

# Enrollment/Change Form

FOR GROUPS



**Mail to:** 2349 Gateway Oaks Drive, Suite 100, Sacramento, CA 95833  
**Send it by secure fax to:** 916.568.0334  
**Update online:** eBill on westernhealth.com  
**Eligibility/Billing:** 888.442.2206 or 916.563.2206

## NEW ENROLLMENT

- New group    Open enrollment
- New hire — date of hire: \_\_\_\_\_
- Newly eligible — reason: \_\_\_\_\_
- \_\_\_\_\_
- COBRA — effective date: \_\_\_\_\_

**Directions:** Complete entire form. **Select a primary care physician (PCP)** for yourself and each family member from the Provider Directory and write his/her name and ID# in the designated area.

## CHANGE

For Changes, Member ID#: \_\_\_\_\_

- Add dependent \*
- Add newborn/newly adopted child \*
- Remove dependent — effective: \_\_\_\_\_
- Change of name    Change of address
- \* Date of qualifying event (if not open enrollment): \_\_\_\_\_

**Directions:** Complete the bolded information (required) in Section I and any sections applicable to the change you are making.

## PLAN INFORMATION

**Employer** \_\_\_\_\_ **Benefit Plan** \_\_\_\_\_ **Effective Date** \_\_\_\_\_  
**Group #** \_\_\_\_\_ **Class** \_\_\_\_\_ **Subgroup** \_\_\_\_\_

## SECTION I — MEMBER INFORMATION

**Employee First Name** \_\_\_\_\_ **Last Name** \_\_\_\_\_ **MI** \_\_\_\_\_

**Social Security Number** \_\_\_\_\_ **Date of Birth** \_\_\_\_\_ **Gender**  Male  Female

**Residential Street Address** (required) \_\_\_\_\_ **Apt./Unit#** \_\_\_\_\_

**City, State, Zip** \_\_\_\_\_

Mailing Address (if different) \_\_\_\_\_ Apt./Unit# \_\_\_\_\_

City, State, Zip \_\_\_\_\_

Email Address \_\_\_\_\_ Job Title \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

PCP Name \_\_\_\_\_ ID# \_\_\_\_\_ Medical Group \_\_\_\_\_

Existing Patient  Yes  No

Are you of Latino, Hispanic or Spanish origin?  Decline to State  Yes  No

How would you describe your race? Check all that apply.  Decline to State  White/Caucasian  American Indian/Alaska Native  Asian  Black/African American  Native Hawaiian/Pacific Islander  Other \_\_\_\_\_

What language do you feel most comfortable speaking?  Decline to State  English  Spanish  Other \_\_\_\_\_

What language do you prefer for written materials?  Decline to State  English  Spanish  Other \_\_\_\_\_

## SECTION II — DEPENDENT INFORMATION

Add  Remove    Spouse  Domestic Partner   Gender  Male  Female

First Name \_\_\_\_\_ Last Name \_\_\_\_\_ MI \_\_\_\_\_

Social Security Number \_\_\_\_\_ Date of Birth \_\_\_\_\_ Existing Patient  Yes  No

PCP Name \_\_\_\_\_ ID# \_\_\_\_\_ Medical Group \_\_\_\_\_

Are you of Latino, Hispanic or Spanish origin?  Decline to State  Yes  No

How would you describe your race? Check all that apply.  Decline to State  White/Caucasian  American Indian/Alaska Native  Asian  Black/African American  Native Hawaiian/Pacific Islander  Other \_\_\_\_\_

What language do you feel most comfortable speaking?  Decline to State  English  Spanish  Other \_\_\_\_\_

What language do you prefer for written materials?  Decline to State  English  Spanish  Other \_\_\_\_\_

Employee First Name \_\_\_\_\_ Last Name \_\_\_\_\_

Add  Remove  Child, up to age 26  Disabled (must meet criteria and provide proof of disability) Gender  Male  Female

First Name \_\_\_\_\_ Last Name \_\_\_\_\_ MI \_\_\_\_\_

Social Security Number \_\_\_\_\_ Date of Birth \_\_\_\_\_ Existing Patient  Yes  No

PCP Name \_\_\_\_\_ ID# \_\_\_\_\_ Medical Group \_\_\_\_\_

Are you of Latino, Hispanic or Spanish origin?  Decline to State  Yes  No

How would you describe your race? Check all that apply.  Decline to State  White/Caucasian  American Indian/Alaska Native  Asian

Black/African American  Native Hawaiian/Pacific Islander  Other \_\_\_\_\_

What language do you feel most comfortable speaking?  Decline to State  English  Spanish  Other \_\_\_\_\_

What language do you prefer for written materials?  Decline to State  English  Spanish  Other \_\_\_\_\_

Add  Remove  Child, up to age 26  Disabled (must meet criteria and provide proof of disability) Gender  Male  Female

First Name \_\_\_\_\_ Last Name \_\_\_\_\_ MI \_\_\_\_\_

Social Security Number \_\_\_\_\_ Date of Birth \_\_\_\_\_ Existing Patient  Yes  No

PCP Name \_\_\_\_\_ ID# \_\_\_\_\_ Medical Group \_\_\_\_\_

Are you of Latino, Hispanic or Spanish origin?  Decline to State  Yes  No

How would you describe your race? Check all that apply.  Decline to State  White/Caucasian  American Indian/Alaska Native  Asian

Black/African American  Native Hawaiian/Pacific Islander  Other \_\_\_\_\_

What language do you feel most comfortable speaking?  Decline to State  English  Spanish  Other \_\_\_\_\_

What language do you prefer for written materials?  Decline to State  English  Spanish  Other \_\_\_\_\_

**Use additional forms if necessary to provide information for all dependents.**

**SECTION III — OTHER HEALTH COVERAGE INFORMATION**

Do any of the enrollees have other health coverage or Medicare? If yes, please complete this section.

Name(s) of Insured \_\_\_\_\_ Insurance Company \_\_\_\_\_ Effective Date \_\_\_\_\_

Subscriber of Coverage \_\_\_\_\_ Policy # / Medicare Claim # \_\_\_\_\_  Primary  Secondary

Name(s) of Insured \_\_\_\_\_ Insurance Company \_\_\_\_\_ Effective Date \_\_\_\_\_

Subscriber of Coverage \_\_\_\_\_ Policy # / Medicare Claim # \_\_\_\_\_  Primary  Secondary

**SECTION IV — SIGNATURE REQUIRED**

By signing below, I acknowledge that I have read, understand and agree to the terms and arbitration agreement stated below. A reproduction of this form shall be valid as an original.

A. On behalf of myself and my eligible Dependents, I hereby apply for health care services coverage offered by Western Health Advantage (WHA) through my Employer, and agree to be bound by the WHA Group Service Agreement, Evidence of Coverage and Disclosure Form, and this Enrollment/Change Form.

**B. ARBITRATION AGREEMENT: I AGREE AND UNDERSTAND THAT ANY AND ALL DISPUTES BETWEEN MYSELF (INCLUDING ANY HEIRS OR ASSIGNS) AND WESTERN HEALTH ADVANTAGE, 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), EXCEPT FOR SMALL CLAIMS COURT CASES AND CLAIMS SUBJECT TO ERISA, SHALL BE DETERMINED BY SUBMISSION TO BINDING ARBITRATION. ANY SUCH DISPUTE WILL NOT BE RESOLVED BY A LAWSUIT OR RESORT TO COURT PROCESS, EXCEPT AS CALIFORNIA LAW PROVIDES FOR JUDICIAL REVIEW OF 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.**

Employee signature: \_\_\_\_\_ Date: \_\_\_\_\_

To the best of my knowledge the information contained herein is true and accurate. I hereby attest that employees and dependents submitted to WHA for coverage meet all eligibility requirements set forth in the Group Service Agreement between WHA and the employer group.

Employer signature: \_\_\_\_\_ Date: \_\_\_\_\_