Enrollment/Change Form

CALIFORNIA LAW PROHIBITS AN HIV TEST FROM BEING REQUIRED OR USED BY HEALTH CARE SERVICE PLANS AS A CONDITION OF OBTAINING HEALTH COVERAGE.

PLAN INFORMATION

Benefit plan
Effective date
Group no.
Class
Subgroup

Fax form to:
916.568.0334

2349 Gateway Oaks Drive
Suite 100
Sacramento, CA 95833

916.563.2250 or
888.563.2250

Visit our website for more information at:
westernhealth.com

ENROLLMENT

❏ New group ❏ Open enrollment

❏ New hire — date of hire: ______________________

❏ Newly eligible — reason: ______________________

____

❏ COBRA — effective date: ______________________

Directions: Complete entire form. Select a Primary Care Physician (PCP) for yourself and each family member from the Provider Directory (or online at westernhealth.com) by writing his/her name and ID number in the appropriate areas below. *If you do not select a PCP, one will be assigned to you.* **Yellow highlighted boxes are required fields and must be completed.**

CHANGE

❏ Add dependent *

❏ Add newborn/newly adopted child *

❏ Remove dependent — effective: ______________________

❏ Change of name

❏ Change of address

❏ Change of PCP (will be effective first of the month following request)

* Date of qualifying event (if outside open enrollment): ___________

Directions: Complete only the *first* section of yellow highlighted boxes (including your name, SS#, gender and date of birth) and any sections applicable to the change you are making.

SECTION I — MEMBER INFORMATION

	Employer	
Employee name: First	Last	MI
SS#	Date of birth	Gender ❏ Male ❏ Female

Physical address (required)	City	ST	Zip
Mailing address	City	ST	Zip

Email address		Job title
Home phone ( )	Work phone ( )	Existing patient of PCP? ❏ Yes ❏ No
PCP name	Medical group	PCP ID#
Racial identity	❏ White/Caucasian ❏ American Indian/Alaskan Native ❏ Asian ❏ Black/African American ❏ Native Hawaiian/Pacific Islander ❏ Other ______	
Ethnic identity	❏ Of Hispanic or Latino origin ❏ Not of Hispanic or Latino origin	
Primary language spoken	❏ English ❏ Spanish ❏ Russian ❏ Chinese ❏ Tagalog ❏ Vietnamese ❏ Other ______	
Primary language written	❏ English ❏ Spanish ❏ Russian ❏ Chinese ❏ Tagalog ❏ Vietnamese ❏ Other ______	

SECTION II — DEPENDENT INFORMATION

❏ Add ❏ Remove	❏ Spouse ❏ Domestic partner	SS#
Name: First	Last	MI
Date of birth	Gender ❏ Male ❏ Female	PCP name
Existing patient of PCP? ❏ Yes ❏ No	Medical group	PCP ID#
Racial identity	❏ White/Caucasian ❏ American Indian/Alaskan Native ❏ Asian ❏ Black/African American ❏ Native Hawaiian/Pacific Islander ❏ Other ______	
Ethnic identity	❏ Of Hispanic or Latino origin ❏ Not of Hispanic or Latino origin	
Primary language spoken	❏ English ❏ Spanish ❏ Russian ❏ Chinese ❏ Tagalog ❏ Vietnamese ❏ Other ______	
Primary language written	❏ English ❏ Spanish ❏ Russian ❏ Chinese ❏ Tagalog ❏ Vietnamese ❏ Other ______	

❏ Add	❏ Child ❏ Full-time student over the age of 19	SS#
❏ Remove	❏ Disabled (must meet criteria and provide proof of disability)	Relationship
Name: First	Last	MI
Date of birth	Gender ❏ Male ❏ Female	PCP name
Existing patient of PCP? ❏ Yes ❏ No	Medical group	PCP ID#
Racial identity	❏ White/Caucasian ❏ American Indian/Alaskan Native ❏ Asian ❏ Black/African American ❏ Native Hawaiian/Pacific Islander ❏ Other ______	
Ethnic identity	❏ Of Hispanic or Latino origin ❏ Not of Hispanic or Latino origin	
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Employee name

❑ Add ❑ Remove	❑ Child ❑ Full-time student over the age of 19	SS#		
	❑ Disabled (must meet criteria and provide proof of disability)	Relationship		
Name: First		Last		MI
Date of birth	Gender ❑ Male ❑ Female	PCP name		
Existing patient of PCP? ❑ Yes ❑ No	Medical group		PCP ID#	
Racial identity	❑ White/Caucasian ❑ American Indian/Alaskan Native ❑ Asian ❑ Black/African American ❑ Native Hawaiian/Pacific Islander ❑ Other ________			
Ethnic identity	❑ Of Hispanic or Latino origin ❑ Not of Hispanic or Latino origin			
Primary language spoken	❑ English ❑ Spanish ❑ Russian ❑ Chinese ❑ Tagalog ❑ Vietnamese ❑ Other ________			
Primary language written	❑ English ❑ Spanish ❑ Russian ❑ Chinese ❑ Tagalog ❑ Vietnamese ❑ Other ________			

Use additional forms if necessary to provide information for all dependents.

SECTION III — OTHER HEALTH COVERAGE INFORMATION

Are any of the enrollees listed in Section II eligible for Medicare? If yes, you must complete this section.

Name(s) of insured	Medicare Health Insurance Claim Number (HIC#)
Check all that apply: ❑ Age 65+ ❑ Disabled ❑ ESRD (End Stage Renal Disease)	

Name(s) of insured	Medicare Health Insurance Claim Number (HIC#)
Check all that apply: ❑ Age 65+ ❑ Disabled ❑ ESRD (End Stage Renal Disease)	

Do any of the enrollees listed in Section II have other health coverage? If yes, please complete this section.

Name(s) of insured	Insurance company		❑ Primary ❑ Secondary
Subscriber of coverage	Policy number	Effective date	

Name(s) of insured	Insurance company		❑ Primary ❑ Secondary
Subscriber of coverage	Policy number	Effective date	

SECTION IV — SIGNATURE REQUIRED

By signing below, I acknowledge that I have read, understand and agree to the terms and arbitration agreement stated below. A reproduction of this form shall be valid as an original.

A. On behalf of myself and my eligible Dependents, I hereby apply for health care services coverage offered by Western Health Advantage (WHA) through my Employer, and agree to be bound by the WHA Group Service Agreement, Evidence of Coverage and Disclosure Form, and this Enrollment/Change Form.

B. ARBITRATION AGREEMENT: I AGREE AND UNDERSTAND THAT ANY AND ALL DISPUTES BETWEEN MYSELF (INCLUDING ANY HEIRS OR ASSIGNS) AND WESTERN HEALTH ADVANTAGE, INCLUDING CLAIMS OF MEDICAL MALPRACTICE (THAT IS AS TO WHETHER ANY MEDICAL SERVICES RENDERED UNDER THE HEALTH PLAN WERE UNNECESSARY OR UNAUTHORIZED OR WERE IMPROPERLY, NEGLIGENTLY OR INCOMPETENTLY RENDERED), EXCEPT FOR SMALL CLAIMS COURT CASES AND CLAIMS SUBJECT TO ERISA, SHALL BE DETERMINED BY SUBMISSION TO BINDING ARBITRATION. ANY SUCH DISPUTE WILL NOT BE RESOLVED BY A LAWSUIT OR RESORT TO COURT PROCESS, EXCEPT AS CALIFORNIA LAW PROVIDES FOR JUDICIAL REVIEW OF ARBITRATION PROCEEDINGS. THE PARTIES, INCLUDING ANY HEIRS OR ASSIGNS, TO THIS ARBITRATION AGREEMENT ARE GIVING UP THEIR CONSTITUTIONAL RIGHT TO HAVE ANY SUCH DISPUTE DECIDED IN A COURT OF LAW BEFORE A JURY, AND INSTEAD ARE ACCEPTING THE USE OF BINDING ARBITRATION.

Employee signature: ______________________ Date: ____________

To the best of my knowledge the information contained herein is true and accurate. I hereby attest that employees and dependents submitted to WHA for coverage meet all eligibility requirements set forth in the Group Service Agreement between WHA and the employer group.

Employer signature: ______________________ Date: ____________