

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:



EMAIL

shpenrollmentmailbox@sutterhealth.org



FAX

916-736-5426

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)

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 healthcare 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)

*** Please complete section C

Section A – Benefit Plan Selection

Select the plan you would like:

Plan ID Plan ID Plan ID

Optional Vision Benefit

If selected by your employer, you and your dependents 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.

Section B – Employee Information

Last Name		First Name		MI
Gender	Date of Birth (Required)	Social Security Number (Required)		Member ID Number
M F U ¹				
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 – You need to select a primary care physician (PCP) for yourself and each covered family member. If you do not select a PCP, one will be assigned. You have the opportunity to change your PCP by calling Member Services at 855-315-5800 (TTY 855-830-3500) or on the Member Portal. To find a PCP, please visit sutterhealthplus.org/providersearch.

I would like to select a PCP

I would like a PCP assigned

PCP First Name

PCP Last Name

Provider ID#

Current Patient?

P

Yes No

¹ Unknown/Undeclared/Nonbinary

Section C – Dependent Information

Section C1 – Spouse/Domestic Partner

Add to my plan

Remove from my plan

Spouse Domestic Partner	Last Name	First Name	MI
Gender	Date of Birth (Required)	Social Security Number (Required)	Email Address
M F U ¹			
Residential Address	City	State	ZIP
Mailing Address (P.O. Box accepted)	Same as residential	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?
P	Yes No

Section C2 – Dependent

Add to my plan

Remove from my plan

Last Name	First Name	MI	
Gender	Date of Birth (Required)	Social Security Number (Required)	Email Address
M F U ¹			
Residential Address	City	State	ZIP
Mailing Address (P.O. Box accepted)	Same as residential	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?
P	Yes No

¹ Unknown/Undeclared/Nonbinary

Section C – Dependent Information Cont.

Section C3 – Dependent

Add to my plan

Remove 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 residential	City	State	ZIP

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

Section C4 – Dependent

Add to my plan

Remove 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 residential	City	State	ZIP

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

¹ Unknown/Undeclared/Nonbinary

Section D – Other Coverage Information

Will you or one of your dependents 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

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)

ໝາຍເຫຼວ: ທ່ານອ່ານໄດ້ຈັດໝາຍສະບັບນີ້ບໍ່? ຖ້າອ່ານບໍ່ໄດ້, ທາງ Sutter Health Plus ມື້ຮຽນກຳລັງຊ່ວຍອ່ານໃຫ້ທ່ານ. ນອກຈາກນັ້ນ, ພວກເຮົາຍັງສາມາດຂຽນແບ່ງພາສາຂອງທ່ານໃຫ້ທ່ານອີກດ້ວຍ. ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃດໆບໍ່ສາມາດບໍລິການ, ກະລຸນາຕິດຕໍ່ ໂທວ່າຍບໍລິການ 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) ਕਸਿ ਤੇ ਇਹ ਪੜ੍ਹਨ ਵੱਚਿ ਤੁਹਾਡੀ ਮੱਦਦ ਕਰਵਾ ਸਕਦਾ ਹੈ। ਤੁਸੀਂ ਇਸ ਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵੱਚਿ ਵੀ ਲਿਖਿਵਾ ਸਕਦੇ ਹੋ। ਮੁਫਤ ਮੱਦਦ ਲਈ ਕਰਿਪਾ ਕਰੋ Sutter Health Plus Member Services ਨੂੰ 855-315-5800 (TTY 855-830-3500) ਉੱਤੇ 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: คุณอ่านออกหรือไม่ ถ้าอ่านไม่ออก Sutter Health Plus สามารถให้คนมาช่วยคุณอ่านได้ นอกจากนี้ คุณยังสามารถขอรับเนื้อหานี้เป็นภาษาของคุณได้อีกด้วย หากต้องการความช่วยเหลือโดยไม่มีค่าใช้จ่าย กรุณาโทรหา Sutter Health Plus Member Services ที่ 855-315-5800 (TTY 855-830-3500) (Thai)

QUAN TRỌNG: 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)