

Small Group Plan

2027 Employee Enrollment/Change Form

How to use this form:

You may use this form to enroll in 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:



EMAIL

shpserviceteam@sutterhealth.org



FAX

916-736-5426

Important Note

The Affordable Care Act (ACA) requires Sutter Health Plan to collect the Social Security number (SSN) or individual taxpayer identification number (ITIN) for each enrolled member. 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 or ITIN other than as required by law. **Please be sure to include all SSNs or ITINs where requested.**

Employer Group Name

Sutter Health Plan Account Number

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)

- ☐ Plan Change**
- ☐ 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

Section A – Benefit Plan Selection

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

Optional Adult 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.

Note: Pediatric vision benefits for members up to age 19 (until the end of the month in which the member turns 19 years of age) are included in all Sutter Health Plan small group plans. Please refer to your Evidence of Coverage for coverage information.

Section B – Employee Information

Last Name

First Name

MI

Gender

☐ M ☐ F ☐ U¹

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 can change your PCP by calling Customer Service at **855-315-5800** (TTY 855-830-3500) or on the Member Portal at shplan.org/memberportal. To find a PCP, please visit sutterhealthplan.org/find-provider.

☐ I would like to select my PCP

☐ I would like a PCP assigned

PCP First Name

PCP Last Name

Provider ID#

P

Current Patient?

Yes

No

¹Unknown/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#

P

Current Patient?

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#

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 ☐ U¹

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 ☐ U¹

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 the 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 the 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.

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Employee Signature

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Date