Large Group Plan

2024 Employee Enrollment/Change Form

How to use this form:

You may use this form to enroll in a Sutter Health Plus plan. You may also use this form to notify us of changes to existing members, such as a name, address, telephone number, or subaccount change. 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.

This form is not used to notify us of a subscriber termination.

How to submit your application:

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

Employers, please email or fax the completed form to:



EMAII

shpenrollmentmailbox@sutterhealth.org



Important Note

The Affordable Care Act (ACA) requires Sutter Health Plus to collect the Social Security numbers (SSNs) for all enrolled 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. 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.**

Group Name and ID	Effective Date
Subaccount Name and ID (If applicable)	

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 healthcare coverage options and rates.

Enrollment - Please complete entire form.

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)			
*** Please complete section C			



Section A - Benefit Plan Selection

elect the plan you would	l like:					
Plan ID	Plan ID		Plan ID			
	oyer, you and your depender overage by checking the bo		matically enrolled	in the optional adult vi	ision benefit	plan. Howev
	me or my dependents in the this coverage until the nex	•			•	tand that I w
etion B – Employee In	formation					
ast Name			First Name			MI
ender Da	ate of Birth (Required)	Social Securi	ty Number (Requir	ed) Me i	mber ID Num	ber
esidential Address			City		State	ZIP
ome Phone	Mobile Phone	Work	Phone	Email Address		•
lailing Address (P.O. Box	c accepted) Same a	s residential	City	<u>*</u>	State	ZIP
revious Name (If any)			Primary Spoken I	_anguage	·····	
If you do not select a P	u need to select a primary c PCP, one will be assigned. Yo 855-830-3500) or on the Me	ou have the opp	ortunity to change	your PCP by calling M	lember Servio	
I would like to sele	ect a PCP I wou	uld like a PCP a	ssigned			
PCP First Name			PCP Last Name			

Current Patient?

No

Yes

Provider ID#

Ρ

¹Unknown/Undeclared/Nonbinary

ction C1 – Spo	use/Domestic Partner	Add to my plan	Remove fro	om my plan		
Spouse Domestic Partner	Last Name		First Name			МІ
Gender M F	Date of Birth (Requ	ired) Social Security Nu	mber (Required)	Email Address		
Residential Add	dress		City		State	ZIP
Mailing Addres	s (P.O. Box accepted)	Same as residential	City		State	ZIP
l would l	ike to select a PCP	I would like a PCP	assigned			
PCP First Na	ame		PCP Last Name	9		
Provider ID#	ŧ		Current Patie	ent? No		

ection C2 – Dependen	t Add to my plan Remo	ve from my plan	
Last Name		First Name	MI
Gender M F U ¹	Date of Birth (Required) Social Security	Number (Required) Email Address	*
Residential Address		City	State ZIP
Mailing Address (P.O.	Box accepted) Same as residentia	City	State ZIP
I would like to	select a PCP I would like a PC	P assigned	
PCP First Name		PCP Last Name	
Provider ID#		Current Patient? Yes No	

¹Unknown/Undeclared/Nonbinary

tion C3 – Dependent	Add to my plan	Remove from m	y plan		
ast Name	, , , , , , , , , , , , , , , , , , , ,	First N			MI
Gender Dat	e of Birth (Required) Soci	al Security Number (Re	equired) Email Addres	SS	<u>i</u>
Residential Address		City		State	ZIP
Mailing Address (P.O. Box	accepted) Same as	s residential City		State	ZIP
I would like to selec	t a PCP I wou	ıld like a PCP assigned	i		
PCP First Name		PCP La	ast Name		
Provider ID# P			rent Patient? Yes No		
ction C4 – Dependent	Add to my plan	Remove from m	y plan		
ast Name		First N	ame		MI
Gender Dat	e of Birth (Required) Soci	al Security Number (Re	equired) Email Addres	ss	
Residential Address		City		State	ZIP
				-	

I would like to select a PCP	I would like a PCP assigned
PCP First Name	PCP Last Name
Provider ID#	Current Patient? Yes No

¹Unknown/Undeclared/Nonbinary

Section D - Other Coverage Information

Will you or one of your depend	dents have any other health	plan coverage (in addition	to Sutter Health Plus) after your enrollment
effective date?				

Yes No

If you check yes, Sutter Health Plus will send you a Coordination of Benefits Form to complete and return.

Section E - Agreement

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 855-315-5800 (TTY 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, 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

Notice of Language Assistance

IMPORTANT: Can you read this? If not, Sutter Health Plus can have somebody help you read it. You may also be able to get this written in your language. For no-cost help, please call Sutter Health Plus Member Services at 855-315-5800 (TTY 855-830-3500). (English)

IMPORTANTE: ¿Puede leer esto? Si no puede, Sutter Health Plus puede proporcionarle alguien que le ayude a leerlo. También puede obtenerlo por escrito en su idioma. Llame a Sutter Health Plus Member Services al 855-315-5800 (TTY 855-830-3500), sin costo alguno. (Spanish)

重要提示:您能讀懂這份文件嗎?如果不能,Sutter Health Plus 可以找人幫助您讀它。您還可能得到用您的語言書寫的這份文件。若需要免費幫助,請致電Sutter Health Plus會員服務,電話號碼855-315-5800 (TTY 855-830-3500)。(Chinese)

نوكى دق (Sutter Health Plus) سالب شلى هرتص نأ ملعاف ارداق نكت مل اذا ؟اذه ةءارق علىع رداق تن أله: قمهم قطوحلم قدعاسم علىع لوصحلل. كتغلب ابوتكم هاقلتت نأ اضًى أكنكمى المك. صنل اذه ةءارق يف كتدعاسم هنكمى اصخش مهىدل (Sutter Health Plus Member) سالب شلى هرتص ءاضعاً تامدخب لاصتال عاجرب ،قىناجم (Arabic) يى رمل صنل فت اله 200 -315-855 فت اله على Services) يى رمل صنل فت اله على المناه على

ԿԱՐԵՎՈՐ ՏԵՂԵԿԱՏՎՈՒԹՅՈՒՆ. Կարո՞ղ եք կարդալ սա։ Եթե ոչ, Sutter Health Plus-ը կարող է տրամադրել մեկին, ով կօգնի Ձեզ կարդալ այն։ Դուք կարող եք նաև ստանալ այն գրված Ձեր լեզվով։ Անվձար օգնության համար խնդրում ենք զանգահարել Sutter Health Plus-ի Անդամների սպասարկման բաժին՝ 855-315-5800 (TTY 855-830-3500) հեռախոսահամարով։ (Armenian)

សារៈសំខាន់៖ តីអ្នកអាចអានសចេក្ដីនរះឬទ? បីសិនមិនអាចទ Sutter Health Plus អាចមាននរណាម្មនាក់ ជួយអានវាជនអ្នក ។ អ្នកក៏អាចនឹងឲ្យបានសចេក្ដីនរះសរសរជោភាសារបស់អ្នកដរែ។ សំរាប់ជំនួយ ដាយឥតអស់ថ្លៃ សូមទូរស័ព្ទទៅ ផុនកែសវោសមាជិក Sutter Health Plus តាមលខេ 855-315-5800 (TTY 855-830-3500)។ (Cambodian)

ىدرف زا دناوت ىم Sutter Health Plus ،ديناوت ىمن رگا ؟ديم هفب و ديناو خب ار بلااطم نيا ديناوت ىم اي آ: مهم هتكن تامدخ تفايرد ى ارب. دراد دوجو ى سراف نابز هب بلااطم ني اهجرت ناكم انين چمه. دناو خب ناتي ارب ارن آ ات دري گب كمك نفلت هرامش اب Sutter Health Plus ى اض عا تامدخ رتف د اب افطل ،ناگي ار كمك و (Farsi)ديري گب سامت (3500-3508-835 TTY) 5800-3588

सहत्वर्पूण: क्या आप इसे पढ़ सकते/सकती हैं? यदि नहीं, तो सट्टर हेल्थ प्लस इसे पढ़ने में किसी से आपकी सहायता करवा सकता है। आप इसे अपनी भाषा मे भी लिखवाने में सर्मथ हो सकते/सकती हैं। निःशुल्क सहायता के सिए, कृपया 855-315-5800 (TTY 855-830-3500) पर सट्टर हेल्थ प्लस मेंबर र्सविसेस को कॉल करें। (Hindi)

LUS TSEEM CEEB: Koj nyeem puas tau tsab ntawv no? Yog koj nyeem tsis tau, Sutter Health Plus muaj neeg pab nyeem rau koj. Tsis tas li ntawd xwb, peb tuaj yeem muab sau ua hom lus koj nyeem tau rau koj tib si. Yog koj xav tau kev pab pub dawb, thov hu rau Sutter Health Plus Lub Chaw Pab Cuam Tswv Cuab ntawm tus xov tooj 855-315-5800 (TTY 855-830-3500). (Hmong)

重要なお知らせ:これを読むことができます?読めない場合は、Sutter Health Plus が読むのをお手伝いします。あなたの言語で表示できるかもしれません。無料のご相談は、Sutter Health Plus Member Services、電話: 855-315-5800 (TTY 855-830-3500) まで。(Japanese)

중요: 귀하는 이것을 읽으실 수 있습니까? 만약 읽으실 수 없다면, Sutter Health Plus 에서 다른 사람에게 부탁하여 그것을 읽으실 수 있도록 도와드릴 수 있습니다. 또한 이것을 귀하의 사용 언어로 작성해 받으실 수도 있습니다. Sutter Health Plus 회원 서비스 855-315-5800 (TTY 855-830-3500)에 전화를 하시어 무상으로 도움을 받으십시오. (Korean)

ໝາຍເຫດ: ທານອານໄດຈ໌ດີໝາຍສະບຸບັນບີ? ຖາ້ອທານອານບໄດ, ້ທາງ Sutter Health Plus ມພີະນຸກັງານຊວ່ຍ ອານໃຫທ້ານ. ນອກຈາກນັ້ນ, ພວກເຮົາຍັງສາມາດຂຽນເປັນພາສາຂອງທານໃຫທ້ານອກີດວ້ຍ. ຖາ້ທານຕອ້ງການ ຄວາມຊວ່ຍເຫຼືອໂດຍບຸເສຍຄາບລໍກິານ, ກະລຸນາຕດິຕ ໜວ່ຍບລໍກິານ ຂອງ Sutter Health Plus ທີ່ໝາຍເລກໂທລະສັບ 855-315-5800 (TTY 855-830-3500). (Laotian)

ਅਹਮਿ: ਕੀ ਤੁਸੀਂ ਇਸ ਨੂੰ ਪੜ੍ਹ ਸਕਦੇ ਹੋ? ਜੇ ਨਹੀਂ ਤਾਂ, Sutter Health Plus (ਸੱਟਰ ਹੈਲਥ ਪਲਸ) ਕਿਸੇ ਤੋਂ ਇਹ ਪੜ੍ਹਨ ਵਿੱਚ ਤੁਹਾਡੀ ਮੱਦਦ ਕਰਵਾ ਸਕਦਾ ਹੈ। ਤੁਸੀਂ ਇਸ ਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਵੀ ਲਖਿਵਾ ਸਕਦੇ ਹੋ। ਮੁਫ਼ਤ ਮੱਦਦ ਲਈ ਕਰਿਪਾ ਕਰ ਕੇ Sutter Health Plus Member Services ਨੂੰ 855-315-5800 (TTY 855-830-3500) ਉਤੇ ਕਾਲ ਕਰੋ। (Punjabi)

ВАЖНО: Вы можете это прочитать? Если нет, Sutter Health Plus может предоставить Вам кого-то, кто сможет помочь Вам прочитать это. Вы также можете получить это в письменной форме на своем языке. Для бесплатной помощи позвоните в Службу поддержки членов Sutter Health Plus по телефону 855-315-5800 (TTY 855-830-3500). (Russian)

MAHALAGA: Nababasa mo ba ito? Kung hindi, maaari kang bigyan ng Sutter Health Plus ng taong babasa para sa iyo. Maaari mo ding hilingin na isulat ito sa iyong wika. Para sa walang-gastos na tulong, mangyaring tumawag sa Sutter Health Plus Member Services sa. 855-315-5800 (TTY 855-830-3500). (Tagalog)

สำคัญ: คุณอำนออกหรือไม่ ถ้าอำนไม่ออก Sutter Health Plus สำมารถให้คนมำช่วยคุณอำนได้ นอกจำกนี คุณยังสำ มารถขอรับเนื้อหำนีเป็นภำษำของคุณได้อีกด้วย หำกต้องกำรควำมช่วยเหลือโดยไม่มีคำใช้จำย กรุณำโทรหำ Sutter Health Plus Member Services ที่ 855-315-5800 (TTY 855-830-3500) (Thai)

QUAN TRONG: Qu. vị có thể đọc thông tin này không? Nếu không, Sutter Health Plus có thể yêu cầu ai đó đọc giúp cho qu. vị. Qu. vị cũng có thể nhận được thông tin này dưới dạng văn bản bằng ngôn ngữ của qu. vị. Để được hỗ trợ miễn phí, vui lòng gọi cho ban Dịch Vụ Thành Viên của Sutter Health Plus theo số 855-315-5800 (TTY 855-830-3500). (Vietnamese)