



Enrollment/Change Form

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

PLAN INFORMATION

Benefit plan
Effective date
Group no.
Class
Subgroup

Fax form to:
916.568.0334

2349 Gateway Oaks Drive
Suite 100
Sacramento, CA 95833

916.563.2250 or
888.563.2250

Visit our website for
more information at:
westernhealth.com

Please select a plan

Premier 20

Advantage 70

1800 HSA

2800 HSA

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 (or online at westernhealth.com) 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.

CHANGE

Add dependent *

Add newborn/newly adopted child *

Remove dependent — effective: _____

Change of name

Change of address

Change of PCP (will be effective first of the month following request)

* Date of qualifying event (if outside open enrollment): _____

Directions: Complete only the first section of yellow highlighted boxes (including your name, SS#, gender and date of birth) and any sections applicable to the change you are making.

SECTION I — MEMBER INFORMATION

Employer: **Placer County Association of Realtors**

Employee name: First _____ Last _____ MI _____

SS# _____ Date of birth: _____ Gender Male Female

Physical address (required) _____ City _____ ST _____ Zip _____

Mailing address _____ City _____ ST _____ Zip _____

Email address _____ Job title _____

Home phone () _____ Work phone () _____ Existing patient of PCP? Yes No

PCP name _____ Medical group _____ PCP ID# _____

Racial identity White/Caucasian American Indian/Alaskan Native Asian Black/African American
 Native Hawaiian/Pacific Islander Other _____

Ethnic identity Of Hispanic or Latino origin Not of Hispanic or Latino origin

Primary language spoken English Spanish Russian Chinese Tagalog Vietnamese Other _____

Primary language written English Spanish Russian Chinese Tagalog Vietnamese Other _____

SECTION II — DEPENDENT INFORMATION

Add Remove Spouse Domestic partner SS# _____

Name: First _____ Last _____ MI _____

Date of birth _____ Gender Male Female PCP name _____

Existing patient of PCP? Yes No Medical group _____ PCP ID# _____

Racial identity White/Caucasian American Indian/Alaskan Native Asian Black/African American
 Native Hawaiian/Pacific Islander Other _____

Ethnic identity Of Hispanic or Latino origin Not of Hispanic or Latino origin

Primary language spoken English Spanish Russian Chinese Tagalog Vietnamese Other _____

Primary language written English Spanish Russian Chinese Tagalog Vietnamese Other _____

Add Child Full-time student over the age of 19 SS# _____

Remove Disabled (must meet criteria and provide proof of disability) Relationship _____

Name: First _____ Last _____ MI _____

Date of birth _____ Gender Male Female PCP name _____

Existing patient of PCP? Yes No Medical group _____ PCP ID# _____

Racial identity White/Caucasian American Indian/Alaskan Native Asian Black/African American
 Native Hawaiian/Pacific Islander Other _____

Ethnic identity Of Hispanic or Latino origin Not of Hispanic or Latino origin

Primary language spoken English Spanish Russian Chinese Tagalog Vietnamese Other _____

Primary language written English Spanish Russian Chinese Tagalog Vietnamese Other _____



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Employee name

<input type="checkbox"/> Add	<input type="checkbox"/> Child	<input type="checkbox"/> Full-time student over the age of 19	SS#
<input type="checkbox"/> Remove	<input type="checkbox"/> Disabled (must meet criteria and provide proof of disability)		Relationship
Name: First		Last	
		MI	
Date of birth	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	PCP name	
Existing patient of PCP?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Medical group	PCP ID#
Racial identity	<input type="checkbox"/> White/Caucasian	<input type="checkbox"/> American Indian/Alaskan Native	<input type="checkbox"/> Asian
	<input type="checkbox"/> Native Hawaiian/Pacific Islander	<input type="checkbox"/> Other	
Ethnic identity	<input type="checkbox"/> Of Hispanic or Latino origin <input type="checkbox"/> Not of Hispanic or Latino origin		
Primary language spoken	<input type="checkbox"/> English	<input type="checkbox"/> Spanish	<input type="checkbox"/> Russian
	<input type="checkbox"/> Chinese	<input type="checkbox"/> Tagalog	<input type="checkbox"/> Vietnamese
	<input type="checkbox"/> Other		
Primary language written	<input type="checkbox"/> English	<input type="checkbox"/> Spanish	<input type="checkbox"/> Russian
	<input type="checkbox"/> Chinese	<input type="checkbox"/> Tagalog	<input type="checkbox"/> Vietnamese
	<input type="checkbox"/> Other		

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

SECTION III — OTHER HEALTH COVERAGE INFORMATION

Are any of the enrollees listed in Section II eligible for Medicare? If yes, you must complete this section.

Name(s) of insured	Medicare Health Insurance Claim Number (HIC#)
Check all that apply: <input type="checkbox"/> Age 65+ <input type="checkbox"/> Disabled <input type="checkbox"/> ESRD (End Stage Renal Disease)	

Name(s) of insured	Medicare Health Insurance Claim Number (HIC#)
Check all that apply: <input type="checkbox"/> Age 65+ <input type="checkbox"/> Disabled <input type="checkbox"/> ESRD (End Stage Renal Disease)	

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

Name(s) of insured	Insurance company	<input type="checkbox"/> Primary <input type="checkbox"/> Secondary
Subscriber of coverage	Policy number	
	Effective date	

Name(s) of insured	Insurance company	<input type="checkbox"/> Primary <input type="checkbox"/> Secondary
Subscriber of coverage	Policy number	
	Effective date	

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: _____