Enrollment/Change Form

Western Health Advantage

FOR LOS RIOS COMMUNITY COLLEGE DISTRICT

Send your completed enrollment form to: **Los Rios Employee Benefits Department**
1919 Spanos Court, Sacramento, CA 95825

- ACTIVE EMPLOYEES: Please send to the attention of **Vickie Weaver Owens**; call 916.568.3051 for assistance
- EARLY RETIREES: Please send to the attention of **Kris Kurk**; 916.568.3060 for assistance

NEW ENROLLMENT

❑ New group ❑ Open enrollment
❑ New hire — date of hire: _____
❑ COBRA — effective date: _____

Prior Los Rios Carrier: ❑ Kaiser Permanente
❑ Sutter Health Plus

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** ❑ HMO ❑ 1800 HSA HMO

Effective Date _____ **Group #**107423 **Class** _____ **Subgroup** _____

Los Rios Employee ID # _____

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: _____