

Minor/Adult Dependent Information

ENROLLMENT APPLICATION/FORM SUPPLEMENT



Mail to: Western Health Advantage, Attn: Eligibility
2349 Gateway Oaks Drive, Suite 100, Sacramento, CA 95833

Fax to: 916.568.0334

Email to: eligibility@westernhealth.com

Direct questions to: 916.563.2206, 888.442.2206 toll-free or 888.877.5378 for TDD/TTY

Complete this form if the Enrollment Application/Form is A) for a minor only or B) a family plan that includes a (1) minor dependent or an (2) adult dependent unable to make health care decisions on their own.

Applicant Name (Minor/Adult Dependent) _____ **Date of Birth** _____

Is the Subscriber or Person Responsibleⁱ listed on the Enrollment Application/Form a parent or guardian legally authorized to receive/release information on the minor or adult dependent applicant? YES NO

If Yes: Provide information on any **other** parent/guardian legally authorized to receive/release information on the minor or adult dependent applicant.

If No: Provide information on **all** parents/guardians legally authorized to represent the minor or adult dependent applicant.

First Name _____ Last Name _____ MI _____

Relationship (check one): Parent Guardian Other _____

Address _____ Apt./Unit# _____

City, State, Zip _____

Email Address _____ Phone _____

First Name _____ Last Name _____ MI _____

Relationship (check one): Parent Guardian Other _____

Address _____ Apt./Unit# _____

City, State, Zip _____

Email Address _____ Phone _____

Does the minor/adult dependent live at the same address as the Person Responsible or Subscriber? YES NO

If No, provide Address _____ Apt./Unit# _____

City, State, Zip _____

I have personally reviewed all information provided on this Enrollment Application/Form Supplement. To the best of my knowledge and belief, all information on this Enrollment Application/Form Supplement, is accurate, true and complete. If WHA determines that information on the Application/Form, including this Supplement, is materially inaccurate, not true or incomplete, I understand that coverage may be terminated or, if the inaccuracy, untruthfulness, or incompleteness was intentional, coverage may be rescinded. I further understand that I must provide WHA with any new information that arises after the submission of this application but before my enrollment with WHA begins.

If sole Applicant on the Enrollment Application/Form is a minor: If the sole applicant is under 18 years of age, and the Responsible Party is not the natural parent of the applicant, copies of the court papers authorizing guardianship must be submitted with the Enrollment Application/Form, or to WHA Member Services upon enrollment.

For adult dependents, copies of the court papers authorizing guardianship or conservatorship must be submitted with the Enrollment Application/Form, or to WHA Member Services upon enrollment.

Responsible Party (on behalf of Applicant or Dependent) Name (print) _____

Signature _____ Date _____

ⁱ A Personal Representative of a minor child or adult child who is unable to make health care decisions is usually the child's parent/s or legal guardian/s. Do not list a parent if the court has removed that parent's rights with respect to the minor applicant or adult dependent.

ⁱⁱ Generally, a HIPAA-covered health plan like Western Health Advantage must allow Personal Representatives to request/receive protected health information on a minor. However, federal and state laws prohibit WHA from providing information on minors 12 years of age or older relating to sensitive services without written authorization from the minor.