SMALL GROUP PLAN
Employee Enrollment/Change Form

Enrollment

You have the right to read the Group Subscriber Contract and *Evidence of Coverage and Disclosure Form* (*EOC*) before enrolling in Sutter Health Plus. To help you make an informed choice, we make available Summary of Benefits and Coverage (SBC) documents. SBCs summarize important information about our health coverage options in a standardized format so you can easily compare benefits and coverage offered by Sutter Health Plus with those of other carriers. To obtain a copy, contact your employer or call Sutter Health Plus Member Services 1-855-315-5800 (TTY 1-855-830-3500). This enrollment form is part of the Group Subscriber Contract and *EOC*. You are accepting the terms, conditions, and provisions of the Group Subscriber Contract and *EOC*.

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 to existing members, such as a name, an address, telephone number or sub-account change. **This form is not used to notify us of a termination.** All changes to accounts, including effective dates and dependent status, will be made in accordance with the contractual agreement between the employer/purchaser and Sutter Health Plus.

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

Fax or email your completed form to:
Fax: 1-916-736-5426
Email: *shpenrollmentmailbox@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.

Sutter Health Plus
Your Health Plan

Small Group Employee Enrollment / Change Form

Group Name .....

Effective Date .....

Enrollment – *Please complete entire form.*

Reason For Request:

- ☐ Annual Open Enrollment
- ☐ Newly Eligible – Reason .....
- ☐ New Hire
- ☐ COBRA – Effective Date .....
- ☐ Cal-COBRA* – Effective Date .....

*Cal-COBRA enrollees will receive a separate Cal-COBRA Election Notice and Enrollment Form to complete. The notice includes important information regarding health care coverage options and rates.

Change – *Complete the required information in Sections B and C, if applicable.*

Member ID *(For Changes)* .....

- ☐ Add Dependent**
- ☐ Add Newborn/Newly Adopted Child**
- ☐ Remove Dependent – Effective Date .....
- ☐ Name Change
- ☐ Address Change
- ☐ Subaccount

From Subaccount ID ..... To Subaccount ID .....

**Date of qualifying event *(if not open enrollment)* .....

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 A – Benefit Plan Selection

STANDARD PLANS

Section A1 – HMO Standard Plan Selection

Platinum	Gold	Silver	Bronze
☐ MS38 HMO	☐ MS37 HMO	☐ MS44 HMO	☐ MS46 HMO
☐ MS50 HMO	☐ MS43 HMO	☐ MS35 HMO	☐ SD08 HDHP HMO
☐ MS41 HMO	☐ MS42 HMO	☐ SD17 HDHP HMO	

PLUS PLANS

Section A2 – HMO Plus Plan Selection *(Plus plans include embedded Infertility and Special Footwear benefits)*

Platinum	Gold	Silver	Bronze
☐ MP38 Plus HMO	☐ MP37 Plus HMO	☐ MP44 Plus HMO	☐ MP46 Plus HMO
☐ MP50 Plus HMO	☐ MP43 Plus HMO	☐ MP35 Plus HMO	☐ SP08 Plus HDHP HMO
☐ MP41 Plus HMO	☐ MP42 Plus HMO	☐ SP17 Plus HDHP HMO	

Optional Adult Vision Benefit

If selected by your employer, you and your dependents age 19 and older will be automatically enrolled in the optional adult vision benefit plan. However, you may opt out of this coverage by checking the box below.

☐ Please do not enroll me or my dependents in the optional adult vision benefit (if selected by my employer). I understand that I will not be able to obtain this coverage until the next applicable open enrollment or special enrollment period.

*Pediatric vision benefits for members age 19 and under (until the end of the month in which the member turns 19 years of age) are included in all Sutter Health Plus small group plans. Please refer to your *EOC* for coverage information.

Section B – Employee Information

Last Name | First Name | MI

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

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

PCP Name | Provider ID# P | Current Patient? ☐ Yes ☐ No

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

City | State | ZIP | City | State | ZIP

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

PCP Name | Provider ID# P | Current Patient? ☐ Yes ☐ No

Section C2 – Dependent One

Add: ☐ Child 1

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

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

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

City | State | ZIP | City | State | ZIP

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

PCP Name | Provider ID# P | Current Patient? ☐ Yes ☐ No

Section C – Dependent Information Cont.

Section C3 – Dependent Two

Add: ☐ Child 2

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

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

Residential Address

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

City | State | ZIP

City | State | ZIP

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

PCP Name | Provider ID# P | Current Patient? ☐ Yes ☐ No

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

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

City | State | ZIP

City | State | ZIP

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

PCP Name | Provider ID# P | Current Patient? ☐ Yes ☐ No

Section D – 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.)

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 E – Agreement

Member accepts the terms, conditions and provisions of the Group Subscriber Contract and *EOC*, upon completion and execution of this enrollment form.

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 Group Subscriber Contract and *EOC*.

Employee Signature **Date**