INDIVIDUAL AND FAMILY PLAN
HEALTH CARE COVERAGE APPLICATION /ENROLLMENT/ CHANGE FORM
SUTTER HEALTH PLUS

Language Assistance
If you have questions about completing this application (in English or another language), please contact Sutter Health Plus (SHP) Member Services at 1-855-315-5800 (TTY: 1-855-830-3500), Monday through Friday from 8:00 a.m. – 7:00 p.m. Pacific Time. If needed, we will provide translation services and other language assistance services to you free of charge. If needed, we will provide translation services and other language assistance free of charge. If you are working with a broker, you may also call him or her for assistance. A broker who helped you read and complete this application must sign the application (see Section 8).

This form is for Individual and Family Plan enrollment. If you would like to make an address or phone number change, please contact Member Services at 1-855-315-5800.

Availability of Evidence of Coverage and Disclosure Form
This application is part of the Individual and Family Plan Membership Agreement and Disclosure Form and Evidence of Coverage. By signing this form, you are accepting the terms, conditions, and provisions contained in this form and the Individual and Family Plan Membership Agreement and Disclosure Form and Evidence of Coverage. You have the right to read the Individual and Family Plan Membership Agreement and Disclosure Form and Evidence of Coverage before applying for coverage and/or enrolling in Sutter Health Plus. To obtain a copy, please contact your broker or you may contact Sutter Health Plus Member Services Department at 1-855-315-5800 (TTY: 1-855-830-3500).

Please keep a copy of this form for your files. **Please be sure to return all pages of this form including this last page as it contains your signature which is necessary to process these changes.** Missing information may delay processing.

Your first month premium must accompany this form.

Mail your completed form to:
Sutter Health Plus
2880 Gateway Oaks Drive, Ste. 150
Sacramento, CA 95833

Section A: Enrollment Purpose

Enrollment Type:	**Applicant Type:**
☐ New Enrollment ☐ Change Plan ☐ Add Dependent(s) If you selected Add Dependent(s), include your Member ID here: _____	☐ Subscriber ☐ Subscriber and Spouse/Domestic Partner ☐ Subscriber and Child(ren) ___ ☐ Child Only ☐ Family: Subscriber, Spouse/Domestic Partner, Child(ren)___

☐ **Event Date**_____
Please refer to Individual and Family Plan Membership Agreement and Disclosure Form and Evidence of Coverage for a list of qualifying events.

Section A1: Plan Details and Account Information

For which plan would you like to apply?
☐ MI01 Platinum Individual Copay $20 ☐ MI02 Gold Individual Copay $30
☐ MI03 Silver Individual Copay $45 ☐ MI04 Bronze Individual Copay $60

Sections to Complete

If you are applying for coverage just for:
- Yourself only (Subscriber), complete Section B (and Section D if applicable)
- Child only, complete Section B and C.

If you are applying for any other coverage, complete Section B and C (and Section D if applicable)

Section B: Subscriber Information

Last Name:	First Name:	MI:

Date of Birth:	Social Security Number (required):	Subscriber ID Number (if known):	☐ Male ☐ Female

Residential Address:	City:	State:	ZIP:

Home Phone:	Mobile Phone:	Work Phone:	Email Address:

Mailing Address: (P.O. Box accepted)	City:	State:	ZIP:

Primary Spoken Language:	Subscriber ID Number (if known):	Previous Name (if any):

Primary Care Physician (PCP) Information – If you do not select a PCP, one will be assigned to you. You have the opportunity to change your PCP by calling Member Services at 1-855-315-5800 (TTY/TDD: 1-855-830-3500).
To find a PCP please visit: sutterhealthplus.org/providersearch

Primary Care Physician (PCP) Name: Are you a current patient? ☐ Yes ☐ No	Primary Care Physician (PCP) ID Number:

Section C: Dependent Information

Section C1: Spouse/Domestic Partner

Add: ☐ Spouse ☐ Domestic Partner	Last Name:	First Name:	MI:

Date of Birth:	Social Security (required):	☐ Male ☐ Female

Residential Address:	City:	State:	ZIP:

Mailing Address: (P.O. Box accepted)	City:	State:	ZIP:

Primary Care Physician (PCP): Is this person a current patient? ☐ Yes ☐ No	Primary Care Physician (PCP) ID:

Section C2: Dependent One					
☐ Add	Last Name:	First Name:			M.I.
Date of Birth:		Social Security (required):			☐ Male ☐ Female
Residential Address:			City:	State:	ZIP:
Mailing Address: (P.O. Box accepted)			City:	State:	ZIP:
Primary Care Physician (PCP) Name: Is this person a current patient? ☐ Yes ☐ No			Primary Care Physician (PCP) ID:		

Section C3: Dependent Two					
☐ Add	Last Name:	First Name:			M.I.
Date of Birth:		Social Security (required):			☐ Male ☐ Female
Residential Address:			City:	State:	ZIP:
Mailing Address: (P.O. Box accepted)			City:	State:	ZIP:
Primary Care Physician (PCP) Name: Is this person a current patient? ☐ Yes ☐ No			Primary Care Physician (PCP) ID:		

Section C4: Dependent Three (If you need additional room, please attach a sheet of paper to the back of this form)					
☐ Add	Last Name:	First Name:			M.I.
Date of Birth:		Social Security (required):			☐ Male ☐ Female
Residential Address:			City:	State:	ZIP:
Mailing Address: (P.O. Box accepted)			City:	State:	ZIP:
Primary Care Physician (PCP) Name: Is this person a current patient? ☐ Yes ☐ No			Primary Care Physician (PCP) ID:		

Section D: Financially Responsible Party for Applicant to Be Covered (for child only or court ordered coverage obligations)

If the financially responsible party is someone other than the Applicant, please complete the information below.

Last Name:	First Name:	MI:
Date of Birth:	Mobile Phone:	
Social Security Number:	Home Phone:	

☐ Male ☐ Female	Street Address: (Must be a residential street address. P.O. boxes are not accepted)		
City:		State:	Zip:
Email Address:			
Primary Spoken Language:	Subscriber ID Number (if known):	Previous Name (if any):	

Section E: Other Coverage Information

If you or any of your above listed dependents have other healthcare coverage, please complete this section (☐ I do not have other coverage):

Primary Policy Holder Name(s) (Last, First, MI):	Policy Number /:	Effective Date:
Insurance Carrier Name:	Phone:	
Insurance Carrier Address:	Individual(s) Covered Under Policy:	

Section F: Prior Coverage Information

Provide the information below for the Applicant's current or most recent health coverage provider.

Is the Applicant an existing or former Sutter Health Plus member? ☐ Yes ☐ No

Prior Health Coverage Provider

Did the applicant have health coverage within the last 63 days? ☐ Yes ☐ No

If "Yes", please provide the following information:

Type of Coverage: ☐ COBRA ☐ Group/Employer ☐ Individual ☐ Other	
Health Coverage Provider:	Policy ID:
Start Date of Coverage:	End Date of Coverage:

Coordination of Benefits

Does the applicant or any dependent listed above have current health insurance (including Medicare or Medicaid) that will NOT be terminated upon acceptance of enrollment with Sutter Health Plus? ☐ Yes ☐ No

If "Yes", please provide the following information:

Type of Coverage: ☐ COBRA ☐ Group/Employer ☐ Individual ☐ Other	
Name(s): (Last, First, MI)	Policy Number and Effective Date:
Insurance Carrier Name:	Insurance Carrier Phone:
Insurance Carrier Address	Member ID Number(s):

If additional space is needed, please provide a separate sheet of paper.

Section F: First Month's Premium and Effective Date

Primary Applicant Effective Date Notification	First month's premium must accompany this form for the application to be considered complete. We will notify you of your effective date in your acceptance letter. If you have questions regarding your enrollment status, please contact your broker or Sutter Health Plus Member Services 1-855-315-5800, Monday through Friday from 8:00 a.m. – 7:00 p.m. Pacific Time.
New Dependent Effective Date Notification	If you and your dependents are enrolling together, the effective date for the primary applicant (subscriber) will also apply to all dependents. A newborn or a newly adopted child is automatically covered from the moment of birth for thirty days following birth. The child must be enrolled within 60 days after birth for membership to become effective and continue coverage beyond the first thirty days after birth. Please reference the Individual and Family Plan Membership Agreement and Disclosure Form and Evidence of Coverage for further details on enrolling a newborn or adopted child.

Section G: Agent, Broker, or Representative Information

For Applicants using an insurance agent, broker, or representative.

The broker of record may receive monetary and / or monetary payments from Sutter Health Plus in connection with the purchase of this coverage. Premiums are the same whether or not you use an agent, broker, or other representative.

Agent, Broker, or Representative Name:

Section G1: To be completed by your Agent, Broker, or Representative after completion of this application.

If you have assisted the Applicant in submitting the application, the law requires that you attest to this assistance. If, in making this attestation, you state as true any material fact you know to be false, you will be subject to a civil penalty of up to ten thousand dollars ($10,000), as authorized under California Health and Safety Code section 1389.8I or Insurance Code section 10119.3, in addition to any other applicable penalties or remedies available under current law.

I assisted the Applicant in submitting this application. To the best of my knowledge, the information on this application is complete and accurate. I explained to the Applicant, in easy-to-understand language, the risk to the Applicant of providing inaccurate information, and the Applicant understood the explanation.

X_____

Agent, Broker, Representative Signature **Today's Date**

Last Name: Knauss	First Name: Kevin	MI:	
Street address: 8712 Pendleton Drive			
City: Granite Bay	State: CA	Zip: 95746	
Phone: (916) 521-7216	Fax:	Email Address: kevin@insuremekevin.com	
Agency Name:	License Number: 0H12644	SHP ID Number: 00979260	

Section I: Member Agreement – Please read the following information carefully.

AGREEMENT TO BE BOUND

I declare that I have read this application, the answers provided, and the documents enclosed. I have had an opportunity to review the Individual and Family Plan Membership Agreement and Disclosure Form and Evidence of Coverage (Agreement) and by signing this document accept all terms and rates and conditions set forth in the Agreement. I certify that the information provided with this application is true, complete, and correct to the best of my knowledge.

If this application is accepted by the health plan, then my signature will result in a binding contract with the health care coverage, terms and conditions set forth in the Individual and Family Plan Subscriber Contract, Evidence of Coverage and Disclosure Form.

AUTHORIZATION TO RELEASE INFORMATION

I authorize Sutter Health Plus to disclose to my Sutter Health Plus broker or agent the status of my application for coverage, as well as that of any Applicant on whose behalf I am executing this authorization, including whether an application was received, accepted, or rejected; if accepted, the effective date of coverage; and information regarding the status of bills and payments for amounts due for coverage.

THIRD PARTY RECOVERY

I understand that by signing below I am agreeing to grant a lien on third party recoveries. For more information please refer to the section entitled Third Party Responsibility – Subrogation in the Individual and Family Plan Subscriber Contract, Evidence of Coverage and Disclosure Form.

BINDING ARBITRATION

Sutter Health Plus (SHP) handles and resolves Member disputes through grievance, appeal and Independent Medical Review processes. However, in the event that a dispute is not resolved in those processes, Sutter Health Plus uses binding arbitration as the final method for resolving all such disputes.

As a condition of your membership in Sutter Health Plus, you agree that any and all disputes between yourself (including any heirs or assigns) and Sutter Health Plus, including claims of medical malpractice (that is as to whether any Medical Services rendered under the health plan were unnecessary or unauthorized or were improperly, negligently or incompetently rendered), except for Small Claims Court cases and claims subject to ERISA, shall be determined by 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. You and Sutter Health Plus, including any heirs or assigns to this Agreement, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of binding arbitration.

I hereby agree to give up my/our right to a jury trial and accept the use of binding arbitration. I understand that the full arbitration provision is contained in the Individual and Family Plan Subscriber Contract, Evidence of Coverage and Disclosure Form.

X_____

Applicant / Financially Responsible Party **Today's Date**