ROCKY MOUNTAIN HEALTH PLANS®
We understand Colorado. We understand you.

BA

Request for Enrollment of Designated Beneficiary

This form must be completed and returned to Rocky Mountain Health Plans (RMHP) before RMHP will consider enrollment of a designated beneficiary. Submitting this form means you are requesting RMHP to enroll a designated beneficiary as a dependent of Employee.

Please complete using black ink only. We cannot process incomplete forms.

Name of Employee:
Name of Designated Beneficiary:
Address:
Employer:

We attest to the following:

1. We are parties to a valid designated beneficiary agreement and have no knowledge of any superseding legal documents.
2. We are both 18 years of age or older.
3. We are both competent to enter into a contract.
4. Neither of us is married or in a civil union with another person.
5. Neither of us are a party to a designated beneficiary agreement with another person.
6. We have entered into the designated beneficiary agreement without force, fraud or duress.
7. Our designated beneficiary agreement is recorded with the clerk & recorder in the following county or counties:

   _____
8. A true and correct certified copy of our recorded designated beneficiary agreement is submitted with this statement.

The undersigned swear and affirm the above facts are true.

Print Employee Name	
Signature of Employee	Date
Print Name of Designated Beneficiary	
Signature of Designated Beneficiary	Date