



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

ENROLLMENT

<input type="checkbox"/> New group <input type="checkbox"/> Open enrollment <input type="checkbox"/> New hire — date of hire: _____ <input type="checkbox"/> Newly eligible — reason: _____ _____ <input type="checkbox"/> 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. <i>If you do not select a PCP, one will be assigned to you.</i> Yellow highlighted boxes are required fields and must be completed.

CHANGE

<input type="checkbox"/> Add dependent * <input type="checkbox"/> Add newborn/newly adopted child * <input type="checkbox"/> Remove dependent — effective: _____ <input type="checkbox"/> Change of name <input type="checkbox"/> Change of address <input type="checkbox"/> Change of PCP (will be effective first of the month following request) * Date of qualifying event (if outside open enrollment): _____
Directions: Complete only the <i>first</i> 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

Employee name: First		Employer	
Last		MI	
SS#	Date of birth	Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female

Physical address (required)	City	ST	Zip
Mailing address	City	ST	Zip
Email address	Job title		
Home phone ()	Work phone ()	Existing patient of PCP? <input type="checkbox"/> Yes <input type="checkbox"/> No	
PCP name	Medical group	PCP ID#	
Racial identity <input type="checkbox"/> White/Caucasian <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> Other _____			
Ethnic identity <input type="checkbox"/> Of Hispanic or Latino origin <input type="checkbox"/> Not of Hispanic or Latino origin			
Primary language spoken <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Russian <input type="checkbox"/> Chinese <input type="checkbox"/> Tagalog <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other _____			
Primary language written <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Russian <input type="checkbox"/> Chinese <input type="checkbox"/> Tagalog <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other _____			

SECTION II — DEPENDENT INFORMATION

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

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

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/Change Form

Employee name

Fax form to:
916.568.0334

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Suite 100
Sacramento, CA 95833

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information at:
westernhealth.com

<input type="checkbox"/> Add	<input type="checkbox"/> Child	<input type="checkbox"/> Disabled (must meet criteria and provide proof of disability)	
<input type="checkbox"/> Remove	<input type="checkbox"/> Full-time student over the age of 19	Relationship	
Name: First		Last	MI
Date of birth	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	PCP name	
Existing patient of PCP? <input type="checkbox"/> Yes <input type="checkbox"/> No	Medical group	PCP ID#	
Racial identity <input type="checkbox"/> White/Caucasian <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> Other _____			
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<input type="checkbox"/> Add	<input type="checkbox"/> Child	<input type="checkbox"/> Disabled (must meet criteria and provide proof of disability)	
<input type="checkbox"/> Remove	<input type="checkbox"/> Full-time student over the age of 19	Relationship	
Name: First		Last	MI
Date of birth	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	PCP name	
Existing patient of PCP? <input type="checkbox"/> Yes <input type="checkbox"/> No	Medical group	PCP ID#	
Racial identity <input type="checkbox"/> White/Caucasian <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> Other _____			
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SECTION III — OTHER HEALTH COVERAGE INFORMATION

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	<input type="checkbox"/> Primary
Subscriber of coverage	Policy number	Effective date <input type="checkbox"/> Secondary

Name(s) of insured	Insurance company	<input type="checkbox"/> Primary
Subscriber of coverage	Policy number	Effective date <input type="checkbox"/> Secondary

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: _____