

Individual/Family

ENROLLMENT APPLICATION AND MEMBERSHIP AGREEMENT



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

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. 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 _____
Gender Male Female
Residential Street Address _____ Apt./Unit# _____
City, State, Zip _____ County _____
Mailing Address _____ Apt./Unit# _____
City, State, Zip _____
Primary Phone _____ Secondary Phone _____
Email Address _____ Existing Patient Yes No
Primary Care Physician _____ ID# _____ Medical Group _____
Preferred Spoken Language English Spanish Russian Chinese Vietnamese Other _____
Preferred Written Language English Spanish Russian Chinese Vietnamese Other _____
Racial Identity White/Caucasian American Indian/Alaskan Native Asian Black/African American
Other _____ Decline to State
Ethnic Identity Of Hispanic or Latino Origin Not Of Hispanic or Latino Origin Decline to State

DEPENDENT ENROLLMENT INFORMATION

Add Remove Spouse Domestic Partner Gender: Male Female
First Name _____ MI _____ Last Name _____
Social Security Number _____ Date of Birth _____ Existing Patient Yes No
Primary Care Physician _____ ID# _____ Medical Group _____
Add Remove Child, up to age 26 Gender: Male Female
First Name _____ MI _____ Last Name _____
Social Security Number _____ Date of Birth _____ Existing Patient Yes No
Primary Care Physician _____ ID# _____ Medical Group _____
Add Remove Child, up to age 26 Gender: Male Female
First Name _____ MI _____ Last Name _____
Social Security Number _____ Date of Birth _____ Existing Patient Yes No
Primary Care Physician _____ ID# _____ Medical Group _____

DEPENDENT ENROLLMENT INFORMATION continued

Add Remove Child, up to age 26 Gender: Male Female
 First Name _____ MI _____ Last Name _____
 Social Security Number _____ Date of Birth _____ Existing Patient Yes No
 Primary Care Physician _____ ID# _____ Medical Group _____

PERSON RESPONSIBLE Check if same as applicant

First Name _____ MI _____ Last Name _____
 Relationship _____
 Address _____ Apt./Unit# _____
 City, State, Zip _____
 Home Phone _____ Day Evening Work Phone _____ Day Evening
 Preferred Spoken Language English Spanish Russian Chinese Vietnamese Other _____

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 _____



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 Bronze 60 HDHP HMO** | Advantage WHA Silver 4250 HDHP HMO** |
| WHA Minimum Coverage HMO* | | Advantage WHA Bronze 7000 HDHP HMO** |

** 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.

SPECIAL ENROLLMENT PERIOD

The annual Open Enrollment period for new coverage is October 15 through January 15. These dates are subject to change 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. 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.

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

Marriage or Divorce

Birth or Adoption

Death

Loss of Minimum Essential Coverage Under an Employer Sponsored Plan:

Termination of Employment

Change in Employment Status

Exhaustion of COBRA Continuation Coverage

Returning from United States Active Duty or California National Guard Under Title 32 of the United States Code

Dependent child's loss of dependent status such as reaching age 26

Permanent Relocation to the WHA Service Area

Provider Network Changes

Court Ordered Coverage for Your Spouse or Minor Child

Immigration Status Change

Released From Incarceration

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. _____

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,

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.

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.

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

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

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 (<i>signing on behalf of self, Applicant, or Dependent under the age of 18</i>) | Today's Date |
| _____ | _____ |
| Dependent (<i>if over the age of 18</i>) | Today's Date |
| _____ | _____ |
| Dependent (<i>if over the age of 18</i>) | Today's Date |
| _____ | _____ |
| Dependent (<i>if over the age of 18</i>) | 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 (<i>signing on behalf of self, Applicant, or Dependent under the age of 18</i>) | Today's Date |
| _____ | _____ |
| Dependent (<i>if over the age of 18</i>) | Today's Date |
| _____ | _____ |
| Dependent (<i>if over the age of 18</i>) | Today's Date |
| _____ | _____ |
| Dependent (<i>if over the age of 18</i>) | 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.

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 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 _____

The broker of record may receive monetary and/or non-monetary payments from WHA in connection with your purchase of

- | | | | | | | |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|

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 _____

Residential Street Address _____ Apt./Unit# _____

City, State, Zip _____

Business Phone _____ Email _____

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 applicantⁱⁱ? 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.

Western Health Advantage complies with applicable Federal and California civil rights laws and does not discriminate on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability, as applicable. Western Health Advantage does not exclude people or treat them differently because of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability.

Western Health Advantage:

Provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

Provides free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services, contact the Member Services Manager at 888.563.2250 and find more information online at <https://www.westernhealth.com/legal/non-discrimination-notice/>.

If you believe that Western Health Advantage has failed to provide these services or discriminated in another way on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability, you can file a grievance by telephone, mail, fax, email, or online with: Member Services Manager, 2349 Gateway Oaks Drive, Suite 100, Sacramento, CA 95833, 888.563.2250 or 916.563.2250, 888.877.5378 (TTY), 916.568.0126 (fax), memberservices@westernhealth.com, <https://www.westernhealth.com/legal/grievance-form/>. If you need help filing a grievance, the Member Services Manager is available to help you. For more information about the Western Health Advantage grievance process and your grievance rights with the California Department of Managed Health Care, please visit our website at <https://www.westernhealth.com/legal/grievance-form/>.

If there is a concern of discrimination based on race, color, national origin, age, disability, or sex, you can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at:

Website: <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>; Mail: U.S. Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201; Phone: 800.368.1019 or 800.537.7697 (TDD). Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

ENGLISH

If you, or someone you're helping, have questions about Western Health Advantage, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 888.563.2250 or TTY 888.877.5378.

SPANISH

Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de Western Health Advantage, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 888.563.2250, o al TTY 888.877.5378 si tiene dificultades auditivas.

CHINESE

如果您或您正在帮助的人有关于Western Health Advantage的问题，您有权以免费的方式获得帮助和信息。如需与翻译人员交谈，请拨打888.563.2250或（TTY）888.877.5378。

VIETNAMESE

Nếu quý vị hay người mà quý vị đang giúp, có câu hỏi về Western Health Advantage, quý vị có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Nếu có thắc mắc về nội dung thông tin, xin gọi số 888.563.2250, hoặc gọi số TTY dành cho người khiếm thính tại số 888.877.5378.

TAGALOG

Kung ikaw, o ang iyong tinutulungan, ay may mga katanungan tungkol sa Western Health Advantage, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa 888.563.2250 o TTY para sa may kapansanan sa pandinig sa 888.877.5378.

KOREAN

Western Health Advantage
888.563.2250
TTY 888.877.5378

ARMENIAN

Western Health Advantage
888.563.2250
TTY 888.877.5378

PERSIAN-FARSI

Western Health Advantage
888.563.2250
888.877.5378

RUSSIAN

Western Health Advantage
888.563.2250
888.877.5378

JAPANESE

Western Health Advantage
888.563.2250
888.877.5378

ARABIC

Western Health Advantage
888.563.2250
888.877.5378

PUNJABI

Western Health Advantage
888.563.2250
888.877.5378

CAMBODIAN-MON-KHMER

Western Health Advantage
888.563.2250
888.877.5378

HMONG

Western Health Advantage
888.563.2250
888.877.5378

HINDI

Western Health Advantage
888.563.2250
888.877.5378

THAI

Western Health Advantage
888.563.2250
888.877.5378