# 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.

This form is not a termination or add request. Please use the Sutter Health Plus Termination and/or Employee Enrollment Form.

**Instructions:**

1. The employer must complete Section A.
2. The employer is responsible for confirming all information prior to submitting. Please make sure effective dates are correct as these affect health plan premiums.
3. The employee must complete Sections B through D.
4. The employee must sign and date the bottom of the form.
5. Once all sections are complete, the employee should make a copy for his/her records and give the completed form to the employer.
6. The employer should return the signed and completed form to the address on the last page of this form.

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.

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

**Mail, Fax, or Scan/Email your completed form to:**
Sutter Health Plus
P.O. Box 160345
Sacramento, CA 95816
Secured Fax: 916-736-5426
Email: shpenrollmentmailbox@sutterhealth.org
Please note all documents must be sent encrypted/secured. If not, please fax all documents

Sutter Health Plus
Your Health Plan

## Section A: Employer Information

| **Group Name:** | **Group Number (if known):** |
|---|---|
| Contact Name: | Phone: |

## Section B: Requested Changes

| | |
|---|---|
| ☐ Name change (complete sections C,D)<br>From: To: | Effective Date: |
| ☐ Address change (complete section C) | Effective Date: |
| ☐ Phone change (complete section C) | Effective Date: |

## Section C: Employee Information (complete with new information)

| | | | | | |
|---|---|---|---|---|---|
| Last Name: | First Name: | MI: | SHP ID Number: | | |
| Residential Address: | | | City: | State: | ZIP: |
| Home Phone: | Mobile Phone: | Work Phone: | Email Address: | | |
| Mailing Address: (P.O. Box accepted) | | | City | State: | ZIP: |

## Section D: Dependent Information

### Section D1: Spouse/Domestic Partner

| | | | |
|---|---|---|---|
| ☐ Spouse<br>☐ Domestic Partner | Last Name: | First Name: | MI: |
| Date of Birth: | Social Security: | SHP ID Number: (if known) | ☐ Female<br>☐ Male |
| Residential Address: | | City: | State: ZIP: |
| Mailing Address: (P.O. Box accepted) | | City | State: ZIP: |

### Section D2: Dependent One

| | | | |
|---|---|---|---|
| ☐ Dependent | Last Name: | First Name: | M.I. |
| Date of Birth: | Social Security: | SHP ID Number: (if known) | ☐ Female<br>☐ Male |
| Residential Address: | | City: | State: ZIP: |
| Mailing Address: (P.O. Box accepted) | | City: | State: ZIP: |

| **Section D3: Dependent Two** | | | | | | | |
|---|---|---|---|---|---|---|---|
| ☐ Dependent | Last Name: | | First Name: | | | | M.I. |
| Date of Birth: | | Social Security: | | SHP ID Number: (if known) | | | ☐ Female<br>☐ Male |
| Residential Address: | | | | City: | | State: | ZIP: |
| Mailing Address: (P.O. Box accepted) | | | | City: | | State: | ZIP: |
| **Section D4: Dependent Three (If you need additional room, please attach a sheet of paper to the back of this form)** | | | | | | | |
| ☐ Dependent | Last Name: | | First Name: | | | | M.I. |
| Date of Birth: | | Social Security: | | SHP ID Number: (if known) | | | ☐ Female<br>☐ Male |
| Residential Address: | | | | City: | | State: | ZIP: |
| Mailing Address: (P.O. Box accepted) | | | | City | | State: | ZIP: |

Employee Signature Date