

Enrollment/Change Form

FOR GROUPS



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 SELECTION** Gateway 30 Gateway 2000 Gateway 4010
 Gateway 70 Gateway 1500 Gateway 6500

PLAN INFORMATION

Association _____ Benefit Plan _____ Effective Date _____
Group # _____ Class _____ Subgroup _____

SECTION I — MEMBER INFORMATION

Member 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 _____
What language do you feel most comfortable speaking? 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 _____

Member 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.

Member 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: _____