

SMALL GROUP PLAN (1-100)

EMPLOYER HEALTH CARE COVERAGE APPLICATION

SUTTER HEALTH PLUS

Language Assistance

If you have questions about completing this application (in English or another language), please contact Sutter Health Plus 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 you are working with a broker, you may also call him or her for assistance.

Availability of Group Subscriber Contract, Evidence of Coverage and Disclosure Form

This application 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 applying for coverage with 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).

Sutter Health Plus must receive a binder check for the application to be complete.

Mail, Fax, or Scan/Email your completed form to:

Sutter Health Plus
P.O. Box 160345
Sacramento, CA 95816
Secured Fax:
Email:

All documents must be sent encrypted/secured if not please fax all documents

Please keep a copy of this application for your records.

Group Name:

DBA:

Requested Effective Date:

Section 1: Benefit Plan Selection

Section 1a: HMO Plan Selection

Please select the plan(s) you would like:

- MS28* (SG \$25)
- MS29* (SG Platinum Coinsurance 2016)
- MS30* (SG Platinum Copay 2016)
- MS27* (SG \$30-\$1500)
- MS22* (SG Gold Coinsurance 2016)
- MS23* (SG Gold Copay 2016)
- MS24* (SG Silver Coinsurance 2016)
- MS25* (SG Silver Copay 2016)
- MS26** (SG Bronze 2016)
- SE05/SE55** (SG Bronze HDHP 40% HSA Eligible)

Please select any and all subaccounts that apply. Please handwrite the name of any additional subaccounts if needed.

- | | |
|---|--------------------------------|
| <input type="checkbox"/> Active | <input type="checkbox"/> _____ |
| <input type="checkbox"/> COBRA | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Early Retirees | <input type="checkbox"/> _____ |

How many invoices do you need? _____

Section 1b: Optional Benefits Selection

Please select the optional benefit plan(s) you would like:

Please note that the Sutter Health Plus core medical plan covers federal and state required essential health benefits, which include, but are not limited to pediatric dental, pediatric vision benefits and acupuncture (please refer to Acupuncture Rider Disclosure). The optional benefits available below are in addition to the essential health benefits already included in the core medical plan. For a detailed description of what is covered under the core medical plan, please speak with your broker or contact Sutter Health Plus.

Dental (Delta Dental)

Adult Dental HMO / DS01
only _____

Decline
only _____

Chiropractic _____

Vision (VSP)

Plan A / VA01 12/24/24

Plan B / VA02 12/12/24

Plan C / VA03 12/12/12

Decline

Decline All Optional Benefits

Acupuncture and Chiropractic (ACN)

Acupuncture

Chiropractic

Acupuncture and

Decline

Section 2: Group information

Legal Company Name:

Street Address: (Must be a street address. P.O. boxes not accepted)		City:	County:	State:	ZIP:
Federal Employer I.D. Number:	SCIN/NAICS Code:	Other Language Considerations:			
Phone:	Fax:	Chief Executive Officer or Proprietor Name:			

Who is your Worker's Compensation Carrier?

Worker's Compensation Policy Number: _____

Are your benefits subject to ERISA regulations? Yes No

Benefits Administrator:

Phone:

Fax:

Email:

Same as above:
 Yes No

Billing Contact (if different from Benefits Administrator):

Billing Address (if different from physical address):

Billing City:

Billing State:

Billing Zip:

Billing Contact E-mail:

Billing Contact Phone:

Section 2b: Group Information Continued

Type of Organization: Sole Proprietorship Corporation Partnership

Other: _____

Employer Contribution: Employees: _____ % of premium Dependents: _____ % of premium

Note: Employer must contribute a minimum of 50% of eligible employee only premium

Employee Eligibility

Minimum hours worked per week: _____

Employee Participation:

1. Total Number of Employees:.....

2. Number of Part-Time, Seasonal, and Temporary Employees:.....

3. Number of Eligible Employees (Subtract Line 2 from Line 1):

4. Number of Eligible Employees Declining or Waiving Coverage (Complete Waiver):

5. Total Number of Eligible Employees Enrolling (Subtract Line 4 from Line 3):

2-19 Employees Cal-COBRA 20+ Employees Federal COBRA

Sutter Health Plus by default will set plan deductibles and out-of-pocket maximums to calendar year. Please check here if you prefer plan year.

Plan year

Will Sutter Health Plus be the only carrier? Yes No

If "No," name of other

carrier(s): _____

Plan (s)

offered: _____

Prior carrier:

Section 2c: Broker Information

Broker Name:

Broker Agency:

Sutter Health Plus Broker ID #:	ACal L&D License #:	License Expiration Date:
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Section 3: Premium Payment Information

Section 3a: Initial Premium Payment

Initial premium payment must be in the form of a corporate check payable to Sutter Health Plus and must be received before the group submission is considered complete. Starter checks will not be permitted unless accompanied by a letter from your financial institution confirming your account name and address.

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

Section 3b: Subsequent Premium Payments

For payment options, please refer to your group approval letter or contact Account Services Monday through Friday 8 a.m. to 5 p.m. at 855-325-5200.

Section 4: Employer Agreement

MANDATORY ARBITRATION:

Group, Member (including any heirs or assigns) and Sutter Health Plus (SHP) agree and understand that any and all disputes by and between them, 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 claims subject to ERISA, shall be determined by submission to 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. Each party, including any heirs or assigns, to this Agreement is giving up its constitutional right to have any such dispute decided in a court of law before a jury, and instead is accepting 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 _____

Employer Signature

Print Name and Title

Today's 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 anytime 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.

Employee eligibility dates are determined by the employer as listed on the Employee Enrollment Form. Generally, employers cannot impose a waiting period greater than 90 days. Benefits are effective the first of the month following the waiting period. If you have questions about rules on waiting periods, please consult your legal counsel.