2021 Western Health Advantage Employer Group Enrollment Request Form

Western Health Advantage

Please contact Western Health Advantage if you need information in another language or format (Braille).

To enroll in Western Health Advantage, please provide the following information:

County of Sonoma
EMPLOYER OR UNION NAME

950201
GROUP #

Western Health Advantage MyCare 10/0 (HMO
PLAN NAME

☐Mr. ☐Mrs. ☐Ms. _____ LAST NAME _____ FIRST NAME ____ MI

__ __/__ __/__ __ __ __ BIRTH DATE (MM/DD/YYYY) _____ E-MAIL ADDRESS ( ) - PHONE NUMBER

SEX: ☐M ☐F _____ PERMANENT RESIDENCE STREET ADDRESS (P.O. BOX IS NOT ALLOWED)

_____ CITY _____ COUNTY _____ STATE _____ ZIP CODE

MAILING ADDRESS (ONLY IF DIFFERENT FROM YOUR PERMANENT RESIDENCE ADDRESS)

_____ CITY _____ COUNTY _____ STATE _____ ZIP CODE

Please Provide Your Medicare Insurance Information

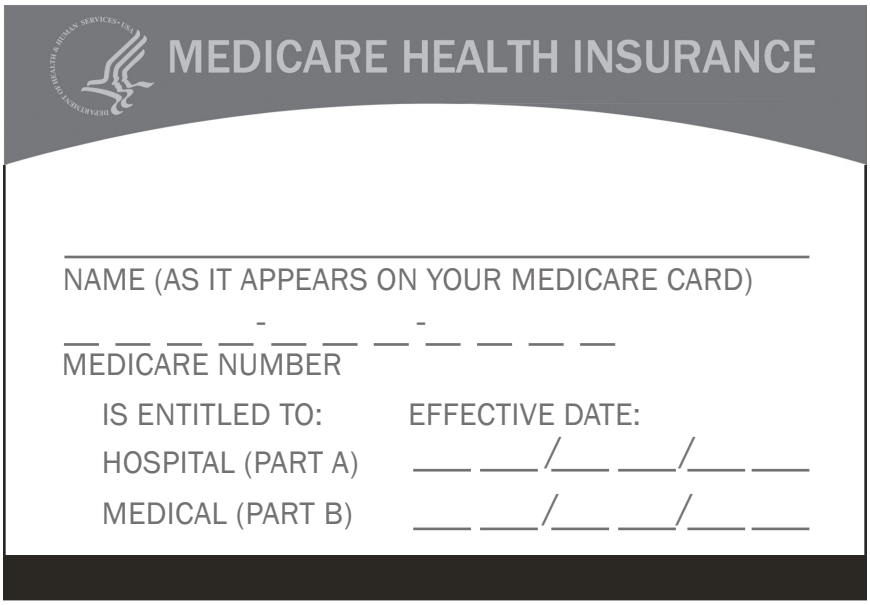
Please take out your red, white and blue Medicare card to complete this section.

+ Fill out this information as it appears on your Medicare card.

-OR-

+ Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board.

⚠ You must have Medicare Part A and Part B to join a Medicare Advantage plan.



OFFICE USE ONLY

NAME OF STAFF MEMBER/AGENT/BROKER (IF ASSISTED IN ENROLLMENT) _____

PLAN ID # _____

EFFECTIVE DATE OF COVERAGE ____/____/____

☐ICEP/IEP ☐AEP ☐SEP (type): _____ ☐Not Eligible _____ ____/____/____ DATE

PBP _____ TRAN. CODE _____ PREMIUMS _____ GROUP # _____ CONTRACT # _____

Please Read and Answer These Important Questions

1. Are you the retiree? If yes, retirement date: __/__/____
M M D D Y Y Y Y

☐Yes ☐No

If no, name of retiree: _____

2. Do you or your spouse work? ☐Yes ☐No

3. Will you have other coverage in addition to Western Health Advantage? ☐Yes ☐No

Some individuals may have other coverage, including other private insurance, TRICARE, Federal Employee Health Benefits coverage, VA benefits, or State pharmaceutical assistance programs. If "yes," please list your other coverage and your identification (ID) number for this coverage:

_____
NAME OF OTHER COVERAGE

_____ _____
ID # FOR COVERAGE GROUP # FOR COVERAGE

CHECK ALL THAT APPLY:
☐Medical
☐Vision
☐Dental
☐Prescription

4. Are you a resident in a long-term care facility, such as a nursing home? ☐Yes ☐No

If "yes," please provide the following information:

_____ ( ) -
NAME OF INSTITUTION PHONE NUMBER OF INSTITUTION

_____
ADDRESS OF INSTITUTION

_____ _____ _____
CITY STATE ZIP

5. Please provide the name of a Primary Care Provider (PCP):

_____ _____
PCP NAME MEDICAL GROUP, CLINIC NAME, OR PCP LOCATION

_____
WHA PROVIDER ID NUMBER (OPTIONAL)

6. Are you a current patient of this doctor? ☐ Yes ☐ No

7. Do you want us to send your information in Spanish? ☐ Yes ☐ No

8. Select one if you want us to send you information in an accessible format.

☐ Braille ☐ Large print ☐ Audio CD

Please contact Western Health Advantage at 888.563.2250 or 916.563.2250 if you need information in an accessible format other than what's listed above. Our office hours are seven days a week, 8 a.m. to 8 p.m. TTY users can call 711.

Please Read and Sign Below

By completing this enrollment application, I agree to the following:

Western Health Advantage is a Medicare Advantage plan and has a contract with the Federal government. I will need to keep my Medicare Parts A and B. I can only be in one Medicare Advantage plan at a time, and I understand that my enrollment in this plan will automatically end my enrollment in another Medicare health plan or prescription drug plan. It is my responsibility to inform you of any prescription drug coverage that I have or may get in the future. Enrollment in this plan is generally for the entire year. Once I enroll, I may leave this plan or make changes only at certain times of the year if an enrollment period is available (Example: Annual Enrollment Period from October 15 - December 7), or under certain special circumstances.

Western Health Advantage serves a specific service area. If I move out of the area that Western Health Advantage serves, I need to notify the plan so I can disenroll and find a new plan in my new area. Once I am a member of Western Health Advantage, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from Western Health Advantage when I get it to know which rules I must follow to get coverage with this Medicare Advantage plan. I understand that people with Medicare aren't usually covered under Medicare while out of the country except for limited coverage near the U.S. border.

I understand that selecting a Western Health Advantage (HMO) plan means that on the date coverage begins, I must get all of my health care from Western Health Advantage network providers, except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by Western Health Advantage and other services contained in my Western Health Advantage Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered provided plan rules are followed. If plan rules are not followed, **NEITHER MEDICARE NOR WESTERN HEALTH ADVANTAGE WILL PAY FOR THE SERVICES.**

I understand that if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with Western Health Advantage, he/she may be paid based on my enrollment in Western Health Advantage.

Release of Information: By joining this Medicare health plan, I acknowledge that the Medicare health plan will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that Western Health Advantage will release my information including my prescription drug event data to Medicare, who may release it for research and other purposes which follow all applicable Federal statutes and regulations. The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.

I understand that my signature (or the signature of the person authorized to act on my behalf under the laws of the State where I live) on this application means that I have read and understand the contents of this application. If signed by an authorized individual (as described above), this signature certifies that: 1) this person is authorized under State law to complete this enrollment and 2) documentation of this authority is available upon request from Medicare.

_____ __ __/__ __/__ __

SIGNATURE **TODAY'S DATE**

If you are the authorized representative, you must sign above and provide the following information:

NAME

ADDRESS

CITY | COUNTY | STATE | ZIP CODE

( ) -
PHONE NUMBER | RELATIONSHIP TO ENROLLEE

Submission Options

Mail pages to:
Western Health Advantage Mail Service
Attn: Membership Accounting
P.O. Box 5648
Portland, OR 97228-5648

Scan and fax pages to:
916.678.5441

Scan and email pages to:
MAEnrollment@westernhealth.com