



# 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 #
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: _____	
<p><b>Directions:</b> 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.</p>	

## CHANGE

FOR CHANGES, Member ID#: _____
<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
* Date of qualifying event (if outside open enrollment): _____
<p><b>Directions:</b> Complete only the yellow highlighted boxes (your name, SS#, gender and date of birth) and any sections applicable to the change you are making.</p>

## 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"/> Decline to state
		<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		<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"/> Decline to state
		<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		<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
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
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Fax form to:  
916.568.0334

2349 Gateway Oaks Dr.  
Suite 100  
Sacramento, CA 95833

916.563.2206 or  
888.563.2250

To update online  
via eBill visit  
westernhealth.com



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Employee name
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<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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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, 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: \_\_\_\_\_