Enrollment Application and Membership Agreement: Individual/Family

Mail your completed application to: Western Health Advantage/Individual Sales
2349 Gateway Oaks Drive, Suite 100, Sacramento, CA 95833
Fax to: 916.568.1338
Apply Online: choosewha.com/apply

Note: Use this form to apply for a Western Health Advantage (WHA) Individual/Family Plan. Please answer all questions completely. You should sign this application only if you understand each question and agree to the response provided, even if a broker assists you with the application. If you have questions about completing this application, please call 916.563.2250 or 711 for TTY. We will provide translation services and other language assistance free of charge if you need it. Or, if you are working with a broker, please call him or her for assistance.

PERSON APPLYING FOR COVERAGE ("APPLICANT")

First Name_____ MI ____ Last Name_____

Social Security Number _____ Date of Birth _____

Residential Street Address _____ Apt./Unit#_____

City, State, Zip _____ County _____

Mailing Address _____ Apt./Unit#_____

City, State, Zip _____

Primary Phone _____ Mobile _____

Email Address_____ Existing Patient ❑ Yes ❑ No

Primary Care Physician _____ ID# _____ Medical Group _____

PERSON RESPONSIBLE ❑ Check if same as applicant

First Name_____ MI ____ Last Name_____

Relationship to Subscriber _____

Address _____ Apt./Unit#_____

City, State, Zip _____

Home Phone_____❑ Day ❑ Evening Mobile _____❑ Day ❑ Evening

Preferred Spoken Language: ❑ English ❑ Spanish ❑ American Sign Language ❑ Arabic ❑ Armenian ❑ Cambodian ❑ Cantonese ❑ Chinese ❑ Formosan ❑ French ❑ German ❑ Gujarati ❑ Hebrew ❑ Hindi ❑ Hmong ❑ Indonesian ❑ Italian ❑ Japanese ❑ Korean ❑ Laotian ❑ Mandarin ❑ Paňjābī ❑ Persian ❑ Portuguese ❑ Russian ❑ Tagalog ❑ Tamil ❑ Telugu ❑ Thai ❑ Urdu ❑ Vietnamese ❑ Choose Not to Answer

CORRESPONDENCE AND BILLING INFORMATION

Send all correspondence to: ❑ Applicant ❑ Person Responsible

Send billing to: ❑ Applicant ❑ Person Responsible ❑ Third Party (provide information below)

Third Party Administrator (TPA) Name_____

Billing Address _____ Apt./Unit#_____

City, State, Zip _____

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APPLICANT INFORMATION

First Name_____ MI ____ Last Name_____

Social Security Number _____ Date of Birth _____

Everyone has unique health needs so WHA collects individual demographic information such as race, ethnicity, language, sexual orientation, and gender identification to reduce obstacles to care and improve health outcomes. **Providing this personal information is voluntary,** but sharing these details helps WHA serve you better. Visit the WHA secure member portal, **mywha.org**, to provide or change these **demographic preferences**. Your information will be kept confidential, and used only for language assistance and demographic data collection purposes.

How would you describe your race? Check all that apply ❑ American Indian or Alaska Native ❑ Asian Indian ❑ Black or African American ❑ Cambodian ❑ Chinese ❑ Filipino ❑ Guamanian or Chamorro ❑ Hmong ❑ Samoan ❑ Vietnamese ❑ White ❑ Japanese ❑ Korean ❑ Laotian ❑ Native Hawaiian ❑ Other Pacific Islander ❑ Other Asian ❑ Other Race ❑ Choose Not to Answer

What is your ethnicity? Check all that apply ❑ Mexican, Mexican American, or Chicano/a ❑ Not Hispanic, Latino, or Spanish origin ❑ Cuban ❑ Guatemalan ❑ Salvadorian ❑ Puerto Rican ❑ Another Hispanic, Latino, or Spanish origin ❑ Choose Not to Answer

What language do you feel most comfortable speaking? ❑ English ❑ Spanish ❑ American Sign Language ❑ Arabic ❑ Armenian ❑ Cambodian ❑ Cantonese ❑ Chinese ❑ Formosan ❑ French ❑ German ❑ Gujarati ❑ Hebrew ❑ Hindi ❑ Hmong ❑ Indonesian ❑ Italian ❑ Japanese ❑ Korean ❑ Lao ❑ Mandarin ❑ Paňjābī ❑ Persian ❑ Portuguese ❑ Russian ❑ Tagalog ❑ Tamil ❑ Telugu ❑ Thai ❑ Urdu ❑ Vietnamese ❑ Choose Not to Answer

What language do you prefer for written materials? ❑ English ❑ Spanish ❑ Arabic ❑ Armenian ❑ Braille ❑ Cambodian ❑ Cantonese ❑ Chinese ❑ Formosan ❑ French ❑ German ❑ Gujarati ❑ Hebrew ❑ Hindi ❑ Hmong ❑ Indonesian ❑ Italian ❑ Japanese ❑ Korean ❑ Lao ❑ Mandarin ❑ Paňjābī ❑ Persian ❑ Portuguese ❑ Russian ❑ Tagalog ❑ Tamil ❑ Telugu ❑ Thai ❑ Urdu ❑ Vietnamese ❑ Choose Not to Answer

What sex were you assigned at birth? ❑ Male ❑ Female ❑ Intersex ❑ Choose Not to Answer

Which of the following best represents how you think of yourself (sexual orientation)? ❑ Straight/Heterosexual ❑ Lesbian/Gay/Homosexual ❑ Bisexual ❑ Other Sexual Orientation ❑ Choose Not to Answer

What is your current gender identity? ❑ Male ❑ Female ❑ Transgender Male/Trans Male/Female-to-male ❑ Transgender Female/Trans Woman/Male-to-female Orientation ❑ Non-Binary ❑ Genderqueer/Gender Diverse/Gender Fluid ❑ Other Gender Identity ❑ Choose Not to Answer

What is your preferred pronoun? ❑ She/Her ❑ He/Him ❑ They/Them ❑ Choose Not to Answer

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DEPENDENT INFORMATION ❑ Add ❑ Remove

Relationship to Subscriber ❑ Spouse/Domestic Partner ❑ Child, up to age 26 ❑ Parent/Stepparent**

First Name_____ MI ____ Last Name_____

Social Security Number _____ Date of Birth _____

Primary Care Physician _____ ID# ___

Medical Group _____ Existing Patient ❑ Yes ❑ No

Sex at Birth* ❑ Male ❑ Female ❑ Intersex ❑ Choose Not to Answer

Race: Check all that apply ❑ American Indian or Alaska Native ❑ Asian Indian
❑ Black or African American ❑ Cambodian ❑ Chinese ❑ Filipino ❑ Guamanian or Chamorro ❑ Hmong
❑ Samoan ❑ Vietnamese ❑ White ❑ Japanese ❑ Korean ❑ Laotian ❑ Native Hawaiian
❑ Other Pacific Islander ❑ Other Asian ❑ Other Race ❑ Choose Not to Answer

Ethnicity: Check all that apply ❑ Mexican, Mexican American, or Chicano/a
❑ Not Hispanic, Latino, or Spanish origin ❑ Cuban ❑ Guatemalan ❑ Salvadorian ❑ Puerto Rican
❑ Another Hispanic, Latino, or Spanish origin ❑ Choose Not to Answer

Preferred spoken language: ❑ English ❑ Spanish ❑ American Sign Language
❑ Arabic ❑ Armenian ❑ Cambodian ❑ Cantonese ❑ Chinese ❑ Formosan ❑ French ❑ German
❑ Gujarati ❑ Hebrew ❑ Hindi ❑ Hmong ❑ Indonesian ❑ Italian ❑ Japanese ❑ Korean ❑ Lao
❑ Mandarin ❑ Paňjābī ❑ Persian ❑ Portuguese ❑ Russian ❑ Tagalog ❑ Tamil ❑ Telugu ❑ Thai
❑ Urdu ❑ Vietnamese ❑ Choose Not to Answer

Preferred written language: ❑ English ❑ Spanish ❑ Arabic ❑ Armenian
❑ Braille ❑ Cambodian ❑ Cantonese ❑ Chinese ❑ Formosan ❑ French ❑ German ❑ Gujarati
❑ Hebrew ❑ Hindi ❑ Hmong ❑ Indonesian ❑ Italian ❑ Japanese ❑ Korean ❑ Lao ❑ Mandarin
❑ Paňjābī ❑ Persian ❑ Portuguese ❑ Russian ❑ Tagalog ❑ Tamil ❑ Telugu ❑ Thai ❑ Urdu
❑ Vietnamese ❑ Choose Not to Answer

Sexual orientation: ❑ Straight/Heterosexual ❑ Lesbian/Gay/Homosexual ❑ Bisexual
❑ Other Sexual Orientation ❑ Choose Not to Answer

Gender identity: ❑ Male ❑ Female ❑ Transgender Male/Trans Male/Female-to-male
❑ Transgender Female/Trans Woman/Male-to-female Orientation ❑ Non-Binary
❑ Genderqueer/Gender Diverse/Gender Fluid ❑ Other Gender Identity ❑ Choose Not to Answer

Preferred pronoun(s): ❑ She/Her ❑ He/Him ❑ They/Them ❑ Choose Not to Answer

*Providing this personal information is voluntary, but sharing these details helps WHA serve you better. Please visit the WHA secure member portal, mywha.org, to provide or change these demographic preferences.

**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.)

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DEPENDENT INFORMATION ❑ Add ❑ Remove

Relationship to Subscriber ❑ Spouse/Domestic Partner ❑ Child, up to age 26 ❑ Parent/Stepparent**

First Name______________________ MI ____ Last Name ______________________

Social Security Number ______________________ Date of Birth ______________________

Primary Care Physician ______________________ ID# ______________________

Medical Group ______________________ Existing Patient ❑ Yes ❑ No

Sex at Birth* ❑ Male ❑ Female ❑ Intersex ❑ Choose Not to Answer

DEPENDENT INFORMATION ❑ Add ❑ Remove

Relationship to Subscriber ❑ Spouse/Domestic Partner ❑ Child, up to age 26 ❑ Parent/Stepparent**

First Name______________________ MI ____ Last Name ______________________

Social Security Number ______________________ Date of Birth ______________________

Primary Care Physician ______________________ ID# ______________________

Medical Group ______________________ Existing Patient ❑ Yes ❑ No

Sex at Birth* ❑ Male ❑ Female ❑ Intersex ❑ Choose Not to Answer

DEPENDENT INFORMATION ❑ Add ❑ Remove

Relationship to Subscriber ❑ Spouse/Domestic Partner ❑ Child, up to age 26 ❑ Parent/Stepparent**

First Name______________________ MI ____ Last Name ______________________

Social Security Number ______________________ Date of Birth ______________________

Primary Care Physician ______________________ ID# ______________________

Medical Group ______________________ Existing Patient ❑ Yes ❑ No

Sex at Birth* ❑ Male ❑ Female ❑ Intersex ❑ Choose Not to Answer

DEPENDENT INFORMATION ❑ Add ❑ Remove

Relationship to Subscriber ❑ Spouse/Domestic Partner ❑ Child, up to age 26 ❑ Parent/Stepparent**

First Name______________________ MI ____ Last Name ______________________

Social Security Number ______________________ Date of Birth ______________________

Primary Care Physician ______________________ ID# ______________________

Medical Group ______________________ Existing Patient ❑ Yes ❑ No

Sex at Birth* ❑ Male ❑ Female ❑ Intersex ❑ Choose Not to Answer

*Providing this personal information is voluntary, but sharing these details helps WHA serve you better. Please visit the WHA secure member portal, mywha.org, to provide or change these demographic preferences.

**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.)

Application must be accompanied by a one-time payment form or check for the first month's premium.

Once enrolled the following options are available for paying your monthly premium:

- Check including eCheck
- Electronic funds transfer (EFT)
- Visa, Mastercard, American Express or Discover

PLAN INFORMATION

1. Which health plan would you like to enroll in? (Select only one plan.)

   ❑ WHA Platinum 90 HMO

   ❑ WHA Gold 80 HMO

   ❑ WHA Off Exchange Silver 70 HMO

   ❑ WHA Bronze 60 HMO

   ❑ WHA Minimum Coverage HMO*

   ❑ Advantage WHA Silver 5300 HDHP HMO**

   ❑ Advantage WHA Bronze 7200 HDHP HMO**

   * Enrollment limited to those age 30 and under OR qualified exemptions

   ** If you are electing the HSA-compatible plan and wish to open a Health Savings Account, be sure to complete an HSA Authorization Form.

2. WHA offers DeltaCare® USA, an adult dental rider, to Individual/Family plans. Note: The adult dental rider is added to all adult members (19 or older) covered on the selected plan.

   ❑ I elect to add the DeltaCare® USA to my plan. I understand that I will see an additional charge of $18.57 per month per adult member on my premium billing statement.

3. Effective Date, I request to be enrolled with an effective date of:

   ❑ 1st of the month following this month (Your application must be received by the 15th of the current month.)

   ❑ 1st of the month following next month (Your application must be received by the 15th of next month.)

   WHA will make every effort to honor your requested effective date. However, if processing is not complete by your requested effective date, you will be enrolled, effective the 1st of the month following approval.

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SPECIAL ENROLLMENT PERIOD

The annual Open Enrollment period for new coverage is November 1 through January 31. These dates are subject to change pursuant to changes in the law. You may change your benefit plan, sign up for health care coverage or add eligible dependents during the Open Enrollment period.

Outside of this Open Enrollment period, you can only sign up for health care, change your coverage or add eligible dependents if you have experienced a qualifying life event. This is called a Special Enrollment Period. You must enroll within 60 days of the qualifying event in order to be eligible for a Special Enrollment Period. If 60 days pass and you do not sign up for health coverage, you will have to wait until the next open enrollment period.

WHA reserves the right to ask for verification of the qualifying event (QE). Please provide copy of the QE with your application to expedite the enrollment process.

I attest that I am or my dependents are eligible to enroll under a Special Enrollment Period due to the following qualifying event:

LOSS OF COVERAGE

- ❑ Loss of employer health coverage due to job loss
- ❑ Employer coverage changed such as a reduction in hours worked
- ❑ COBRA coverage ended
- ❑ Loss of Medi-Cal or Medicaid coverage
- ❑ End of military service

FAMILY AND AGE CHANGES

- ❑ Turning 26 years old and no longer eligible as a dependent on your parent's plan
- ❑ Getting married
- ❑ Birth of a child or recent adoption
- ❑ Divorce or legal separation from the person through whom you were covered as a dependent
- ❑ Death of the person through whom you were covered as a dependent
- ❑ Court ordered coverage for your dependent

OTHER

- ❑ Permanent Relocation
- ❑ Moved outside the service area of your existing health insurance carrier
- ❑ Moved within California with access to new plans
- ❑ Other_____

Note: Qualifying Events are established by state and federal law. WHA will enroll applicants consistent with the law, and this list will be deemed amended following any change to relevant laws.

CONDITIONS OF ACCEPTANCE

Please read the following information and sign in the space(s) provided on the following page. **Please read this section carefully. This section contains important information, including the reasons WHA may terminate or rescind coverage.**

You must fully answer each question in this application even though you may already be a WHA member.

Be sure to complete the Application/Agreement accurately. If you are unsure about the answer to any question, take the time to make sure the information is accurate before submitting your Application/Agreement. By signing this Application/Agreement, you represent that all responses are true, complete, and accurate to the best of your knowledge, and that if WHA accepts your application for coverage, the Application/Agreement, together with the Combined Evidence of Coverage and Disclosure Form (EOC/DF), will constitute the plan contract between you and WHA. If WHA accepts the Applicant or Dependent(s) for coverage, coverage will begin on the first of the month following acceptance, or the first of the following month, based on your selection under "Effective Date" in this Application/Agreement. Your Application/Agreement is effective through December 31. If you comply with all the terms of this Application/Agreement and the EOC/DF, WHA will automatically renew this Application/Agreement each year on January 1. Terms of the Application/Agreement and the EOC/DF will remain the same when we renew it unless WHA has amended the documents as described under "Amendment of Agreement" in the EOC/DF.

Upon acceptance, you will be provided with an EOC/DF. By accepting benefits under a WHA Individual/Family Plan, you agree to be bound by the Application/Agreement and by the EOC/DF. The EOC/DF for the Individual Advantage Plans is available upon request from WHA or your broker prior to enrollment.

WHA may adopt reasonable policies, procedures, and interpretations to promote orderly and efficient administration of this agreement. You may not assign this agreement or any of the rights, interests, claims for money due, benefits, or obligations hereunder without WHA's prior written consent. In any dispute between you and WHA, a medical group or any participating provider, each party will bear its own attorneys' fees and other expenses. WHA's failure to enforce any provision of this Application/Agreement, or of the EOC/DF, will not constitute a waiver of that or any other provision, or impair WHA's right thereafter to require your strict performance of any provision.

If covered by a WHA Individual/Family Plan, in the event you suffer injury, illness or death due to the act or omission of a third party, WHA will furnish Covered Services. In the event any recovery is obtained on your behalf, you or your representative must reimburse WHA for the value of Covered Services as set forth in the EOC/DF. By executing this Application/Agreement, you grant on your behalf and on Applicant's behalf, a lien on any such recovery and agree to cooperate with WHA when there is any possibility that a recovery may be received.

The Applicant and dependents must live within WHA's Service Area. You may contact your broker or WHA to determine whether the Applicant lives within WHA's Service Area, or you may view the Service Area Map on WHA's website. When the Applicant is enrolled for coverage and at any time no longer lives within the Service Area, the Applicant is no longer eligible for coverage. When the Dependent is enrolled for coverage and at any time no longer lives within the Service Area, the Dependent is no longer eligible for coverage. Living outside the Service Area is a material fact that must be reported to WHA.

If WHA accepts your application for coverage, that coverage may be terminated for fraud or intentional misrepresentation of a material fact, including but not limited to fraud or material misrepresentation or omission in providing or failing to provide material information to WHA, the use of the services of the plan, or for knowingly permitting such fraud or material misrepresentation or omission by another. Such termination shall be effective upon the mailing of written notice by WHA to you. WHA may terminate an individual's coverage only if allowed (or not disallowed) by federal and state laws and regulations.

Before making any decision to rescind, WHA would notify you in writing of the grounds for rescission. WHA's notice will tell you why your application is believed to be inaccurate or incomplete and will invite you to provide WHA with additional information. If, after considering your response, WHA decides to rescind, WHA will send written notice to you at least 30 days before the date we rescind your coverage, explaining the basis for the decision and how you can appeal it.

All faxed and mailed correspondence must be signed and dated by the affected individual or someone legally authorized to act on his or her behalf. You must complete any applications, forms, or statements requested in WHA's normal course of business or as specified in this Application/Agreement. WHA's notices to you will be sent to the most recent address WHA has for you. You are responsible for notifying WHA of any change in address. Regardless of when you notify WHA that the Applicant moved, the Applicant will no longer be eligible for coverage if he or she moves out of the service area.

Except as preempted by federal law, this Application/Agreement and the EOC/DF will be governed in accord with California law and any provision that is required to be in these documents by state or federal law shall bind you and WHA, whether or not set forth in these documents.

You or your authorized representative may request a copy of your completed application by calling 916.563.2250.

AGREEMENT

I have reviewed all responses in this Application/Agreement. With my signature below, I represent that the information provided in this Application/Agreement is complete and accurate to the best of my knowledge, and I understand and agree to the Conditions of Acceptance and the authorizations I have provided. I alone am responsible for the accuracy and completeness of the information provided on this Application/Agreement. I have personally reviewed all information provided on this Application/Agreement, even if I did not fill out the form myself. To the best of my knowledge and belief, all information on this Application/Agreement, is accurate, true and complete. If WHA determines that information on this application 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 I have completed this Application/Agreement on another individual's behalf, I represent that I have legal authority to sign on behalf of the Applicant.

_____ _____

Applicant/Financially responsible party (*signing on behalf of self, Applicant, or Dependent under the age of 18*) Today's Date

_____ _____

Dependent (*if over the age of 18*) Today's Date

_____ _____

Dependent (*if over the age of 18*) Today's Date

_____ _____

Dependent (*if over the age of 18*) Today's Date

Important: all Applicants age 18 or over must sign and date above on the appropriate signature line. Parent or legal guardian must sign for family members under the age of 18.

AUTHORIZATION TO RELEASE INFORMATION

All Applicants: Please read the following information and sign in the space(s) provided below.

I authorize WHA to disclose to my WHA broker or agent the status of my application for coverage, as well as that of any Applicant on whose behalf I am executing this authorization, including whether an application was received, accepted, or rejected; if accepted, the effective date of coverage; and information regarding the status of bills and payments for amounts due for coverage.

If this authorization is completed on behalf of an individual other than myself, I represent that I have legal authority to sign on behalf of that individual.

_____ _____

Applicant/Financially responsible party (*signing on behalf of self, Applicant, or Dependent under the age of 18*) Today's Date

_____ _____

Dependent (*if over the age of 18*) Today's Date

_____ _____

Dependent (*if over the age of 18*) Today's Date

_____ _____

Dependent (*if over the age of 18*) Today's Date

Important: all Applicants age 18 or over must sign and date above on the appropriate signature line. Parent or legal guardian must sign for family members under the age of 18.

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WESTERN HEALTH ADVANTAGE ARBITRATION AGREEMENT

I understand and agree that (except for Small Claims Court cases, claims subject to a Medicare appeals procedure, and, if I am enrolled in coverage that is subject to the ERISA claims procedure regulation [29 CFR 2560.503·1], certain benefit-related disputes) any dispute between myself (including any heirs or assigns) on the one hand and WHA, any contracted health care providers, administrators, or other associated parties on the other hand, 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), shall be determined by submission to binding 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.

_____ _____

Applicant/Financially responsible party (*signing on behalf of self, Applicant, or Dependent under the age of 18*) Today's Date

_____ _____

Dependent (*if over the age of 18*) Today's Date

_____ _____

Dependent (*if over the age of 18*) Today's Date

_____ _____

Dependent (*if over the age of 18*) Today's Date

Important: all Applicants age 18 or over must sign and date above on the appropriate signature line. Parent or legal guardian must sign for family members under the age of 18.

AGENT OR BROKER REPRESENTATIVE INFORMATION

FOR APPLICANTS USING AN INSURANCE AGENT OR BROKER

Agent or Broker Name _____

Western Health Advantage will compensate the broker of record a 5% commission per member per month with the purchase of this coverage from WHA.

TO BE COMPLETED BY YOUR AGENT OR BROKER AFTER COMPLETION OF THIS APPLICATION

You must answer the following question by selecting Yes or No:

❑ Yes ❑ No I assisted the applicant in the submission of this application. To the best of my knowledge, the information on this application is complete and accurate. I explained to the Applicant, or the Person Financially Responsible, as appropriate, in easy-to-understand language, the risk to the Applicant of providing inaccurate information, and the Applicant, or the Person Financially Responsible understood the explanation.

Notice to agent or broker: If you have assisted in the submission of this application, the law requires that you attest to this assistance. If, in making this attestation, you state as true any material fact you know to be false, you will be subject to a civil penalty of up to ten thousand dollars ($10,000), as authorized under California Health and Safety Code section 1389.8(c) or Insurance Code section 10119.3, in addition to any other applicable penalties or remedies available under current law.

_____ _____

Agent or Broker Signature Today's Date

Agent or Broker Representative Information

First Name_____ MI ____ Last Name_____

WHA Broker Identification Number _____

Residential Street Address _____ Apt./Unit#_____

City, State, Zip _____

Business Phone _____ Email _____

Enrollment Application/Form Supplement: Minor/Adult Dependent Information

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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.)