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: ENROLLEE (STUDENT) INFORMATION - REQUIRED

Last name	First name	MI	Sex ☐ M ☐ F
Student ID		Date of Birth (MM/DD/YYYY) / /	
Sacramento-area Street address		Phone no, ( )	
City	State	Zip code	Social Security no.
Marital Status	PCP Name	Medical Group	

SECTION 2: TYPE OF ACTIVITY - REQUIRED

☐ New coverage ☐ Reinstate Coverage ☐ Add spouse or dependent ☐ Remove spouse or dependent

Begin Insurance Quarter (choose one)

☐ Winter ☐ Spring ☐ Summer ☐ Fall

SECTION 3: SPOUSE/DEPENDENTS TO BE COVERED/REMOVED

Relationship	Last name	First name	MI	Sex	Date of Birth (MM/DD/YYYY)
Spouse				☐ M ☐ F	/ /

Social Security no.	PCP Name	Existing Patient?
		☐ Y ☐ N

Relationship	Last name	First name	MI	F/T student	Sex	Date of Birth (MM/DD/YYYY)
Child 1				☐ Y ☐ N	☐ M ☐ F	/ /

Social Security no.	PCP Name	Existing Patient?
		☐ Y ☐ N

All incoming students are required to complete the insurance Enrollment/Change Form. The enrollment form is good for the duration of each student's participation in the UC Davis MD program.

Students who waive out of the UC Davis WHA insurance package are required to provide evidence of insurance annually. Failure to provide evidence of insurance by the date your annual insurance expires, as listed in your myRecordTracker account, will result in enrollment in the WHA insurance package and you will be charged all applicable fees per the Insurance Fee Schedule. Once enrolled and charged fees for the WHA insurance package, the student may terminate coverage only after providing evidence of outside coverage. The effective date of termination is dependent on when the student provides evidence of outside insurance coverage. If provided between the 1st – 10th of the month, termination will apply to 1st date of that month. If provided between the 11th – 31st, termination will apply to 1st day of the following month. There will be no waiver or reimbursement of previously charged fees.

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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/

SECTION 4: REQUIRED SIGNATURE - REQUIRED

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's Office staff signature: ______________________________ Date: ____________

Office Use Only

Effective quarter: __________ Effective month: __________ ☐ Excel: __________ ☐ WHA site: __________

☐ Premier site: __________ ☐ VSP site: __________ ☐ TSAAREV: __________ ☐ Depend. TSAAREV: __________

☐ Excel: __________ ☐ Billing Doc: __________ ☐ MyRecordTracker: ______ ☐ Dep. in WHA/Premier/VSP: ________

☐ TSAEXPP/Banner Waiver added/removed: __________ ☐ Notify Financial Aid: __________