Enrollment/Change Form: Los Rios Community College District

Western Health Advantage

Send your completed enrollment form to: **Los Rios Employee Benefits Department**
1919 Spanos Court, Sacramento, CA 95825
ACTIVE EMPLOYEES: Send Attn: Benefits Department; call 916.568.3070 for assistance
EARLY RETIREES: Send Attn: Kris Kurk; 916.568.3060 for assistance

NEW ENROLLMENT: Complete entire form.

Select a primary care physician (PCP) for you and your dependents by searching online at **choosewha.com/directory**. Indicate provider name, WHA Provider ID# and medical group.

❑ New hire — date of hire _____

❑ Newly eligible — reason _____

❑ COBRA — effective date _____

❑ Retirement date _____

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

CHANGE: Complete required information (**in bold**) in Section I and any sections applicable to the change you are making.

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)

PLAN INFORMATION

Benefit Plan ❑ Premier 0/20/0 HMO Prime ❑ Western 1800/0/0 HDHP HMO PRIME **Effective Date** _____

Employer LOS RIOS COMMUNITY COLLEGE DISTRICT **Group #**107423 **LR Employee ID#**_____

Class_____ **Subgroup**_____

SECTION I — MEMBER INFORMATION

Employee First Name _____ **Last Name** _____ **MI** _____

Social Security # _____ **Date of Birth** _____ ❑ **Male** ❑ **Female** ❑ **Unspecified**

Residential Street Address _____ **Apt./Unit#**_____

City, State, Zip _____

Mailing Address (if different) _____ Apt./Unit#_____

City, State, Zip _____

Email Address _____ Job Title _____

Home Phone _____ Work Phone _____

PCP Name _____ **WHA Provider 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

First Name _____ Last Name _____ MI _____

Social Security # _____ Date of Birth _____ ❑ Male ❑ Female ❑ Unspecified

PCP Name _____ WHA Provider 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 _____

Employee First Name _____ **Last Name** _____ **MI** _____

❑ Add ❑ Remove | ❑ Child, up to age 26 ❑ Disabled (must meet criteria and provide proof of disability)

First Name _____ Last Name _____ MI _____

Social Security # _____ Date of Birth _____ ❑ Male ❑ Female ❑ Unspecified

PCP Name _____ WHA Provider 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 _____

❑ Add ❑ Remove | ❑ Child, up to age 26 ❑ Disabled (must meet criteria and provide proof of disability)

First Name _____ Last Name _____ MI _____

Social Security # _____ Date of Birth _____ ❑ Male ❑ Female ❑ Unspecified

PCP Name _____ WHA Provider 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 _____

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 _____