

SOLO Health Plan Application Checklist

Unanswered questions or incomplete/omitted information will result in the return or delay of your application. Please make sure the following are complete **BEFORE** you mail your application.

- Detach the tan colored application from the booklet for submission.
- Complete all sections of the application, including details and explanations if asked for.
- Include copies of required medical records (if age 50 or older and for any child between two and six months of age). See the next page for details of required medical records.
- Child-only applicants are listed as the subscriber. Complete a separate application for each child who is applying.
- Attach and write the applicant's name on additional pages if applicable.
- If you or any family member applying for coverage was previously covered by health insurance, complete the chart on page 2.
- If paying by automatic bank draft each month, attach a voided check. Write VOID on the signature line of the blank check.
- Sign in each applicable place, by the **X** on pages 6, 7, and 8.

Note: If your application is approved, your coverage will automatically begin on the first of the month following the date of approval unless an alternate date is requested and approved. Your first premium will be due and collected on the 4th day of the month in which your coverage begins.

If you want to withdraw your application for any reason, please contact the SOLO Sales Team immediately at 800-453-2981, option 4, or email to SOLO_Sales_Team@rmhp.org.

Rocky Mountain Health Plans (RMHP)

Medical Record Requirements

PLEASE NOTE: In order to complete your RMHP application, the following must be submitted within 30 days. If you have not had these required physical exams, please schedule an appointment with your doctor to do so. Your application cannot be processed without these requirements.

ADULTS

To enroll in an RMHP health plan, adults 50 years of age or older must have:

- History and physical within the last 12 months
- Pap test (unless documented hysterectomy) and mammogram within the last 12 months
- PSA within the last 12 months
- Lipid panel within the last 12 months
- Fasting blood glucose test results
- Liver function tests, within the last 12 months, if on statins
- Results from any other tests recommended during your physical exam

CHILDREN

To enroll in an RMHP health plan, children must have medical records from:

- 2-month Well Child check to include immunizations (babies less than 2 months of age are deferred until 2-month Well Child check)
- 2 most recent Well Child checks (for children less than 6 months)
- Recommended immunizations (for children up to age 18)
- If the mother is applying within 2 months of a child's birth, please provide the record from the 6-week post-partum check-up.

Rocky Mountain Health Plans accepts children for enrollment any time after their 2-month Well Child check.

Please have your doctor submit this information to us within 30 days of your enrollment application date.

Information should be mailed or faxed to:

Rocky Mountain Health Plans
Attention: SOLO Sales
2775 Crossroads Boulevard, PO Box 10600, Grand Junction, CO 81502
Fax: 970-244-7992

If you have any questions about these enrollment requirements, please call the RMHP SOLO Sales Department at 800-453-2981, option 4, or 970-244-7800, option 4.

RMHP reserves the right to request additional information, as needed, by our medical underwriters.

SOLO Health Plan Application

Thank you for your interest in the SOLO plan, underwritten by Rocky Mountain HealthCare Options, Inc. (RMHCO). 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 (including mammogram, PAP, or PSA) or procedures, a fasting blood glucose, and a lipid panel. **Infants** who are at least two months of age and under six months of age will require medical records from their two and/ or four month well-child check along with immunization records. 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.

If you have questions or need additional information as you complete this application, call your broker or RMHP at 800-453-2981, option 4.

Fax the completed application and medical records to 970-244-7992.

Please check the plan for which you are applying below. Be sure to check the Accident Rider or Prescription Drug rider if you want to add those to the medical plan. Generic drug coverage will be included if a different drug rider option is not selected.

SOLO VIEW PLANS	
Choose Plan Deductible Option	Prescription Drug Rider \$15 copay for Generic drugs is included in the plan unless another option is selected.
<input type="checkbox"/> SOLO \$500	<input type="checkbox"/> Discount Plan – You pay 100% of the RMHP discounted rate for prescription drugs
<input type="checkbox"/> SOLO \$500 w/ Maternity rider	<input type="checkbox"/> Brand Name Drug Rider \$15 / \$40 / \$60
<input type="checkbox"/> SOLO \$1,500	<input type="checkbox"/> Brand Name with \$250 Deductible Rider \$15 Generic copay (no deductible) \$40 / \$60 Brand Name copay after \$250 deductible
<input type="checkbox"/> SOLO \$2,500	Optional Accident Rider
<input type="checkbox"/> SOLO \$4,000	<input type="checkbox"/> Optional Accident Rider \$1 to \$1,000 covered in full for each accident, then deductible and coinsurance apply.

SOLO VIEW HSA PLANS	
Choose Plan Deductible Option	Prescription Drug Rider Generic prescription drug coverage is included with the plan and covered at 100% after deductible.
<input type="checkbox"/> SOLO HSA \$2,500/100	<input type="checkbox"/> Brand Name Drug Rider Generic and Brand Name prescription drugs are covered at 100% after deductible.
<input type="checkbox"/> SOLO HSA \$3,250/100	Optional Accident Rider
<input type="checkbox"/> SOLO HSA \$5,000/100	<input type="checkbox"/> Optional Accident Rider \$1 to \$1,000 covered in full for each accident, then deductible and coinsurance apply.

Effective Date

The effective date of coverage is the first of the month following the application approval date unless a later effective date is requested.

- 1st of the month following application approval date
- 15th of the month following application approval date
- 1st of _____ (write month here)

Please Tell Us How You Heard About Us

- Family member Broker Friend Newspaper/radio Health plan member Website Other _____

Did you work with a SOLO Sales Representative? Yes No Sales Representative Name: Scott P. Erickson

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

Are you applying to add a dependent to your existing SOLO Health Plan policy? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Subscriber: Last Name ¹		First Name		MI	Social Security Number ²
Address		City		State	County Zip Code
Tobacco use in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No				Email Address:	
Date of Birth — Mo/Day/Year _____		Height _____		Weight _____ <input type="checkbox"/> M <input type="checkbox"/> F	
<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Legally separated <input type="checkbox"/> Common law marriage (statement will be required)					

(continued on page 2)

For RMHP USE

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	Tobacco Use in the Past 12 Months?
Spouse									<input type="checkbox"/> Yes <input type="checkbox"/> No
Dependent									<input type="checkbox"/> Yes <input type="checkbox"/> No
Dependent over age 19 and under 25: Married? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Financially dependent or same household as the subscriber									
Dependent									<input type="checkbox"/> Yes <input type="checkbox"/> No
Dependent over age 19 and under 25: Married? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Financially dependent or same household as the subscriber									
Dependent									<input type="checkbox"/> Yes <input type="checkbox"/> No
Dependent over age 19 and under 25: Married? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Financially dependent or same household as the subscriber									
Dependent									<input type="checkbox"/> Yes <input type="checkbox"/> No
Dependent over age 19 and under 25: Married? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Financially dependent or same household as the subscriber									
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, <u>complete an application for each child subscriber.</u> ² Supply social security numbers if known. Missing numbers will be requested after enrollment.									

If you have had insurance coverage in the last 12 months, provide the information requested below.

List Each Policyholder's Covered 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: _____ Others on policy: _____		From: _____ To: _____	
Policyholder's Name: _____ Policy #: _____ Group Name: _____ S.S. Number: _____ Others on policy: _____		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 Health Plans will not pay for services related to a preexisting condition for 12 consecutive months after the Member's original membership Effective Date. (This 12 months is the pre-existing condition limitation period.)

Upon approval of your application, 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 RMHP. 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; (d) a state health benefits risk pool (including but not limited to the Cover Colorado Uninsurable Health Insurance Plan and CHP+) or (e) other federal coverage. **You must provide proof of creditable coverage for every family member listed on this application who has had health care coverage within the last 12 months.**

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 RMHP to help you obtain proof of creditable coverage. Contact RMHP at 970-244-7800, option 4 or 800-453-2981, option 4.

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.

For RMHP USE

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 could result in retroactive termination of coverage. Any failure to notify RMHP 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 later of the effective date of coverage or the date coverage is approved could also result in retroactive termination of coverage. RMHP 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. This additional information may be used to determine if RMHP will accept or decline your application prior to the effective date of coverage. No notice of acceptance related to your application can bind RMHP to coverage prior to the effective date of coverage, and failure to provide additional requested information could result in your application not being accepted.

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 (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		

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.

FamilyMember	Condition/Disease/Disorder	Date of Last Treatment	Date of Last Hospitalization	Doctor's Name and City

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: _____

3. Have you or any family member listed on this application been advised or are planning to have medical or surgical treatment that has not yet been performed?
 Yes No (If yes, please explain.) Person's name: _____
4. Have you or any family member 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: _____
5. Have you or any family member listed on this application seen a provider for **ANY** reason in the past 12 months (including but not limited to sickness, physical exam, mammogram, Pap smear, prostate screening, injury, labwork, etc.)?
 Yes No If yes, complete the chart below for each visit in the past 12 months. Add and label another page if necessary.

Family Member	Reason for Treatment	Date of Treatment	Doctor's Name and Address

6. 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

7. 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

8. Does anyone listed on this application drink alcohol? Yes No
 If yes, person's name: _____ How much weekly? _____
 Name: _____ How much weekly? _____

9. 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, list female family members and dates of their last menstrual period (whether or not they are applying for coverage):**
 Name: _____ Month _____ Day _____ Year _____
 Name: _____ Month _____ Day _____ Year _____
 If no cycle, why? _____
 If any member's initial menstrual cycle has not yet begun, give her name: _____
 * If you or your spouse is pregnant, this plan is not available to you, regardless of whether or not the pregnant person is applying for coverage.
10. Is any person applying for coverage expecting a child or in the process of adoption or surrogacy with anyone, whether or not that other person is also applying for coverage on this application? Yes No
 Applicant Name: _____ When is the child expected to be born or adopted? _____
11. 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: _____
12. Have you or any family member listed on this application ever had an
 abnormal Pap smear? Yes No
 abnormal mammogram? Yes No
 abnormal PSA? Yes No
 If yes, explain: _____
 Name: _____
 * If you answered "Yes", provide the results from your last two screenings with your application.
13. Disclose occupation and type of work all applicants do:

14. Disclose all hobbies all applicants participate in:

15. Have you or any family member listed on this application had a weight change during the past year? Yes No If yes, provide name(s):
 Increased by 10 lbs. or more: _____
 Decreased by 10 lbs. or more: _____
 Reason for each person's weight change: _____
16. If any family member listed on the application is six months of age or younger, fill in below and **submit medical records from the two and/or four month well-child check along with 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
17. Have all applicants under the age of 18 years had all recommended immunizations? Yes No
 If no, list child's name and explain: _____