



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.

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.

CHANGE

FOR CHANGES, Member ID#: _____

Add dependent *
 Add newborn/newly adopted child *
 Remove dependent — effective: _____
 Change of name
 Change of address

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

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

PLAN INFORMATION

Benefit plan
Effective date
Group #
Class
Subgroup

Fax form to:
916.568.0334

2349 Gateway Oaks Dr.
Suite 100
Sacramento, CA 95833

916.563.2206 or
888.563.2200

To update online
via eBill visit
westernhealth.com

SECTION I — MEMBER INFORMATION

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

Physical address (required)	City	ST	Zip
Mailing address (if different)	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#	
Primary language spoken	<input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Russian <input type="checkbox"/> Chinese <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other	<input type="checkbox"/> Decline to state	
Primary language written	<input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Russian <input type="checkbox"/> Chinese <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other	<input type="checkbox"/> Decline to state	
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 _____	<input type="checkbox"/> Decline to state	
Ethnic identity	<input type="checkbox"/> Of Hispanic or Latino origin <input type="checkbox"/> Not of Hispanic or Latino origin	<input type="checkbox"/> Decline to state	

SECTION II — DEPENDENT INFORMATION

<input type="checkbox"/> Add <input type="checkbox"/> Remove	<input type="checkbox"/> Spouse <input type="checkbox"/> Domestic partner	SS#	
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#
Primary language spoken	<input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Russian <input type="checkbox"/> Chinese <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other	<input type="checkbox"/> Decline to state	
Primary language written	<input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Russian <input type="checkbox"/> Chinese <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other	<input type="checkbox"/> Decline to state	
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 _____	<input type="checkbox"/> Decline to state	
Ethnic identity	<input type="checkbox"/> Of Hispanic or Latino origin <input type="checkbox"/> Not of Hispanic or Latino origin	<input type="checkbox"/> Decline to state	

<input type="checkbox"/> Add	<input type="checkbox"/> Child, up to age 26	SS#	
<input type="checkbox"/> Remove	<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#
Primary language spoken	<input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Russian <input type="checkbox"/> Chinese <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other	<input type="checkbox"/> Decline to state	
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Employee name

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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#
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Name: First		Last MI
Date of birth	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	PCP name
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Use additional forms if necessary to provide information for all dependents.

SECTION III — OTHER HEALTH COVERAGE INFORMATION

Do any of the enrollees have other health coverage or Medicare? If yes, please complete this section.

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

Name(s) of insured	Insurance company	<input type="checkbox"/> Primary
Subscriber of coverage	Policy # / Medicare claim #	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, NEGLIGENCE 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: _____