ROCKY MOUNTAIN ADMINISTRATORS
809 South Railway Avenue – P.O. Box 788
Worland, WY 82401
Phone – 307-347-2606 or 1-800-383-8808
Fax – 307-347-2646

EMPLOYEE ENROLLMENT/CHANGE FORM

To be completed by the EMPLOYEE ONLY
Please Print Legibly with Blue or Black Ink

NOTE: If you make a mistake when completing an answer, please correct, initial and date

NOTICE: A person who knowingly and with intent to defraud an insurer files an application or statement of claim containing any false, incomplete or misleading information may be guilty of insurance fraud which is a crime.

☐ **New Enrollment** ☐ **Open Enrollment** ☐ **Enrollment Change** ☐ **Rehire** ☐ **Special Enrollee**

EMPLOYER INFORMATION: ALL FULL-TIME EMPLOYEES MUST COMPLETE THIS SECTION. PLEASE PRINT.

Employer Name _____ Group No. _____

Location _____
City State County Zip

EMPLOYEE INFORMATION: Include JR, SR, or numerical designation in the name. **PLEASE PRINT.**

Last Name _____ First Name _____ Mi _____ Jr./Sr./# _____

Social Security Number _____ Date of Birth _____ Gender ☐ Male ☐ Female

Street/Mailing Address _____ Marital Status ☐ Single ☐ Married

City _____ State _____ Country _____ Zip _____

Work Phone _____ Home Phone _____ Email _____

Date Employed Full Time _____ Job Title _____

Hours Worked Per Week _____ Annual Salary $ _____

If no longer employed, but on **COBRA**, enter employment termination date _____

BENEFICIARY: (For Life Insurance Only)

Name _____ Relationship _____
First MI Last

Address _____ Phone Number _____
Street / PO Box City State Zip

BENEFITS APPLIED FOR: (See Waiver if not applying for coverage for you or any of your dependents.) ☐ **New** ☐ **Change**

Applied For:	**Coverage Type:**			
☐Employee Only	☐Medical	☐Dental	☐Vision	☐Other_____
☐Employee and Spouse	☐Medical	☐Dental	☐Vision	☐Other_____
☐Employee and Children	☐Medical	☐Dental	☐Vision	☐Other_____
☐Family	☐Medical	☐Dental	☐Vision	☐Other_____

DEPENDENT INFORMATION: List **spouse** and all your **dependents** applying for coverage under this plan. PLEASE PRINT.

Add/ Drop	Relationship to You	First Name	Last Name	MI	Jr./Sr./#	Date of Birth	Gender M / F	Social Security Number
A							M	
A							F	
A							F	
A							F	
A							F	
A							F	

OTHER BENEFITS: Do you or any dependents listed on page 1 have coverage under another benefit plan? ☐ Yes ☐ No

Name of Covered Person _____ Relationship to You _____

Social Security Number of Covered Person _____ Date of Birth _____

Other Benefit Plan: Name _____ State _____ Phone _____

Name of Sponsoring Employer (if applicable) _____ Group Number _____

Type of Plan: ☐ **Group** ☐ **Individual** ☐ **Medicare** ☐ **Tricare** ☐ **O**ther _____

Types of Coverage: ☐ **Medical** Effective Date _____ ☐ **HMO** ☐ **PPO**

☐ **Dental** Effective Date _____ ☐ **Rx** Effective Date _____ ☐ **Vision** Effective Date _____

Is the Covered Person retired ? ☐ YES ☐ NO If **YES**, enter date of retirement _____

Are you and all dependents listed on page 1 covered under this plan? ☐ YES ☐ NO If **NO**, list names of covered individuals.

_____ _____ _____

_____ _____ _____

Are you or your dependents listed on page 1 eligible for any other coverage? ☐ YES ☐ NO

If **YES**, attach another page with the same information requested above.

* If you have other benefits, please attach any additional pages to this form. ☐ Check this box if you used an additional form.

PROOF OF PRIOR COVERAGE: Complete this section only if you or your dependents are not covered under your employer's current group health plan. Did you or your dependent(s) have MAJOR MEDICAL coverage with another carrier(s) other than your current employer coverage? ☐ Yes ☐ No

If yes, complete the following. Please attach certificate(s) of creditable coverage from prior plan(s)):

Employer Name _____ Phone _____

Prior Carrier Name _____ Phone _____

Policy No. _____ Effective Date _____ Termination Date _____

Covered Members (check all that apply) ☐ Employee ☐ Spouse ☐ Child(ren)

WAIVER OF COVERAGE: This is to certify that I have been given the opportunity to apply for group medical, dental and/or any other coverage offered by my employer and that I have decided not to apply. **I understand that if I choose to apply for this coverage in the future, I or my dependents may be considered late enrollees and coverage may be delayed for up to 18 months.**

I also understand that if my employer offers any ancillary benefits (Employee Life, Employee Short Term Disability or Employee Long Term Disability), I will be covered under these benefits unless I decline all coverage offered by my employer or am not otherwise eligible for that coverage.

☐ Declining **all** group coverage offered by my employer at this time

☐ Medical coverage declined for:	☐ Employee	☐ Spouse	☐ Child(ren)
☐ Dental coverage, if available, declined for:	☐ Employee	☐ Spouse	☐ Child(ren)
☐ Other coverage, if available, _____ declined for:	☐ Employee	☐ Spouse	☐ Child(ren)

Reason for declining coverage:

☐ Covered by Spouse's Group Health Plan	☐ Government Plan
☐ Individual Medical Plan	☐ Medicare
☐ COBRA	☐ Medicaid
☐ Not Affordable	☐ State Plan
☐ Other (explain) _____	

AGREEMENT AND AUTHORIZATION: Unless waived above, I request insurance under my employer's insurance plan as it is now or as it may be amended in the future. I authorize my employer to make deductions from my earnings for my share of the cost, if any, for the benefits to which I may become entitled. I represent that all statements and answers made in this application are complete and true, and I understand that answers will be the basis of any coverage issued.

I authorize Plan Sponsor, Rocky Mountain Administrators, LLC, its reinsures and other authorized representatives, to obtain, use, and/or disclose certain information about me as indicated below.

Rocky Mountain Administrators, LLC obtain and maintain Protected Health Information (PHI) about me to perform specific functions. This Authorization describes the type of information that is collected and my rights regarding how that information can be used.

Protected Health Information (PHI) includes individually identifiable health information that is created or received by my provider, my health plan or insurer, a data clearinghouse, a health authority, employer, school or university. PHI can be maintained or transmitted in any form or medium. It relates to the past, present, or future:

- Condition of my physical or mental health:
- Health care provided to me; or
- Payment for the health care provided to me.

PHI does not include summary health information or information that has been de-identified according to the standards for de-identification provided for in the HIPAA Privacy Rule.

This information may be obtained from a number of sources including, but not limited to, applications for health plan coverage, questionnaires, health care providers, claims for payment filed by myself or health care providers, referrals made by health care providers, and my medical records. Other sources of PHI include group health plan administrators, insurance carriers, the Medical Information Bureau, employers, and other business partners such as pharmacy benefit managers, third-party administrators, consultants, agents or brokers. PHI may be obtained over the telephone, by mail, or e-mail.

Rocky Mountain Administrators, LLC are committed to the privacy of your PHI and has required all business associates and vendors to agree in writing to those same protections. Despite these efforts, we are required by law to advise you that your information may at some point fall outside of the protections.

I understand I have a right to inspect and copy my own PHI to be used or disclosed. I also understand that failure to sign this Authorization will result in my application not being considered. A simulated, faxed or copied image of this Authorization shall be as valid as the original.

Employee Signature _____ **Date** _____

IMPORTANT NOTICE: PLEASE DETACH AND READ

SPECIAL ENROLLMENT RIGHTS

Special Enrollments

If you are declining enrollment for yourself or your dependents (including your spouse) because of health insurance coverage, or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days or any longer period that applies under the plan after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage). In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days or any longer period that applies under the plan after the marriage, birth, adoption, or placement for adoption.

Special Information for people on FMLA leave. If you are taking leave under the Family and Medical Leave Act (FMLA) and you drop health coverage during your leave, any days without health coverage while on FMLA leave will not count toward your days break in coverage. In addition, if you do not return from leave, the 30-day period to request special enrollment in another plan will not start before your FMLA leave ends.

To request special enrollment or obtain more information, contact your human resource department.

<u>This form MUST be left with ALL Applicants</u>

NOTICE OF CONSUMER PRIVACY PRACTICES
Effective: April 14, 2004
ROCKY MOUNTAIN ADMINISTRATORS, LLC

Please read and review our Privacy Notice and, if applicable, share it with those individuals receiving coverage under your policy or Plan.

Privacy Practices Introduction

This Plan is subject to the Health Insurance Portability and Accountability Act (HIPAA). On the basis of that law, privacy regulations apply to certain protected health information. This privacy notice describes the type of information that is collected and your rights regarding how that information can be used.

In order to provide insurance coverage and/or health plan administrative services, we must obtain and maintain Protected Health Information (PHI).

PHI is individually identifiable health information that is created or received by your provider, health plan or insurer, a data clearing house, a health authority, employer, school or university. PHI can be maintained or transmitted in any form or medium. It relates to the past, present or future:

- Condition of your physical or mental health
- Health care provided to your: or
- Payment for the health care provided to you

PHI does not include summary health information or information that has been de-identified according to the standards for de-identification provided for in the HIPAA Privacy Rule.

We have developed privacy policies and procedures in order to ensure the privacy of your PHI. These policies and procedures are based on appropriate administrative, technical and physical safeguards necessary to maintain confidentiality.

Permitted/required use and disclosure of your protected health information (PHI)
Your PHI will be used and disclosed for the purpose of routine treatment, payment of your benefits and health care operation, including plan and benefit administration.

Use and Disclosure for Treatment
Your PHI may be used by, and disclosed to, health care providers including, but not limited to, doctors, nurses, laboratory technicians, medical students and other health care personnel involved in your treatment.

Use and Disclosure for Payment
Your PHI may be used by and disclosed to, individuals involved in the collection of your premium and the payment of your benefits and other claims administration, including claim payment and adjudication of subrogation of health benefit claims. The use and disclosure also includes verification of participation and enrollment in the plan, eligibility for coverage and plan benefits. Your PHI may be shared with persons involved in utilization review, including pre-certification, pre-authorization, and concurrent and retrospective review, to assist in reimbursement of health care claims or other claims payment.

Use and Disclosure for Health Care Operations
Your PHI may be used and disclosed for plan operation purposes including, but not limited to: underwriting; premium rating; billing premium adjustments; submitting claims; placing a contract for reinsurance of risk relating to claims for health care, including stop-loss and excess loss insurance; quality review assessments; audits; including fraud and abuse detection and compliance programs; business management and planning; the sale, transfer, merger or consolidation of a covered entity; legal or administrative services; actuarial pricing, studies and review; complaint review; and regulatory review and other legal compliance. In addition, your PHI may be used and disclosed for case management, and care coordination, contacting of health care providers and patients with information about treatment, drug and disease management alternatives and other related functions that do not include treatment.

Other Uses and Disclosures of PHI
We or out approved business associates, may use and disclose your protected health information for reasons permitted by the Rule, including, but not limited to the following:

- Those required by law
- Required by a court order or other legal proceeding
- Law enforcement purposes
- Complying with worker's compensation or other similar laws
- Public health activities
- Reporting abuse, neglect or domestic violence
- Disclosures to coroners, medical examiners and funeral directors
- Organ, eye or tissue donation purposes
- National security and intelligence agencies as authorized by law

Your PHI may also be used or disclosed between your health plan, plan sponsor and any approved business associates as required or permitted by law.

There are some services provided to the plan through business associates. Examples include accountants, attorneys, actuaries, medical consultants, as well as those who provide managed care, quality assurance, claims auditing, claims monitoring and rehabilitation services. When these services are contacted, it may be necessary to disclose y our health information to our business associates in order to them to perform the job we have asked them to do. To protect employees' health information, however, the company will require the business associate to appropriately safeguard this information.

Unless specifically requested not to, we will communicate PHI in connection with treatment, payment or health care operations with any family member covered under your plan. Should any family member want a restriction on such disclosure of PHI, they must request such restriction in writing. Although we are not required to agree to a requested restriction, we will consider all factors explained in the request.

All efforts will be made to use, disclose or request only the minimum necessary amount of the covered person's PHI to accomplish the intended purpose. Uses and disclosures of PHI for purpose other than those described will be made only with your written authorization.

Your Individual Rights with Respect to PHI
Upon written request, you have the right to:

- Request restrictions on certain uses and disclosures of your PHI. We are not required to agree to requested restriction.
- Receive confidential communication of PHI
- Access our records containing descriptions of your PHI
- Request an amendment to your PHI. We are not required to agree to a requested amendment.
- Receive an accounting of PHI disclosures.

Our Duties Regarding the Use and Disclosure of PHI
We are committed to maintaining your privacy and are required:

- By law to maintain the privacy of PHI to provide you with notice of our legal duties and privacy practices with respect to PHI.
- To abide by the terms of the Notice of Privacy Practices currently in effect.

We reserve the right to change the terms of this privacy notice, and have such change be effective for all PHI that is maintained. Notification of a revised privacy notice will be provided through one of the following:

- U.S. Postal Service
- Revised Plan Document
- Internet E-mail

HOW TO FILE A COMPLAINT REGARDING THE USE AND DISCLOSRUE OF YOUR PHI
If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of Health and Human Services. All complaints must be in writing. Please be assured that you may not be retaliated against for filing a complaint.

HOW TO CONTACT US
You may contact our representative at:
Privacy Officer / HIPAA Compliance Department
Rocky Mountain Administrators
P.O. Box 788
Worland, WY 82401
307-347-2606