University of California, Davis
School of Medicine, Registrar's Office

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

4610 X Street, Suite 1208, Sacramento CA 95817-2200 / Phone: (916) 734-4027 / Fax: (916) 734-2178

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 in the attached page) 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 address:**
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 __

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

Please return this form to the SOM, Registrar's Office. 4610 X Street, Suite 1208, Sacramento, CA 95817.

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 3. SIGNATURE REQUIRED

Student signature: _____ Date: _____

SOM Registrar Administrator signature: _____Date: _____

Section 4. 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:
Asha Repace - Registrar Administrator
Phone: (916) 734-4664
Email: arepace@ucdavis.edu or hs-studentrecords@ucdavis.edu