INDIVIDUAL AND FAMILY PLAN

Health Care Coverage Application / Enrollment / Change Form

Enrollment

This application is part of the Individual and Family Plan Membership Agreement and *Evidence of Coverage and Disclosure Form* (*EOC*). 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 *EOC*. You have the right to read the Individual and Family Plan Membership Agreement and *EOC* before applying for coverage or enrolling in Sutter Health Plus. To obtain a copy, contact your broker or call Sutter Health Plus Member Services at 1-855-315-5800 (TTY 1-855-830-3500).

Important Note

The Affordable Care Act (ACA) requires Sutter Health Plus to collect the Social Security numbers (SSN) for all enrolled family members. Sutter Health Plus is required to provide IRS Form 1095-B to the IRS with a copy to you. Form 1095-B includes information you will need to report on your income tax return showing that you and your covered family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year. Individuals who do not have minimum essential coverage and do not qualify for an exemption may be liable for the individual shared responsibility payment. Sutter Health Plus will not use or share your SSN other than as required by law. **Please be sure to include all SSNs where requested.**

Change Request

This form is also used to inform us of changes, such as a name, an address or telephone number.
This form is not used to notify us of a termination.

For Sutter Health Plus to process your request, you must sign and return Section I of this form. Missing information may delay processing.

Your first month's premium must accompany this form (for new policy holders).

Mail your completed form to:
Sutter Health Plus
2480 Natomas Park Dr., Ste. 150
Sacramento, CA 95833

Fax or email changes and plan renewals to:
Fax: 1-916-736-5090
Email: *shpifp@sutterhealth.org*

You must encrypt or secure any documents sent by email. If you cannot encrypt or secure emails, please fax all documents and keep a copy for your files.

Language Assistance

If you have questions about completing this application, please contact Sutter Health Plus Member Services at 1-855-315-5800 (TTY 1-855-830-3500), Monday through Friday from 8 a.m. to 7 p.m. Sutter Health Plus provides translation services and other language assistance services to you free of charge. If you are working with a broker, you may also call him or her for assistance. The broker who helped you read and complete this application must sign the application (see Section H).

Sutter Health Plus
Your Health Plan

Section A – Enrollment

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

If Yes, please include your Subscriber ID here .....

Enrollment Period

☐ **Annual Open Enrollment Period**

☐ **Special Enrollment Period**

Qualifying Event Date .....

(Please complete the Attestation Form for Qualifying Events for Special Enrollment included)

☐ **Demographic Change Only**

- ☐ Name Change
- ☐ Address Change
- ☐ Phone Number Change

Enrollment or Change Type

☐ **New Enrollment**

- ☐ Subscriber Only
- ☐ Subscriber and Spouse/Domestic Partner
- ☐ Subscriber and Child(ren)
- ☐ Child Only
- ☐ Family: Subscriber, Spouse/Domestic Partner, Child(ren)

☐ **Existing Subscriber**

- ☐ Change Plan
- ☐ Add Dependent(s)

Requested Effective Date .....

Section A1 – Plan Details and Account Information

Select the plan you would like

☐ Platinum MI01 HMO* ☐ Gold MI02 HMO* ☐ Silver MI03 HMO* ☐ Bronze MI04 HMO**

Sections to Complete

If you are applying for coverage for:

- Yourself only (subscriber), complete **Section B** *and Section E if applicable*
- Child only, complete **Sections B, D and E**

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

If you are updating or changing name, address or phone, complete **Section B** for subscriber *and Section C for dependents if applicable*

You need to select a primary care physician (PCP) for yourself and each covered family member. Please include your PCP's name and provider ID in **Sections B and C**.

Section B – Subscriber Information

Last Name **First Name** **MI**

Gender ☐ M ☐ F **Date of Birth** **Social Security Number** *(Required)*

Residential Address **City** **State** **ZIP**

Home Phone **Mobile Phone** **Work Phone** **Email Address**

Mailing Address *(P.O. Box Accepted)* ☐ same as residential **City** **State** **ZIP**

Previous Name *(If Any)* **Primary Spoken Language**

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 1-855-830-3500) or on the Member Portal. To find a PCP please visit ***sutterhealthplus.org/providersearch.***

☐ **I would like to select my PCP** ☐ **I would like a PCP assigned**

Current Patient? ☐ Yes ☐ No

PCP Name ..... **Provider ID** .....

Section C – Dependent Information

Section C1 – Spouse/Domestic Partner

Add:
☐ Spouse
☐ Domestic Partner

Last Name | Date of Birth | Gender ☐ M ☐ F

First Name | MI | Social Security Number *(Required)*

Residential Address

City | State | ZIP

Mailing Address *(P.O. Box Accepted)* ☐ same as residential

City | State | ZIP

☐ I would like to select my PCP ☐ I would like a PCP assigned

Current Patient? ☐ Yes ☐ No

PCP Name | Provider ID

Section C2 – Dependent One

Add:
☐ Child 1

Last Name | Date of Birth | Gender ☐ M ☐ F

First Name | MI | Social Security Number *(Required)*

Residential Address

City | State | ZIP

Mailing Address *(P.O. Box Accepted)* ☐ same as residential

City | State | ZIP

☐ I would like to select my PCP ☐ I would like a PCP assigned

Current Patient? ☐ Yes ☐ No

PCP Name | Provider ID

Section C3 – Dependent Two

Add:
☐ Child 2

Last Name | Date of Birth | Gender ☐ M ☐ F

First Name | MI | Social Security Number *(Required)*

Residential Address

City | State | ZIP

Mailing Address *(P.O. Box Accepted)* ☐ same as residential

City | State | ZIP

☐ I would like to select my PCP ☐ I would like a PCP assigned

Current Patient? ☐ Yes ☐ No

PCP Name | Provider ID

Section C4 – Dependent Three *(If you need additional room, please attach information to the back of this form).*

Add:
☐ Child 3

Last Name | Date of Birth | Gender ☐ M ☐ F

First Name | MI | Social Security Number *(Required)*

Residential Address

City | State | ZIP

Mailing Address *(P.O. Box Accepted)* ☐ same as residential

City | State | ZIP

☐ I would like to select my PCP ☐ I would like a PCP assigned

Current Patient? ☐ Yes ☐ No

PCP Name | Provider 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**

Gender ☐ M ☐ F | **Date of Birth** | **Social Security Number** *(Required)*

Residential Address | **City** | **State** | **ZIP**

Home Phone | **Mobile Phone** | **Email Address**

Mailing Address *(P.O. Box Accepted)* ☐ same as residential | **City** | **State** | **ZIP**

Previous Name *(If Any)* | **Primary Spoken Language**

Section E – Parent or Legal Guardian *(if the primary applicant is a child under 18)*

☐ same as financially responsible party

Last Name | **First Name** | **MI** | **Date of Birth** | **Gender** ☐ M ☐ F

Residential Address | **City** | **State** | **ZIP**

Home Phone | **Mobile Phone** | **Work Phone** | **Email Address**

Mailing Address *(P.O. Box Accepted)* ☐ same as residential | **City** | **State** | **ZIP**

Previous Name *(If Any)* | **Primary Spoken Language**

Section F – Premium Payment Information and Effective Date

Section F1 – First Month's Premium Payment

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 at 1-855-315-5800, Monday through Friday from 8 a.m. to 7 p.m.

Please send initial premium payment to:
Sutter Health Plus
Attn: Sales Department
2480 Natomas Park Dr., Ste. 150
Sacramento, CA 95833

Section F2 – Subsequent Premium Payments

To ensure we promptly process and post payments to your account, please mail premium checks to the following address:

Sutter Health Plus
P.O. Box 740143
Los Angeles, CA 90074-0143

Please include the subscriber identification number in the memo line of your check.

Section F3 – 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 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. A newly adopted child's (including a child placed with you for adoption) membership will begin on the date when the adopting parent gains the legal right to control the child's health care. Please reference the Indvidual and Family Plan Membership Agreement and *EOC* for more information on enrolling a newborn or adopted child.

Section G – Other Coverage Information

Do you or any of your dependents covered under Sutter Health Plus have any other health plan coverage (in addition to Sutter Health Plus)?

☐ Yes ☐ No (If "Yes," please complete all of the information below.)

Type of Coverage ☐ COBRA ☐ Group/Employer ☐ Individual ☐ Other _____

Will your current health care coverage be terminated upon acceptance or enrollment with Sutter Health Plus? ☐ Yes ☐ No

Primary Policy Holder Name(s) (Last, First, MI) | **Policy Number** | **Effective Date**

Insurance Carrier Name | **Policy Holder Date of Birth**

All Dependents' Names and Other Health Plan ID Numbers

Section H – Agent, Broker or Representative Information

For applicants using an insurance agent, broker, or representative

The broker of record may receive 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 Kevin Knauss

Section H1 – 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 1389.8l 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.

Agent, Broker or Representative Signature | **Date**

Section H1 – To be completed by your agent, broker, or representative after completion of this application.

Last Name	First Name	MI
Knauss	Kevin	

Street Address
8712 Pendleton Drive

City	County	State	ZIP
Granite Bay	Placer	CA	95608

Phone	Fax	Email Address
(916) 521-7216		kevin@insuremekevin.com

Agency Name	License Number	SHP ID Number
	0H12644	979260

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 *EOC* (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 and *EOC*.

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 and *EOC*.

Binding Arbitration

Sutter Health Plus 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 and *EOC*.

Applicant / Financially Responsible Party **Date**

***Note:** This plan's prescription drug coverage is, on average, expected to equal or exceed the value of standard Medicare Part D benefit. This is considered creditable coverage. Since this coverage is creditable, Medicare-eligible individuals do not have to enroll in a Medicare prescription drug plan while they maintain this coverage. Be aware, however, that if the individual has a subsequent break in this coverage of 63 days or longer any time after he or she was first eligible to enroll in a Medicare prescription drug plan, the individual could be subject to a late enrollment penalty in addition to the Medicare Part D premium.

****Note:** This plan's prescription drug coverage is not, on average, expected to equal or exceed the value of standard Medicare Part D benefit. Therefore, this coverage is considered non-creditable. This is important for individuals who are or will become eligible for Medicare Part D. Most likely, the individual would receive more help with medication costs if he or she joined a Medicare Part D plan than if he or she only had coverage through this plan. The individual could also be subject to a higher premium (a penalty) if he or she does not join a Medicare drug plan when he or she first becomes eligible.

ATTESTATION FORM

Qualifying Events for Special Enrollment

You may enroll or change your coverage outside of the annual open enrollment period if you meet one of the requirements for a qualifying event. To be considered eligible in most cases, your application for coverage due to a qualifying event must occur within 60 days of the qualifying event. An eligible individual or dependent who experiences a loss of minimum essential coverage, has 60 days prior to and 60 days following the loss of coverage to enroll. Unless otherwise indicated, coverage will become effective the first day of the month following receipt of the application.

Instructions: Select the applicable qualifying/triggering event below and complete the qualifying event details section. Be sure to sign and date the attestation and submit this form along with your Health Care Coverage Application/Enrollment/Change Form and first month premium (if applicable).

Qualifying/Triggering Events

☐ **Loss of minimum essential health care coverage due to a reason that is not your fault. For example:**

- Changes in employer-sponsored coverage, such as termination of employment, reduction in work hours, changes in employer premium contribution, or exhaustion of COBRA benefits
- The death of the individual responsible for coverage
- Changes in dependent status
- Termination of government-sponsored coverage, such as Medi-Cal or Access for Infants and Mothers Program (AIM)

Coverage will be effective on the first day of the month following either the date other coverage ends or the date Sutter Health Plus receives the application, whichever is later. Loss of coverage due to voluntary termination, failure to pay premiums and rescission do not qualify as triggering events.

☐ Gain or become a dependent due to marriage or domestic partnership.

☐ Gain or become a dependent due to birth, adoption, placement for adoption or placement in foster care. Coverage will be effective on the date of the event unless you request a later effective date.

☐ Court order to provide coverage. Coverage will be effective on the date the court order is effective unless your request a later effective date.

☐ You are receiving services for one of the following conditions from a contracting provider that is no longer participating in the health benefit plan.

- Acute condition
- Terminal illness
- Pregnancy
- Serious chronic condition
- Authorized surgery or procedure
- Care of a newborn child between birth and age 36 months

☐ Permanent relocation into a Sutter Health Plus service area.

☐ Return from active duty service in the U.S. military reserve forces or the California National Guard.

☐ Divorce, legal separation, or dissolution of domestic partnership.

☐ Death of a dependent.

☐ Change in eligibility for federal financial assistance through Covered California, including if your employer is changing or discontinuing your current coverage options within the next 60 days.

Qualifying/Triggering Events Cont.

☐	Change in eligibility for federal financial assistance through Covered California, including if your employer is changing or discontinuing your current coverage options within the next 60 days.
☐	Released from incarceration.
☐	Health coverage issuer substantially violated a material provision of the health coverage contract.
☐	Did not enroll in health coverage during the previous annual open enrollment because you were misinformed that you were covered under minimum essential coverage.
☐	Enrollment or non-enrollment in health coverage was unintentional, inadvertent, or erroneous due to the error, misrepresentation, misconduct, or inaction of a Covered California employee, agent, or other entity providing enrollment assistance or conducting enrollment activities.
☐	Victims of domestic abuse or spousal abandonment who are currently enrolled in minimum essential coverage and seek to apply for coverage apart from the perpetrator of the abuse or abandonment. Dependents of a victim of domestic abuse or spousal abandonment, on the same application as the victim, may enroll in coverage at the same time as the victim.
☐	Applied for Medi-Cal coverage, either through Covered California or a local county human services agency, and determined ineligible after open enrollment has ended or more than 60 days after a qualifying event.

Qualifying Event Details

Date of Qualifying Event .....

Individual(s) that experienced the Qualifying Event .....

.....

Requested Effective Date .....

I hereby attest that I and/or my dependent(s) have experienced a qualifying event to be eligible for a special enrollment period. By signing this attestation, I certify that the information provided above is true, complete, and accurate to the best of my knowledge.

....

Applicant / Financially Responsible Party **Date**

Return Materials to:
Sutter Health Plus
2480 Natomas Park Dr., Ste. 150
Sacramento, CA 95833
Phone: 1-855-320-2350
Fax: 1-916-736-5090
Email: *shpifp@sutterhealth.org*

sutterhealthplus.org