Enrollment Application/Form Supplement: Minor/Adult Dependent Information

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 711 for TTY

Complete this form if the Enrollment Application/Form is A) for a minor only or B) a family plan that includes: (1) a minor dependent, (2) an adult dependent unable to make health care decisions on their own or (3) a dependent parent or stepparent who is eligible for or enrolled in Medicare*.

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

Is the Subscriber or Person Responsible[i] listed on the Enrollment Application/Form a parent or guardian legally authorized to receive/release information on the minor or adult dependent applicant[ii]? ❑ 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 _____

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 _____

continued

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.

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

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 _____

*For additional information concerning covered benefits for a dependent parent or stepparent who is eligible for or enrolled in Medicare, contact the Health Insurance Counseling and Advocacy Program (HICAP) or your agent. HICAP provides health insurance counseling for California senior citizens. Call the HICAP toll-free telephone number, 1.800.434.0222, for a referral to your local HICAP office, or see the listing provided below. HICAP is a service provided free of charge by the State of California.

El Dorado, Placer, Sacramento, and Yolo Counties	Address: 505 12th Street, Sacramento, CA 95814 Telephone: 916.376-8915 (Monday – Friday: 9 a.m. – 4 p.m.)
Marin, Napa, Solano, and Sonoma Counties	Address: 1129 Industrial Ave, Suite 201, Petaluma, CA 94954 Telephone: 707.526.4108 (Monday – Friday: 9 a.m. – 3 p.m.)