UCDAVIS HEALTH | SCHOOL OF MEDICINE

Registrar's Office

4610 X Street, Suite 1208, Sacramento, CA 95817
Tel: 916-734-4027 | Fax: 916-734-2178
hs-studentrecords@ucdavis.edu

Insurance Enrollment/Change Form (MD Students Only)

WHA Health/Premier Dental/VSP Vision is a combined package of health, dental and vision coverage for UCD medical students. Complete this entire form. Please select a Primary Care Provider (PCP) for yourself and each of your family members from the provider directory (see the PCP link on page 2). If you do not select a PCP, one will be assigned to you.

SECTION 1: ENROLEE (STUDENT) INFORMATION

Student ID	**SSN** - -	**Date of Birth** / /
Last Name	**First Name**	**MI**
Gender ☐ Male ☐ Female	**Phone**	**Begin Insurance Quarter (choose one)** ☐ **Winter** ☐ **Spring** ☐ **Summer** ☐ **Fall**
Sacramento-area Street Address	**City**	**State** **Zip**
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

☐ **Add** ☐ **Remove**	**SSN** - -	**Date of Birth** / /
Last Name	**First Name** **MI**	**Relationship**
Gender ☐ Male ☐ Female	**PCP Name**	**Existing Patient?** ☐ Yes ☐ No
☐ **Add** ☐ **Remove**	**SSN** - -	**Date of Birth** / /
Last Name	**First Name** **MI**	**Relationship**
Gender ☐ Male ☐ Female	**PCP Name**	**Existing Patient?** ☐ Yes ☐ No
☐ **Add** ☐ **Remove**	**SSN** - -	**Date of Birth** / /
Last Name	**First Name** **MI**	**Relationship**
Gender ☐ Male ☐ Female	**PCP Name**	**Existing Patient?** ☐ Yes ☐ No

Effective date of marriage, adoption, birth, or termination: ___________________________

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SECTION 3: ADDITIONAL HEALTH INSURANCE 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

SECTION 4: REQUIRED SIGNATURE

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.

Student signature: _____ Date : _____

SOM Registrar Administrator signature: _____ Date: _____

For UCD Primary Care Providers, visit:

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

For PCPs affiliated with a non-UCD Medical Group, visit:

https://www.westernhealth.com/search-for-providers/advanced-search/

Office Use Only

Effective quarter: _____ Effective month: _____ Excel: _____
WHA: _____ Premier: _____ VSP: _____
TSAEXPP: _____ TSAAREV: _____ Notify Financial Aid: _____
Dependents in TSAAREV: _____ Dep. in WHA/Premier/VSP: _____ HSSIS: _____