



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 <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	
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	
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	

<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	
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	
Racial identity	<input type="checkbox"/> White/Caucasian <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American	
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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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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

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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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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

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: _____



WHA Enrollment/Change Form-Dental

This addendum must accompany a WHA Enrollment/Change Form. All dependents enrolled under the medical plan will be enrolled under the dental plan.

WHA Group #:
Effective Date:

MEMBER INFORMATION	Employer
	Employee name: First Last

Dental Coverage: DHMO PPO

OTHER DENTAL COVERAGE: Do you or your dependents have other dental coverage? Yes No (If yes, complete the information below.)

Name of insured:	Social security number:		
Insured's employer:	Name of insurance carrier:		
Employer's street address:			
City:	State:	Zip:	Phone: ()
Are your dependent children enrolled under your spouse's (or registered domestic partner) dental plan? <input type="checkbox"/> Yes <input type="checkbox"/> No			

To locate a provider, visit premierlife.com or call Member Services, at 866.650.3660 DMHO 888.715.0760 PPO

FOR DHMO ONLY, PLEASE COMPLETE THIS SECTION: Please select a Primary Care Dentist (PCD) from the provider directory for yourself and each of your family members. Fill in the Provider ID number and Office ID number in the appropriate areas. If a selection is not made, a PCD will be assigned for you.

Relationship to Subscriber:	Last Name	First Name	DHMO PCD Office ID #	DHMO PCD ID #
Self				
Spouse/partner				
Child				
Child				
Child				

CALIFORNIA LAW PROHIBITS AN HIV TEST FROM BEING REQUIRED OR USED BY HEALTH INSURANCE COMPANIES AS A CONDITION OF OBTAINING HEALTH INSURANCE COVERAGE. THEREFORE, PREMIER ACCESS INSURANCE COMPANY WILL NOT REQUIRE THAT AN HIV TEST BE REQUIRED AS A CONDITION OF OBTAINING COVERAGE. IN ACCORDANCE WITH CALIFORNIA HEALTH AND SAFETY CODE SECTION 120980, PREMIER ACCESS INSURANCE COMPANY COMPLIES IN ALL RESPECTS WITH THE PROHIBITION AGAINST THE UNAUTHORIZED DISCLOSURES OF AN HIV TEST.

I, on my behalf and on behalf of my dependent(s) on this enrollment form, hereby (1) request coverage for the group insurance for which I am or may become eligible; (2) authorize my employer to make the necessary deductions for the contributions, if any, required for the insurance, or agree that the contributions be added to my dues; (3) state that I became a full-time employee on the date stated on the reverse, and do currently work the number of hours per week stated on the reverse, (4) agree to be bound by benefits, copayments, deductibles, exclusions, limitations, and other terms and conditions of the Premier* Certificate of Insurance, (5) agree that if I or my dependents receive dental services after my coverage is terminated or lapses, that I am responsible to reimburse Premier for any unrecovered payments made by Premier for such services, and (6) understand that verification of eligibility by Premier does not guarantee payment of claims and that retroactive eligibility changes supercede verifications of eligibility.

DENTAL RELEASE: I, on my behalf and on behalf of my Dependent(s) listed on this Enrollment Form, hereby authorize Premier to release dental information to official government agencies and to other individuals when required under appropriate federal or state law, or pursuant to legal process and to release and obtain dental information to or from other appropriate agencies and providers for the provision of necessary dental services and supplies covered by Premier. If you request, Premier will provide a copy to you of any information it discloses to third parties regarding your dental information. This Dental Release authorization shall remain in effect thirty months from the date the application is signed. This Dental Release authorization solely provides authorization of Premier to release dental information to official government agencies and to other individuals when required under appropriate federal or state law, or pursuant to legal process and to release and obtain dental information to or from other appropriate agencies and providers for the provision of necessary dental services and supplies covered by Premier. The dental information is being collected by Premier solely for the specific purpose of premium underwriting.

RIGHT OF REIMBURSEMENT: I, on my behalf and on behalf of my Dependent(s) listed on this Enrollment Form, hereby agree that in the event any dental services provided to me or my Dependent(s) covered by Premier are the primary financial responsibility of another party, because of other dental coverage, I will fully inform Premier and will execute such assignments, liens or other documents which may be necessary to enable Premier to recover the value of services and supplies provided.

NOTICE: Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud and may be subject to fines and confinement in prison.

To the best of my knowledge or belief, I have answered truthfully and completely the information requested on this form. I understand that Premier Access Insurance Company reserves the right to rescind or terminate coverage if any material misrepresentation is made in this enrollment form. I have read and agree to this notice on this form.

MANDATORY BINDING ARBITRATION: Premier Access Insurance Company uses binding arbitration to settle disputes, including to settle claims of dental malpractice. The insured understands and agrees that if a dispute arises in connection with this policy, the parties waive the right to a jury trial and must settle the dispute through binding arbitration. The Premier Certificate of Insurance contains a provision that further addresses this issue. Premier Access Insurance Company does not use binding arbitration in connection with any dispute that an insured's life insurance coverage.

Employee signature: _____ Date: _____

Dental services offered herein are underwritten and administered by either, Premier Access Insurance Co (PAIC), a life/disability insurer licensed under the insurance laws of California or Access Dental Plan, Inc. (ADP), a specialized health care service plan licensed in the State of California under the Knox-Keene Health Care Service Plan Act of 1975.