SMALL GROUP PLAN (1-100)
EMPLOYEE ENROLLMENT 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.

Availability of Group Subscriber Contract and Evidence of Coverage and Disclosure Form
This enrollment form is part of the Group Subscriber Contract, which includes the Evidence of Coverage and Disclosure Form. By signing this enrollment form, you are accepting the terms, conditions, and provisions contained in the enrollment form as well as those in the Group Subscriber Contract and Evidence of Coverage and Disclosure Form.

You have the right to read the Group Subscriber Contract and Evidence of Coverage and Disclosure Form before 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).

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 SHP with those of other carriers.

Important Note: The Affordable Care Act (ACA) requires SHP to collect the Social Security numbers (SSN) for all enrolled family members. SHP 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. SHP will not use or share your SSN other than as required by law. ***Please be sure to include all SSNs where requested!***

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

New Enrollment Form

Group Name:	Group Number (if known):	Coverage Effective Date:

Reason for Request: Please check the appropriate box and provide the event date.

☐ Annual Open Enrollment ☐ Newly eligible_____

Event Date: / /

Section A: Benefit Plan Selection

Select the plan you would like:

☐ MS28* (SG Platinum $25)
☐ MS29* (SG Platinum Coinsurance)
☐ MS30* (SG Platinum Copay $30)
☐ MS27* (SG Gold $30 - $1500)
☐ MS22* (SG Gold Coinsurance)
☐ MS23* (SG Gold Copay)
☐ MS24* (SG Silver Coinsurance)
☐ MS25* (SG Silver Copay)
☐ MS26** (SG Bronze)
☐ SE05/SE55** (SG Bronze HDHP 40% HSA Eligible)

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 dependents under the age of 19 are included in all Sutter Health Plus health benefit plans. Please refer to your EOC for coverage information.

Section B: Employee 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:

Previous Name (if any):	Primary Spoken Language:

Work Address: (Must be a street address. P.O. Boxes are not accepted)	City:	State:	ZIP:

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: 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:

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: Other Coverage Information

If you or any of your above listed dependents have other health care 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 E: Agreement

Member accepts the terms, conditions and provisions of the Group Subscriber Contract and Evidence of Coverage and Disclosure Form, upon completion and execution of this Enrollment 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, SHP 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 Evidence of Coverage and Disclosure Form.

X_____

Employee Signature Date