Enrollment/Change Form

Directions: Complete entire form. An identification card cannot be issued without selection of a Primary Care Physician (PCP). Please select a PCP for yourself and each of your family members from the provider directory 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.

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

Date of marriage, adoption, COBRA or termination effective: ______________________________

Benefit plan:
Effective date:
Group no.:
Class:
Subgroup:

- ❑ New group
- ❑ Open enrollment
- ❑ New hire
- ❑ Newly eligible
- ❑ COBRA
- ❑ Add dependent
- ❑ Add newborn/newly adopted child
- ❑ Terminate employee
- ❑ Remove dependent
- ❑ Change of name
- ❑ Change of address
- ❑ New PCP

Fax Enrollment/Change Form to: 916.568.0334

1331 Garden Highway
Suite 100
Sacramento, CA 95833

916.563.2250 or
888.563.2250

Visit our website for more information at: westernhealth.com

SECTION I — ENROLLEE DATA

Gender: ❑ Male ❑ Female	SS#	Date of birth	
Employee name: First	Last	MI	
Address	City	ST	Zip
Home phone ( )	Work phone ( )	Date of hire	
Employer name	Title		
PCP name	Medical group	PCP ID#	
Existing patient? ❑ Yes ❑ No	Hearing impaired? ❑ Yes ❑ No	Vision impaired? ❑ Yes ❑ No	
Primary language: ❑ English ❑ Spanish ❑ Cantonese ❑ Hmong ❑ Russian ❑ Other			

SECTION II — SPOUSE/DEPENDENTS TO BE COVERED/REMOVED

Please list all family members to be covered/removed by this enrollment form. Use additional forms to list additional dependents.
If dependent child is age 19 or over, is he/she a full-time student? ❑ Yes ❑ No

❑ Add ❑ Remove	Name: First		Last	MI
Date of birth	Gender ❑ Male ❑ Female	Relationship	PCP name	
PCP ID#		Medical group		Existing patient? ❑ Yes ❑ No
❑ Add ❑ Remove	Name: First		Last	MI
Date of birth	Gender ❑ Male ❑ Female	Relationship	PCP name	
PCP ID#		Medical group		Existing patient? ❑ Yes ❑ No
❑ Add ❑ Remove	Name: First		Last	MI
Date of birth	Gender ❑ Male ❑ Female	Relationship	PCP name	
PCP ID#		Medical group		Existing patient? ❑ Yes ❑ No

SECTION III — PLEASE LIST OTHER HEALTH INSURANCE OR COVERAGE

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

Name of insured	Insurance company	Policy number	Type of coverage	Subscriber of coverage	Effective date
			❑ Primary ❑ Secondary		
			❑ Primary ❑ Secondary		
			❑ Primary ❑ Secondary		

SECTION IV — SIGNATURE REQUIRED FOR TERMS AND CONDITIONS AND ARBITRATION CLAUSE—READ CAREFULLY

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

A. I desire to participate in the coverages selected and hereby authorize my Employer to make the necessary deduction(s) from my wage/salary to pay my portion of the premium. I understand that all services must be obtained from plan doctors.

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 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: ____________________

Distribution: White – WHA Pink – Employer Copy Canary – Employee Copy

Keep last copy as temporary ID card — see back for terms and conditions

Enrollment/Change Form

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TERMS AND CONDITIONS

On behalf of myself and my eligible Dependents, I hereby apply for health care services coverage indicated in Western Health Advantage's group health plan offered through my Employer, and agree to and understand the following:

1. To be bound by Western Health Advantage Group Service Agreement ("Agreement"), Evidence of Coverage and Disclosure Form, and this Enrollment/Change Form.
2. That my Employer may deduct from my earnings the employee contribution required to cover my share of the premium, if any.
3. Western Health Advantage or a designee shall have access to and use of my medical records and the medical records of my dependents, including mental health medical records and medical records from drug and alcohol abuse treatment or prevention, for purposes of utilization review, quality assurance, surveys, processing of claims, financial audits, rating, diagnosis and treatment, billing, claims management, medical data processing and administrative or health care operations, and any other purposes authorized by law.
4. Any material omission or misrepresentation in answering the questions on this application may result in the denial of benefits and the termination of my and/or my Dependents' membership in Western Health Advantage.
5. Coverage shall not begin until acceptance of this enrollment by Western Health Advantage. Upon acceptance of this Enrollment Change Form, Western Health Advantage shall be bound by the terms of the Agreement and the Evidence of Coverage and Disclosure Form, and any Amendments to either of those.
6. My Dependents and I must live or work in Western Health Advantage's service area.
7. I represent that the information supplied is true and I hereby authorize payroll deductions from my earnings for any contributions or fees required to maintain my eligibility.