ENROLLMENT/CHANGE FORM

BENEFIT PLAN		**EFF. DATE**	
GROUP NO.		**DIV. NO.**	

1331 Garden Highway, Suite 100
Sacramento, CA 95833
(916) 563-2250 or (888) 563-2250
Fax Enrollment/Change Form to:
(916) 568-0334
Visit our website for more information at:
www.westernhealth.com

☐ NEW GROUP ☐ COBRA ☐ CHANGE OF ADDRESS
☐ OPEN ENROLLMENT ☐ TERMINATE EMPLOYEE ☐ ADD DEPENDENT
☐ NEW HIRE ☐ NEW PRIMARY PHYSICIAN ☐ REMOVE DEPENDENT
☐ NEWLY ELIGIBLE ☐ CHANGE OF NAME ☐ ADD NEWBORN/NEWLY ADOPTED CHILD

DATE OF MARRIAGE, ADOPTION, COBRA OR TERMINATION EFFECTIVE DATE

CALIFORNIA LAW PROHIBITS AN HIV TEST FROM BEING REQUIRED OR USED BY HEALTH CARE SERVICE PLANS AS A CONDITION OF OBTAINING HEALTH COVERAGE.

DIRECTIONS: Complete Entire Form. An Identification Card cannot be issued without selection of a Primary Care Physician (PCP). Please select a PCP for you and each of your family members from the Provider Directory by writing his/her name and ID number in the appropriate areas below. If you do not select a PCP one will be assigned to you. Yellow highlighted boxes are required fields and must be completed.

SECTION I - ENROLLEE DATA ☐ Male ☐ Female				SSN	
EMPLOYEE NAME	FIRST		LAST		MI
MAILING ADDRESS					
CITY/STATE/ZIP				DATE OF BIRTH	
HOME PHONE	( )	EMPLOYER		DATE OF HIRE	
WORK PHONE	( )	OCCUPATION		E-MAIL ADDRESS	
PRIMARY CARE PHYSICIAN NAME		PRIMARY CARE PHYSICIAN ID NUMBER		MEDICAL GROUP	
EXISTING PATIENT? **? Yes ? No**	PRIMARY LANGUAGE: ☐ ENGLISH ☐ SPANISH ☐ CANTONESE ☐ HMONG ☐ RUSSIAN ☐ OTHER_____			?HEARING IMPAIRED? ?VISION IMPAIRED?	

SECTION II - SPOUSE/DEPENDENTS TO BE COVERED

Please list all family members to be covered by this enrollment form. If dependent child is age 19 or over, is he/she a full-time student and/or IRS dependent? ☐ Yes ☐ No

USE ADDITIONAL FORMS TO LIST ADDITIONAL DEPENDENTS

1	Last Name	Sex	Date of Birth	Primary Care Physician Name	Primary Care Physician ID Number
	First Name	M.I.	Relationship	Medical Group Name	Existing Patient? ? Yes ? No
2	Last Name	Sex	Date of Birth	Primary Care Physician Name	Primary Care Physician ID Number
	First Name	M.I.	Relationship	Medical Group Name	Existing Patient? ? Yes ? No
3	Last Name	Sex	Date of Birth	Primary Care Physician Name	Primary Care Physician ID Number
	First Name	M.I.	Relationship	Medical Group Name	Existing Patient? ? Yes ? No
4	Last Name	Sex	Date of Birth	Primary Care Physician Name	Primary Care Physician ID Number
	First Name	M.I.	Relationship	Medical Group Name	Existing Patient? ? Yes ? No

SECTION III - PLEASE LIST OTHER HEALTH INSURANCE OR COVERAGE

Do any of the enrollees listed in Section II have another health coverage? If yes, please complete this section.

Name of Insured	Insurance Company	Policy Number	Primary or Secondary Coverage	Subscriber of Coverage	Effective Date

PLEASE READ BEFORE SIGNING! Any dispute between a member and Western Health Advantage must first be submitted according to the WHA internal grievance procedure, as described in the Evidence of Coverage. Any dispute between a member and WHA not resolved through the internal grievance procedure must be submitted to binding arbitration, as described in the Evidence of Coverage.

I understand that in order for services to be covered, I must obtain them under the direction of a plan doctor. A Contracted Plan Provider must provide all routine medical services. I authorize a periodic deduction for coverage from payroll, if necessary. I hereby authorize the release of medical information as necessary and for the reasons stated on the reverse side of this Enrollment Form.

Employee Signature: _____ Date: _____

Employer Signature: _____ Date: _____

ENROLLMENT/CHANGE FORM

KEEP LAST COPY AS TEMPORARY ID CARD. SEE BACK FOR FURTHER CONDITIONS
DISTRIBUTION: White – WHA Pink – EMPLOYER COPY Canary – EMPLOYEE COPY

ENROLLMENT PROVISIONS:

I hereby request coverage for myself and my dependents listed on this enrollment application who are currently enrolled or may become eligible for coverage under the Western Health Advantage (WHA) agreement purchased by my employer, and I hereby authorize my employer to deduct from my earnings the amount required to cover my share of the pre-paid fees. I agree that my dependents and myself will comply with the following:

- **That we will be bound by the terms and conditions of the Group Agreement, as it may be amended;**
- **That we will obtain all health care services from providers associated with WHA, unless WHA specifically authorizes otherwise;**
- **That all providers that have rendered services to my and my dependents are authorized to make medical information and records regarding such services available to WHA and their providers who in turn, share such records among themselves. Such information may also be released to appropriate governmental agencies;**
- **That we shall assist WHA in the completion and submission of consents, releases, assignments and any other documents.**

- **ARBITRATION AGREEMENT: I understand that any dispute or controversy which may arise under the agreement between myself (and or any enrolled family member) and WHA, must be submitted to binding arbitration in lieu of a jury or court trial if the amount in dispute exceeds the jurisdictional limits of small claims court. If any such dispute is within the jurisdictional limits of small claims court, the matter will be resolved in small claims court.**

- **AUTHORIZATION TO OBTAIN OR RELEASE MEDICAL INFORMATION: WHA is authorized to obtain and release medical information in compliance with the Insurance and Privacy Protection Act, Section 56.10 et. Eq. of the California Civil Code. I agree and understand that WHA is authorized to obtain and release medical information for myself and my dependents in compliance with the terms of the WHA contract and the Insurance Information and Privacy Act, Section 791 et. Seg. of the California Insurance Code. Furthermore I authorize the release of all my and my dependents medical records to WHA, or its authorized agents for performance of any one or more of the following;**
  - **The administration of this policy**
  - **WHA Quality assurance activities and utilization review by WHA or its authorized agents**
  - **Bona fide medical emergencies, treatment, or coordination of care**
  - **Payment and medical information necessary to process claims**
  - **Creation and provision of statistical data to the employer, and**
  - **Any other exceptions provided by law.**

  Where the release of names or identifying demographic information is not necessary to the function being performed, such information will not be released.