WHA/ Premier Access/ VSP
Insurance Enrollment/Change Form
(Medical Students Only)

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UC Davis Medical Student Enrollment/Change Form for WHA/Premier/VSP***

Directions: Complete the entire form. Please select a Primary Care Provider (see the PCP link on page 2) for yourself and each of your family members from the provider directory by writing his/her name in the appropriate areas below. The selected PCP has to be a UCD Medical Group doctor. If you don't select a PCP one will be assigned to you.

Section 1. ENROLLEE (STUDENT) DATA

Gender (please circle): Male Female	SSN#:	Date of Birth:
Student ID:	Matriculation Date:	Begin Insurance Quarter (circle one) Winter Spring Summer Fall
Name: First	Last	MI
Address: Street (Provide Sacramento address only)	City	State ZIP
Home Phone:	Cell Phone:	E-mail:
Marital Status:	PCP Name:	Medical Group:

Section 2. SPOUSE/DEPENDENTS TO BE COVERED/REMOVED

Please list all family members to be covered/removed by this enrollment form. If dependent child is age 19 or older, is he/she a full time student? ( ) Yes ( ) No ( ) N/A

Circle One: Add Remove	Name: Last	First MI
Date of Birth:	Gender: Male Female	Relationship:
PCP Name:	SSN#:	Existing patient: Yes No
Circle One: Add Remove	Name: Last	First MI
Date of Birth:	Gender: Male Female	Relationship:
PCP Name:	SSN#:	Existing patient: Yes No
Circle One: Add Remove	Name: Last	First MI
Date of Birth:	Gender: Male Female	Relationship:
PCP Name:	SSN#:	Existing patient: Yes No

Date of marriage, adoption or termination effective: ______________

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Section 3. PLEASE LIST OTHER HEALTH INSURANCE OR COVERAGE

Do any of the enrollees listed in Section 2 have other health coverage? If yes, please complete this section.

Name of Insured	Insurance Company	Policy Number	Type of Coverage	Subscriber of Coverage	Effective Date
			P* S*		
			P* S*		
			P* S*		

P- primary, S*- secondary*

Signature required for terms and conditions and arbitration clause – Read carefully

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 where 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 agreement are giving up their constitutional right to have any such disputes decided in a court of law before a jury, and instead are accepting the use of binding arbitration.

Section 4. SIGNATURE REQUIRED

Student signature: ____ Date: ______________

SOM Registrar Administrator signature: ___________________________________Date: _______________

Section 5. TO BE COMPLETED BY UCD SOM REGISTRAR'S OFFICE:

- o New Group
- o New Student
- o Newly Eligible
- o Add Dependent
- o Add newborn/newly adopted child
- o Terminate Student
- o Remove Dependent
- o Change of Name
- o Change of Address
- o New PCP

Benefit Plan: ____________
Effective Date: ____________
Group Number: __________
Class: __________________
Subgroup: ________________

*** WHA Health/Premier Dental/VSP Vision is a combined package of health, dental and vision coverage for UCD medical students.

For UCD Primary Care Providers please go to:

http://www.ucdmc.ucdavis.edu/mdprogram/registrar/primary_care_physicians.html

For more information, please contact:

hs-studentrecords@ucdavis.edu or (916) 734-4027