Large Group Plan

Employee Enrollment/Change Form

How to use this form:

You may use this form to enroll coverage with Sutter Health 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 Plan.

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

How to submit your application:

For Sutter Health Plan 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:

Important Note

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

Employer Group Name Schools Insurance Group

Sutter Health Plan Account Number 074120

Effective Date

Subaccount Name and Group Number (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 Change

From Subaccount ID _____ To Subaccount ID _____

** **Date of qualifying event** (If not open enrollment) _____

*** Please complete section C

Sutter Health Plan

Section A – Benefit Plan Selection

Select the plan you would like:

☐ Plan ID Traditional HMO (ML41) ☐ Plan ID 1000 DHMO (LG24) ☐ Plan ID 1750 HDHP HMO (HL14) ☐ Plan ID 2500 HDHP HMO (HL13)

Optional 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.

Section B – Employee Information

Last Name | **First Name** | **MI**

Gender ☐ M ☐ F ☐ U[1] | **Date of Birth** (Required) | **Social Security Number** (Required) | **Member ID Number**

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 Customer Service at **855-315-5800** (TTY 855-830-3500) or on the Member Portal. To find a PCP, please visit **sutterhealthplan.org/providersearch**.

☐ **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 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
☐ 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 C2 – 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 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 Plan) after your enrollment effective date?

☐ **Yes** ☐ **No**

If you check yes, Sutter Health Plan 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 Plan. 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 Plan with those of other carriers. To obtain a copy, contact your employer or call Sutter Health Plan Customer Service **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 Plan 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 Plan uses binding arbitration as the final method for resolving all such disputes.

As a condition of your membership in Sutter Health Plan, you agree that any and all disputes between yourself (including any heirs or assigns) and Sutter Health Plan, 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 Plan, 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**