ Date \_\_\_\_\_

**\* Please see other side for important information \***

MK105R1201P

Plans underwritten by Rocky Mountain HMO			Plans underwritten by HealthCare Options, Inc. (HCO)		
C1000	NH10/H10	FITT Single Track	PPO	POS (w/H10/NH10)	Indemnity
C5000	NH20/H20	FITT (Care Track 1 of Triple Track)		POS (w/C50/NC50)	
	NC50/C50	H10 Plus			
<i>Rocky Mountain HMO</i> HMO Basic Health Benefit Plan for Colorado			FITT (Care Tracks 2&3 of Triple Track)		
<i>Rocky Mountain HMO</i> HMO Standard Health Benefit Plan for Colorado					

*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. 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 HMO/HCO to any interested party upon request. Such access plans contain information on providers, 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 POLICY HOLDER 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.**