Enrollment/Change Form: Group Enrollees

Mail to: Western Health Advantage, Attn: Enrollment

2349 Gateway Oaks Drive, Suite 100, Sacramento, CA 95833

Health Advantage

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/TYY

NEW ENROLLMENT: Complete entire form. Select a primary care physician (PCP) for you and your	CHANGE: Complete required information (in bold) in Section I and any sections applicable to the change you are making. For Changes, Member ID#	
dependents by searching online at choosewha.com/directory.		
ndicate provider name, WHA Provider ID# and medical group.		
New group	'	fective
New hire — date of hire	☐ Change of name ☐ Cha	
Newly eligible — reason	*Date of qualifying event (if not open enrollment)	
COBRA — effective date		,
PLAN INFORMATION		
mployer	Benefit Plan	Effective Date
Broup #	_ Class	Subgroup
SECTION I — MEMBER INFORMATION		
imployee First Name	Last Name	MI
ocial Security Number	Date of Birth	□ Male □ Female
Residential Street Address		Apt./Unit#
City, State, Zip		
Nailing Address (if different)		Apt./Unit#
City, State, Zip		
mail Address	_ Job Title	
lome Phone	Work Phone	
PCP Name	WHA Provider ID#	
Nedical Group	_ Existing Patient □ Yes □ No	
are you of Latino, Hispanic or Spanish origin? 🗖 Decline to State	☐ Yes ☐ No	
low would you describe your race? Check all that apply. 🗖 Declir 🕽 Asian 🗖 Black/African American 🗖 Native Hawaiian/Pacific Islar		
Vhat language do you feel most comfortable speaking? 🗖 Declir	ne to State 🗅 English 🗅 Spanish	n 🖵 Other
What language do you prefer for written materials? 🗖 Decline to	State 🛭 English 🖺 Spanish 🖫 O	ther
SECTION II — DEPENDENT INFORMATION		
☐ Add ☐ Remove ☐ Spouse ☐ Domestic Partner		
irst Name	_ Last Name	MI
ocial Security Number		
CP Name		
Medical Group		
Are you of Latino, Hispanic or Spanish origin? 🗖 Decline to State		
How would you describe your race? Check all that apply. 🗖 Declir Asian 🗖 Black/African American 🗖 Native Hawaiian/Pacific Islan		
Vhat language do you feel most comfortable speaking? 🖵 Declir	ne to State 🖬 English 🖬 Spanish	n 🖵 Other
What language do you prefer for written materials? ☐ Decline to	State 🗆 English 🗆 Spanish 🗀 O)ther

WHA 211 Enroll 10.18

Employee First Name	Last Name	MI
☐ Add ☐ Remove ☐ Child, up to age 26 ☐ Disabled	d (must meet criteria and provide proof of	f disability)
First Name	·	
Social Security Number		
PCP Name	WHA Provider ID#	
Medical Group		
Are you of Latino, Hispanic or Spanish origin? Decline	•	
How would you describe your race? Check all that apply. Asian Black/African American Native Hawaiian/Pag		
What language do you feel most comfortable speaking?	☐ Decline to State ☐ English ☐ Spanish ☐	Other
What language do you prefer for written materials? • De	ecline to State 🗆 English 🗅 Spanish 🖵 Othe	er
☐ Add ☐ Remove ☐ Child, up to age 26 ☐ Disable	d (must meet criteria and provide proof of	f disability)
First Name	Last Name	MI
Social Security Number	Date of Birth	
PCP Name	WHA Provider ID#	
Medical Group	Existing Patient 🛭 Yes 🖫 No	
Are you of Latino, Hispanic or Spanish origin? 🗖 Decline t	to State 🛘 Yes 🖨 No	
How would you describe your race? Check all that apply. ☐ Asian ☐ Black/African American ☐ Native Hawaiian/Pac		
What language do you feel most comfortable speaking?	🗖 Decline to State 🗖 English 🗖 Spanish 🗖	Other
What language do you prefer for written materials? \Box De	ecline to State 🛘 English 🖵 Spanish 🖵 Othe	er
SECTION III — OTHER HEALTH COVERAGE Do any of the enrollees have other health coverage or Me Name(s) of Insured	edicare? If yes, please complete this section	
Subscriber of Coverage	' '	
Name(s) of Insured	•	
Subscriber of Coverage	• •	
· ·		
SECTION IV — SIGNATURE REQUIRED		
By signing below, I acknowledge that I have read, unders reproduction of this form shall be valid as an original. A. On behalf of myself and my eligible Dependents, I herel (WHA) through my Employer, and agree to be bound Form, and this Enrollment/Change Form.	by apply for health care services coverage of	ffered by Western Health Advantage
B. ARBITRATION AGREEMENT: I AGREE AND UNDERS' HEIRS OR ASSIGNS) AND WESTERN HEALTH ADVA WHETHER ANY MEDICAL SERVICES RENDERED UI WERE IMPROPERLY, NEGLIGENTLY OR INCOMPETEN SUBJECT TO ERISA, SHALL BE DETERMINED BY SU RESOLVED BY A LAWSUIT OR RESORT TO COURT POF ARBITRATION PROCEEDINGS. THE PARTIES, INC GIVING UP THEIR CONSTITUTIONAL RIGHT TO HAVE INSTEAD ARE ACCEPTING THE USE OF BINDING AR	INTAGE, INCLUDING CLAIMS OF MEDICANDER THE HEALTH PLAN WERE UNNED NTLY RENDERED), EXCEPT FOR SMALL CLAIMS OF THE BINDING ARBITRATION. APPROCESS, EXCEPT AS CALIFORNIA LAW ELUDING ANY HEIRS OR ASSIGNS, TO THIS E ANY SUCH DISPUTE DECIDED IN A COL	AL MALPRACTICE (THAT IS AS TO CESSARY OR UNAUTHORIZED OR AIMS COURT CASES AND CLAIMS ANY SUCH DISPUTE WILL NOT BE PROVIDES FOR JUDICIAL REVIEW S ARBITRATION AGREEMENT ARE
Employee Signature	Date	
To the best of my knowledge the information contains submitted to WHA for coverage meet all eligibility remembers and the submitted to what is a submitted to wh		

Employer Signature _____

Date ___