Enrollment/Change Form: Group Enrollees

Mail your completed application to: Western Health Advantage, Attn: Enrollment
2349 Gateway Oaks Drive, Suite 100, Sacramento, CA 95833
Fax to: 916.568.0334
Direct questions to: 916.563.2206, 888.442.2206 toll-free or 711 for TTY

NEW ENROLLMENT Complete entire form.

❑ New Group ❑ Open Enrollment

New Hire – date of hire: _____

COBRA – effective date: _____

CHANGE Complete Enrollee/Subscriber Information section in addition to any applicable changes.

Subscriber Member ID Number: _____

Include effective date of change or date of qualifying event (if not open enrollment)

❑ Add Dependent – date: _____

❑ Add Newborn/Newly Adopted Child – date: _____

❑ Remove Dependent – date: _____

❑ Change of Name – date: _____

❑ Change of Address – date: _____

PLAN INFORMATION

Employer _____ Group Number _____

Class _____ Subgroup _____

Benefit Plan _____ Effective Date _____

PCP SELECTION

For new or added enrollment, indicate Primary Care Physician (PCP) Name, WHA Provider ID# and Medical Group for you and/or your dependents. Search WHA's provider network online at **choosewha.com/directory**.

ENROLLEE/SUBSCRIBER

First Name _____ MI ____ Last Name _____

Social Security Number _____ Date of Birth _____

Sex at Birth ❑ Male ❑ Female ❑ Intersex ❑ Choose Not to Answer

Residential Street Address _____ Apt./Unit# _____

City, State, Zip _____ County _____

Mailing Address _____ Apt./Unit# _____

City, State, Zip _____

Primary Phone _____ Mobile _____

Email Address _____ Existing Patient ❑ Yes ❑ No

Primary Care Physician _____ ID# _____ Medical Group _____

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DEPENDENT ❑ Add ❑ **Remove —** ❑ Spouse ❑ Domestic Partner

First Name________________________ MI ____ Last Name ________________________

Social Security Number ____________________ Date of Birth ________________________

Sex at Birth ❑ Male ❑ Female ❑ Intersex ❑ Choose Not to Answer

Primary Phone ________________________ Mobile ________________________

Email Address________________________ Existing Patient ❑ Yes ❑ No

Primary Care Physician ____________________ ID# __________ Medical Group __________

DEPENDENT ❑ Add ❑ **Remove —** ❑ Child, up to age 26 ❑ Disabled (must meet criteria/provide proof of disability)

First Name________________________ MI ____ Last Name ________________________

Social Security Number ____________________ Date of Birth ________________________

Sex at Birth ❑ Male ❑ Female ❑ Intersex ❑ Choose Not to Answer

Primary Phone ________________________ Mobile ________________________

Email Address________________________ Existing Patient ❑ Yes ❑ No

Primary Care Physician ____________________ ID# __________ Medical Group __________

DEPENDENT ❑ Add ❑ **Remove —** ❑ Child, up to age 26 ❑ Disabled (must meet criteria/provide proof of disability)

First Name________________________ MI ____ Last Name ________________________

Social Security Number ____________________ Date of Birth ________________________

Sex at Birth ❑ Male ❑ Female ❑ Intersex ❑ Choose Not to Answer

Primary Phone ________________________ Mobile ________________________

Email Address________________________ Existing Patient ❑ Yes ❑ No

Primary Care Physician ____________________ ID# __________ Medical Group __________

DEPENDENT ❑ Add ❑ **Remove —** ❑ Child, up to age 26 ❑ Disabled (must meet criteria/provide proof of disability)

First Name________________________ MI ____ Last Name ________________________

Social Security Number ____________________ Date of Birth ________________________

Sex at Birth ❑ Male ❑ Female ❑ Intersex ❑ Choose Not to Answer

Primary Phone ________________________ Mobile ________________________

Email Address________________________ Existing Patient ❑ Yes ❑ No

Primary Care Physician ____________________ ID# __________ Medical Group __________

DEPENDENT ❑ Add ❑ **Remove —** ❑ Child, up to age 26 ❑ Disabled (must meet criteria/provide proof of disability)

First Name________________________ MI ____ Last Name ________________________

Social Security Number ____________________ Date of Birth ________________________

Sex at Birth ❑ Male ❑ Female ❑ Intersex ❑ Choose Not to Answer

Primary Phone ________________________ Mobile ________________________

Email Address________________________ Existing Patient ❑ Yes ❑ No

Primary Care Physician ____________________ ID# __________ Medical Group __________

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DEMOGRAPHIC PREFERENCES

Everyone has unique health needs so WHA collects individual demographic information such as race, ethnicity, language, sexual orientation, and gender identification to reduce obstacles to care and improve health outcomes. **Providing this personal information is voluntary**, but sharing these details helps WHA serve you better. Visit the WHA secure member portal, **mywha.org**, to provide or change these **demographic preferences**. Your information will be kept confidential, and used only for language assistance and demographic data collection purposes.

Enrollee/Subscriber Preferences

How would you describe your race? Check all that apply ❑ American Indian or Alaska Native ❑ Asian Indian ❑ Black or African American ❑ Cambodian ❑ Chinese ❑ Filipino ❑ Guamanian or Chamorron ❑ Hmong ❑ Samoan ❑ Vietnamese ❑ White ❑ Japanese ❑ Korean ❑ Laotian ❑ Native Hawaiian ❑ Other Pacific Islander ❑ Other Asian ❑ Other Race ❑ Choose Not to Answer

What is your ethnicity? Check all that apply ❑ Mexican, Mexican American, or Chicano/a ❑ Not Hispanic, Latino, or Spanish origin ❑ Cuban ❑ Guatemalan ❑ Salvadorian ❑ Puerto Rican ❑ Another Hispanic, Latino, or Spanish origin ❑ Choose Not to Answer

What language do you feel most comfortable speaking? ❑ English ❑ Spanish ❑ American Sign Language ❑ Arabic ❑ Armenian ❑ Cambodian ❑ Cantonese ❑ Chinese ❑ Formosan ❑ French ❑ German ❑ Gujarati ❑ Hebrew ❑ Hindi ❑ Hmong ❑ Indonesian ❑ Italian ❑ Japanese ❑ Korean ❑ Laotian ❑ Mandarin ❑ Panjabi ❑ Persian ❑ Portuguese ❑ Russian ❑ Tagalog ❑ Tamil ❑ Telugu ❑ Thai ❑ Urdu ❑ Vietnamese ❑ Choose Not to Answer

What language do you prefer for written materials? If different than spoken language: _____

Does this information above apply to all dependents included in this form?

❑ Yes ❑ No — please provide Dependent Preferences section below for each dependent or visit mywha.org.

Dependent Preferences

Dependent Full Name: _____

How would you describe your race? Check all that apply ❑ American Indian or Alaska Native ❑ Asian Indian ❑ Black or African American ❑ Cambodian ❑ Chinese ❑ Filipino ❑ Guamanian or Chamorron ❑ Hmong ❑ Samoan ❑ Vietnamese ❑ White ❑ Japanese ❑ Korean ❑ Laotian ❑ Native Hawaiian ❑ Other Pacific Islander ❑ Other Asian ❑ Other Race ❑ Choose Not to Answer

What is your ethnicity? Check all that apply ❑ Mexican, Mexican American, or Chicano/a ❑ Not Hispanic, Latino, or Spanish origin ❑ Cuban ❑ Guatemalan ❑ Salvadorian ❑ Puerto Rican ❑ Another Hispanic, Latino, or Spanish origin ❑ Choose Not to Answer

What language do you feel most comfortable speaking? ❑ English ❑ Spanish ❑ American Sign Language ❑ Arabic ❑ Armenian ❑ Cambodian ❑ Cantonese ❑ Chinese ❑ Formosan ❑ French ❑ German ❑ Gujarati ❑ Hebrew ❑ Hindi ❑ Hmong ❑ Indonesian ❑ Italian ❑ Japanese ❑ Korean ❑ Laotian ❑ Mandarin ❑ Panjabi ❑ Persian ❑ Portuguese ❑ Russian ❑ Tagalog ❑ Tamil ❑ Telugu ❑ Thai ❑ Urdu ❑ Vietnamese ❑ Choose Not to Answer

What language do you prefer for written materials? If different than spoken language: _____

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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

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 _____

Western Health Advantage complies with applicable Federal and California civil rights laws and does not discriminate on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability, as applicable. Western Health Advantage does not exclude people or treat them differently because of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability.

Western Health Advantage:

Provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

Provides free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services, contact the Member Services Manager at 888.563.2250 and find more information online at https://www.westernhealth.com/legal/non-discrimination-notice/.

If you believe that Western Health Advantage has failed to provide these services or discriminated in another way on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability, you can file a grievance by telephone, mail, fax, email, or online with: Member Services Manager, 2349 Gateway Oaks Drive, Suite 100, Sacramento, CA 95833, 888.563.2250 or 916.563.2250, 711 (TTY), 916.568.0126 (fax), memberservices@westernhealth.com, https://www.westernhealth.com/legal/grievance-form/. If you need help filing a grievance, the Member Services Manager is available to help you. For more information about the Western Health Advantage grievance process and your grievance rights with the California Department of Managed Health Care, please visit our website at https://www.westernhealth.com/legal/grievance-form/.

If there is a concern of discrimination based on race, color, national origin, age, disability, or sex, you can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at:

Website: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf; Mail: U.S. Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201; Phone: 800.368.1019 or 800.537.7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

ENGLISH
If you, or someone you're helping, have questions about Western Health Advantage, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 888.563.2250 or TTY 711.

SPANISH
Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de Western Health Advantage, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 888.563.2250, o al TTY 711 si tiene dificultades auditivas.

CHINESE
如果您，或是您正在協助的對象，有關於 Western Health Advantage**方面的問題，您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥電話**888.563.2250**或聽障人士專線**(TTY) 711**。**

VIETNAMESE
Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Western Health Advantage, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi số 888.563.2250, hoặc gọi đường dây TTY dành cho người khiếm thính tại số 711.

TAGALOG
Kung ikaw, o ang iyong tinutulungan, ay may mga katanungan tungkol sa Western Health Advantage, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa 888.563.2250 o TTY para sa may kapansanan sa pandinig sa 711.

KOREAN
만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 Western Health Advantage에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담 없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 888.563.2250이나 청각 장애인용 TTY 711로 연락하십시오.

ARMENIAN
Եթե Դուք կամ Ձեր կողմից օգնություն ստացող անձը հարցեր ունի Western Health Advantage-ի մասին, Դուք իրավունք ունեք անվճար օգնություն և տեղեկություններ ստանալու Ձեր նախընտրած լեզվով: Թարգմանչի հետ խոսելու համար զանգահարե՛ք 888.563.2250 համարով կամ TTY 711՝ լսողության հետ խնդիրներ ունեցողների համար:

PERSIAN-FARSI
اگر شما، یا کسی که شما به او کمک میکنید ، سوال در مورد Western Health Advantage (وسترن هلث اَدونتیج) داشته باشید حق این را دارید که کمک و اطلاعات به زبان خود را به طور رایگان دریافت نمایید. لطفا با شماره تلفن 888.563.2250 تماس بگیرید. افراد ناشنوا می توانند به شماره711 پیام تایپی ارسال کنند

RUSSIAN
Если у вас или лица, которому вы помогаете, имеются вопросы по поводу Western Health Advantage, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону 888.563.2250 или воспользуйтесь линией TTY для лиц с нарушениями слуха по номеру 711.

JAPANESE
ご本人様、またはお客様の身の回りの方でも、Western Health Advantageについてご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合、888.563.2250までお電話ください。聴覚障がい者用TTYをご利用の場合は、711までお電話ください。

ARABIC
إن كان لديك أو لدى شخص تساعده أسئلة بخصو Western Health Advantage، فلديك الحق في الحصول على المساعدة والمعلومات الضرو ية بلغتك من دون اية تكلفة. للتحدث مع مترجم اتصل بـ 888.563.2250، أو برقم الهاتف النصي (TTY) لضعاف السمع 711.

PUNJABI
ਜੇਕਰ ਤੁਸੀਂ, ਜਾਂ ਜਿਸ ਕਿਸੇ ਦੀ ਤੁਸੀਂ ਮਦਦ ਕਰ ਰਹੇ ਹੋ, ਦੇ Western Health Advantage ਬਾਰੇ ਸਵਾਲ ਹਨ ਤਾਂ, ਤੁਹਾਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮਦਦ ਅਤੇ ਜਾਣਕਾਰੀ ਹਾਸਲ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੈ। ਦੁਭਾਸੀਏ ਨਾਲ ਗੱਲ ਕਰਨ ਲਈ, 888.563.2250 'ਤੇ ਜਾਂ ਪੂਰੀ ਤਰ੍ਹਾਂ ਸੁਣਨ ਵਿੱਚ ਅਸਮਰਥ ਟੀਟੀਵਾਈ ਲਈ 711 'ਤੇ ਕਾਲ ਕਰੋ।

CAMBODIAN-MON-KHMER
ប្រសិនបើអ្នក ឬនរណាម្នាក់ដែលកំពុងជួយអ្នក មានសំណួរអំពី Western Health Advantage ទេ,
អ្នកមានសិទ្ធិទទួលជំនួយនឹងព័ត៌មាន
នៅក្នុងភាសារបស់អ្នក ដោយមិនអស់ប្រាក់។ ដើម្បីនិយាយជាមួយអ្នកបកប្រែ សូមទូរស័ព្ទ 888.563.2250 ឬ TTY សម្រាប់
អ្នកត្រចៀកថ្លង់ តាមលេខ 711។

HMONG
Yog koj, los yog tej tus neeg uas koj pab ntawd, muaj lus nug txog Western Health Advantage, koj muaj cai kom lawv muab cov ntshiab lus qhia uas tau muab sau ua koj hom lus pub dawb rau koj. Yog koj xav nrog ib tug neeg txhais lus tham, hu rau 888.563.2250 los sis TTY rau cov neeg uas tsis hnov lus zoo nyob ntawm 711.

HINDI
यदि आप, या जिस किसी की आप मदद कर रहे हो, के Western Health Advantage के बारे में प्रश्न हैं तो, आपको अपनी भाषा में मदद तथा जानकारी प्राप्त करने का अधिकार है। दुभाशिए के साथ बात करने के लिए, 888.563.2250 पर या पूरी तरह श्रवण में असमर्थ टीटीवाई के लिए 711 पर कॉल करो।

THAI
หากคุณ หรือคนที่คุณกำลังช่วยเหลือมีคำถามเกี่ยวกับ Western Health Advantage
คุณมีสิทธิที่จะได้รับความช่วยเหลือและข้อมูลในภาษาของคุณได้โดยไม่มีค่าใช้จ่าย เพื่อพูดคุยกับล่าม โทร 888.563.2250 หรือใช้TTY
สำหรับคนหูหนวกโดยโทร 711