

Small Group Plan

2027 Employer Healthcare Coverage Application

How to submit this application:

You must email or fax your signed and completed form to Sutter Health Plan. Missing information may delay processing your application.



EMAIL

shpserviceteam@sutterhealth.org



FAX

916-736-5418

To complete the application process, please make your initial premium payment online or by check. (Please select one.)

☐ **ONLINE**

Pay your initial premium through the Sutter Health Plan Online Payment Center:

sutterhealthplan.org/binderpayment

If you paid online, please include the email confirmation number for faster processing.

Confirmation # _____

☐ **CHECK**

Sutter Health Plan

P.O. Box 278136

Sacramento, CA 95827-8136

If paying by check, please include a copy with your application for faster processing.

Legal Company Name

DBA (Account Name)

Requested Effective Date

Section A – Benefit Plan Selection (All deductibles and out-of-pocket maximums will accrue on a calendar-year basis.)

STANDARD PLANS

Section A1 – HMO Standard Plan Selection

Platinum

☐ MS01 HMO

Gold

☐ SD42 HDHP HMO

☐ MS10 HMO

☐ MS32 HMO

Silver

☐ SD41 HDHP HMO

☐ MS45 HMO

Bronze

☐ SD33 HDHP HMO

☐ MS59 HMO

PLUS PLANS

Section A2 – HMO Plus Plan Selection (Plus plans include embedded Infertility benefits)

Platinum

☐ MP01 HMO

Gold

☐ SP42 HDHP HMO

☐ MP10 HMO

☐ MP32 HMO

Silver

☐ SP41 HDHP HMO

☐ MP45 HMO

Bronze

☐ SP33 HDHP HMO

☐ MP59 HMO

All Sutter Health Plan plans prescription drug coverage is, on average, expected to equal or exceed the standard Medicare Part D benefit value. 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 any time after they were 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.

Section A3 – Optional Benefits Selection

☐ Decline all optional benefits

Please select the plan(s) you would like:

Acupuncture and Chiropractic

Not available for HDHPs

- ☐ Acupuncture-only plan ID
- ☐ Chiropractic-only plan ID
- ☐ Acupuncture and Chiropractic plan ID
- ☐ Decline

Dental

- ☐ Adult Dental HMO/DS01
- ☐ Decline

Vision

- ☐ Plan A / VA01 12/24/24
- ☐ Plan B / VA02 12/12/24
- ☐ Plan C / VA03 12/12/12
- ☐ Decline

Section A4 – Subaccounts (Enrollment/Billing Unit)

Are any special or additional subaccounts needed (other than standard Active and/or COBRA)?

If Yes, complete the subaccount rows below. If a physical address is the same as listed in Section B, leave address blank.

☐ Yes ☐ No

Use this section to identify any subaccounts and provide address and billing details, if applicable. Complete one row for each subaccount. Standard Active and COBRA subaccounts do not need to be listed separately unless the physical address or billing setup differs from the primary street address listed in Section B below.

Subaccount #1**Subaccount Type** (select all that apply)

Active COBRA Cal-COBRA* Early Retirees Other:

Physical street address for this subaccount (only complete if different from primary street address listed in Section B)**Street Address** (P.O. Boxes not accepted)**City****State****ZIP****Separate invoice needed for this subaccount?** (If yes, provide address below.)

Yes

No

Billing Address**City****State****ZIP****Subaccount #2****Subaccount Type** (select all that apply)

Active COBRA Cal-COBRA* Early Retirees Other:

Physical street address for this subaccount (only complete if different from primary street address listed in Section B)**Street Address** (P.O. Boxes not accepted)**City****State****ZIP****Separate invoice needed for this subaccount?** (If yes, provide address below.)

Yes

No

Billing Address**City****State****ZIP**

*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.

Section A5 – Subaccounts Cont.

Subaccount #3

Subaccount Type (select all that apply)

Active

COBRA

Cal-COBRA*

Early Retirees

Other: _____

Physical street address for this subaccount (only complete if different from primary street address listed in Section B)

Street Address (P.O. Boxes not accepted)

City

State

ZIP

Separate invoice needed for this subaccount? (If yes, provide address below.)

Yes

No

Billing Address

City

State

ZIP

Subaccount #4

Subaccount Type (select all that apply)

Active

COBRA

Cal-COBRA*

Early Retirees

Other: _____

Physical street address for this subaccount (only complete if different from primary street address listed in Section B)

Street Address (P.O. Boxes not accepted)

City

State

ZIP

Separate invoice needed for this subaccount? (If yes, provide address below.)

Yes

No

Billing Address

City

State

ZIP

Optional Notes / Clarifications

*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.

Section B – Group Information

Street Address (P.O. Boxes not accepted)		City	County	State	ZIP
Federal Employer ID Number		SIC Code*			
Phone	Fax	Chief Executive Officer or Proprietor			
Workers' Compensation Carrier		Workers' Compensation Policy Number			
☐ We affirm that we have a valid legal exemption from Workers' Compensation coverage requirements pursuant to the California Labor Code.					
Are your benefits subject to ERISA regulations? ☐ Yes ☐ No					
Type of Organization					
☐ Sole Proprietorship ☐ Corporation ☐ Partnership ☐ LLC ☐ Other _____					

Benefits Administrator / Enrollment Contact		Title			
Phone		Email			
Correspondence Address ☐ Same as street address above		City	State	ZIP	
Billing Contact (If different from above)		Billing Address ☐ Same as correspondence address			
Billing City		Billing State		Billing ZIP	
Billing Contact Email		Billing Contact Phone			

Note: Additional contacts can be provided via a separate sheet. Please provide name, title, email address and phone number.

Employer Contribution (A value is required for both employees and dependents. If N/A, enter "0.")

Employees _____ % of premium or \$ _____ Dependents _____ % of premium or \$ _____

Please apply: ☐ Across all plans ☐ To the lowest-cost plan

Note: Employer must contribute a minimum of 50% of eligible employee premium for the lowest-cost medical plan offered by the employer.

Employee Eligibility Minimum hours worked per week _____

* Look up your SIC Code on the Division of Corporation Finance: Standard Industrial Classification (SIC) Code List at sec.gov/info/edgar/siccodes.htm.

Section B – Group Information Cont.

Total Employee Participation (Please enter a value for each line. If N/A, enter "0.")

..... **Total full-time and full-time equivalent employees** (Sole proprietors, spouses of sole proprietors, partners of partnership and the spouses of partners are not eligible employees pursuant to California Health and Safety Code section 1357.500.)

..... **Total eligible employees in group**

Of the total number of eligible employees, please tell us:

..... Number of employees enrolling with Sutter Health Plan

..... Number of waivers (enrolled with another carrier offered by this employer)

..... Number of waivers (for any other reason)

Eligible Employees – Employees eligible for health plan benefits who live, physically work or reside within the Sutter Health Plan licensed service area.

Full-time Employee – Employee working a minimum of 30 hours per week on average.

Full-time Equivalent (FTE) Employee – A combination of employees, each of whom individually is not a full-time employee, but who, in combination, are equivalent to a full-time employee.

Will Sutter Health Plan be the only carrier? ☐ Yes ☐ No

If "No":

Name of other carrier(s)

Plan(s) offered

Prior carrier

Note: Please be advised that Sutter Health Plan does not permit age-banded rates to be used alongside small employer rates.

Continuation Coverage

☐ Federal COBRA (20 or more employees for at least 50% of the previous calendar year.)

☐ Cal-COBRA (Up to 19 employees for at least 50% of the previous calendar year.)

Federal COBRA Administrator's Contact Information

Vendor

Contact Name

Correspondence Address

City

State

ZIP

Phone

Email

Please mail the COBRA billing statement to:

☐ COBRA Administrator

☐ Group Benefits Administrator

Section C – Broker & General Agency Information

Section C1 – Broker Information

Broker Agency Name

Agency License Number and Expiration Date

Exp.

Sutter Health Plan Agency ID

A-

Broker/Agent Name

Agent License Number and Expiration Date

Exp.

Sutter Health Plan Agent ID

C-

Broker Account Manager Name

Broker Account Manager Email

Section C2 – General Agency Information

General Agency Name

General Agency Contact Name

Section D – Premium Payment Information

Section D1 – Initial Premium Payment

You can make your initial premium payment online or by check. If paying by check, it must be in the form of a corporate check payable to Sutter Health Plan and received before the group submission is considered complete. Temporary checks will not be permitted unless accompanied by a letter from your financial institution confirming your account name and address.



ONLINE

Pay your initial premium through the Sutter Health Plan Online Payment Center:

sutterhealthplan.org/binderpayment



CHECK

Sutter Health Plan
P.O. Box 278136
Sacramento, CA 95827-8136

Section D2 – Subsequent Premium Payments

You can make your subsequent premium payments online or by check.



ONLINE

After you register for a portal account, you can pay your monthly premium online through your Sutter Health Plan portal account and the Sutter Health Plan Online Payment Center.

shplan.org/employerportal



CHECK

Please make your check payable to Sutter Health Plan and include your Sutter Health Plan account name and account number with your payment.

Sutter Health Plan
P.O. Box 278136
Sacramento, CA 95827-8136

If you have questions about completing this form, please contact Sutter Health Plan Customer Service at **855-315-5800**.

This application is part of the Group Subscriber Contract, which includes the Evidence of Coverage and Disclosure Form (EOC). By signing this application form, you are accepting the terms, conditions, and provisions contained in the enrollment form as well as those in the Group Subscriber Contract and EOC. You have the right to read the Group Subscriber Contract and EOC before applying for coverage with Sutter Health Plan. To obtain a copy, contact your broker or call Sutter Health Plan Customer Service at **855-315-5800** (TTY 855-830-3500).

Mandatory Arbitration

Group, member (including any heirs or assigns) and Sutter Health Plan 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 EOC.

.....	
Employer Signature	Date
.....	
Print Name and Title	

Note: 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.