# 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

| Employer | | |
|---|---|---|
| Employee name: First | Last | MI |
| SS# | Date of birth | Gender ❑ Male ❑ 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? ❑ Yes ❑ No |
| PCP name | Medical group | PCP ID# |

| | | |
|---|---|---|
| Primary language spoken | ❑ English ❑ Spanish ❑ Russian ❑ Chinese ❑ Vietnamese ❑ Other | ❑ Decline to state |
| Primary language written | ❑ English ❑ Spanish ❑ Russian ❑ Chinese ❑ Vietnamese ❑ Other | ❑ Decline to state |
| Racial identity | ❑ White/Caucasian ❑ American Indian/Alaskan Native ❑ Asian ❑ Black/African American ❑ Native Hawaiian/Pacific Islander ❑ Other ______________________ | ❑ Decline to state |
| Ethnic identity | ❑ Of Hispanic or Latino origin ❑ Not of Hispanic or Latino origin | ❑ Decline to state |

## 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# | |

| | | |
|---|---|---|
| Primary language spoken | ❑ English ❑ Spanish ❑ Russian ❑ Chinese ❑ Vietnamese ❑ Other | ❑ Decline to state |
| Primary language written | ❑ English ❑ Spanish ❑ Russian ❑ Chinese ❑ Vietnamese ❑ Other | ❑ Decline to state |
| Racial identity | ❑ White/Caucasian ❑ American Indian/Alaskan Native ❑ Asian ❑ Black/African American ❑ Native Hawaiian/Pacific Islander ❑ Other______________________ | ❑ Decline to state |
| Ethnic identity | ❑ Of Hispanic or Latino origin ❑ Not of Hispanic or Latino origin | ❑ Decline to state |

| ❑ Add | ❑ Child, up to age 26 | 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# | |

| | | |
|---|---|---|
| Primary language spoken | ❑ English ❑ Spanish ❑ Russian ❑ Chinese ❑ Vietnamese ❑ Other | ❑ Decline to state |
| Primary language written | ❑ English ❑ Spanish ❑ Russian ❑ Chinese ❑ Vietnamese ❑ Other | ❑ Decline to state |
| Racial identity | ❑ White/Caucasian ❑ American Indian/Alaskan Native ❑ Asian ❑ Black/African American ❑ Native Hawaiian/Pacific Islander ❑ Other______________________ | ❑ Decline to state |
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| Employee name |
|---|
| |

| ❑ Add | ❑ Child, up to age 26 | | 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# | |
| Primary language spoken | ❑ English ❑ Spanish ❑ Russian ❑ Chinese ❑ Vietnamese ❑ Other ❑ Decline to state | | | |
| Primary language written | ❑ English ❑ Spanish ❑ Russian ❑ Chinese ❑ Vietnamese ❑ Other ❑ Decline to state | | | |
| Racial identity | ❑ White/Caucasian ❑ American Indian/Alaskan Native ❑ Asian ❑ Black/African American ❑ Decline to state ❑ Native Hawaiian/Pacific Islander ❑ Other_______________________________________ | | | |

| ❑ Add | ❑ Child, up to age 26 | | 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# | |
| Primary language spoken | ❑ English ❑ Spanish ❑ Russian ❑ Chinese ❑ Vietnamese ❑ Other ❑ Decline to state | | | |
| Primary language written | ❑ English ❑ Spanish ❑ Russian ❑ Chinese ❑ Vietnamese ❑ Other ❑ Decline to state | | | |
| Racial identity | ❑ White/Caucasian ❑ American Indian/Alaskan Native ❑ Asian ❑ Black/African American ❑ Decline to state ❑ Native Hawaiian/Pacific Islander ❑ Other_______________________________________ | | | |

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 | | ❑ Primary |
|---|---|---|---|
| Subscriber of coverage | Policy # / Medicare claim # | Effective date | ❑ Secondary |

| Name(s) of insured | Insurance company | | ❑ Primary |
|---|---|---|---|
| Subscriber of coverage | Policy # / Medicare claim # | Effective date | ❑ 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:___________________________