Individual and Family Plan

2026 Healthcare Coverage Application/Enrollment/Change Form

How to use this form:

You may use this form to apply for a Sutter Health Plan individual and family plan or make changes to an existing policy. **Do not use this form to notify us of a termination.**

Please note:

- If you are selecting the same plan for yourself, spouse/domestic partner or dependent(s), please complete one application.
- If your spouse/domestic partner or dependent(s) want a different plan they must complete a separate application.
- You and your dependents* (other than a dependent child) must live or reside in the Sutter Health Plan licensed service area to be eligible for coverage.
- If you or any dependent you're applying for are entitled to Medicare Part A or are enrolled in Medicare Part B, that applicant is not eligible to apply for new Sutter Health Plan coverage; visit **Medicare.gov** to learn more about Medicare plan options.

The Health Insurance Counseling & Advocacy Program (HICAP) provides health insurance counseling to senior California residents free of charge by calling **800-434-0222**. You may also contact your local HICAP for more information about Medicare rights and benefits (see page 9 for contact information).

How to submit your application:

You must email, fax or mail your signed and completed form to us. Missing information may delay processing your application. **Do not include payment with your application.**

EMAIL
shpifp@sutterhealth.org

FAX
916-736-5090

MAIL
Sutter Health Plan
P.O. Box 160345
Sacramento, CA 95816

How to submit your first month's premium payment:

If you are applying for coverage as a new policyholder, or on behalf of a new policyholder, please make your first month's premium payment online or by check.

ONLINE
Pay your first month's premium through the Sutter Health Plan Online Payment Center:

sutterhealthplan.org/binderpayment

CHECK
Complete the Remittance Slip on page 10 and make your check payable to Sutter Health Plan.

Mail your first month's premium and completed Remittance Slip to:

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

Do not include your application with your payment; it may delay processing your application.

Important Note

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

Language Assistance

If you have questions about completing this application, please contact Sutter Health Plan Customer Service at **855-315-5800** (TTY 855-830-3500), Monday through Friday, from 8 a.m. to 7 p.m. We provide translation services and other language assistance services to you free of charge. If you are working with a broker, you may also call them for assistance. If a broker helped you read and complete this application, they must sign the application (see Section H).

* A dependent may be:

- Your spouse.
- Child of a subscriber or spouse.
- Parent or stepparent of a subscriber who meets the definition of a qualifying relative under section 152(d) of Title 26 of the United States Code.

Sutter Health Plan

Section A – Enrollment

Is the applicant an existing or former Sutter Health Plan member? ☐ Yes ☐ No

If Yes, please include your Member ID here .....

Enrollment Period

☐ **Annual Open Enrollment Period**

☐ **Special Enrollment Period**

Qualifying Event Date .....

Please complete the Attestation Form for Qualifying Events for Special Enrollment included.

☐ **Contact Information Change Only**

Name Change

Address Change

Phone Number Change

Enrollment or Change Type

☐ **New Enrollment**

☐ **Existing Subscriber**

Change Plan

Add Dependent(s)

Requested Effective Date .....

Section A1 – Plan Details and Account Information

Select the plan you would like

☐ (2026) Platinum MI01 HMO* ☐ (2026) Gold MI02 HMO* ☐ (2026) Silver MI03 HMO* ☐ (2026) Bronze MI04 HMO*

Sections to Complete

If you are applying for coverage for:

- Yourself only (subscriber), complete **Section B** (and **Section E** if applicable).
- Child only, complete **Sections B, D and E**.

If you are applying for any other coverage, complete **Sections B and C** (and **Section D** if applicable).

If you are updating or changing name, address or phone, complete **Section B** for subscriber (and **Section C** for dependents if information is different from subscriber).

You need to select a primary care physician (PCP) for yourself and each covered family member. Please include your PCP's name and provider ID in **Sections B and C**.

* 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 B – Subscriber Information

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

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

Residential Address | **City** | **State** | **ZIP**

Home Phone | **Mobile Phone** | **Work Phone**

Mailing Address (P.O. Box accepted) ☐ Same as residential | **City** | **State** | **ZIP**

Previous Name (If any) | **Primary Spoken Language**

Is the subscriber purchasing this plan using a health reimbursement arrangement (HRA)? ☐ Yes ☐ No

If yes, please select what type:

Individual Coverage Health Reimbursement Arrangement (ICHRA)

Qualified Small Employer Health Reimbursement Arrangement (QSEHRA)

With an ICHRA or QSEHRA, your employer funds an account that helps you pay your monthly premiums and out-of-pocket costs for your plan as an alternative to traditional group health insurance.

Please note that using your employer's HRA to cover these costs will not affect your eligibility for a Sutter Health Plan individual and family plan.

PCP Information – You need to select a 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 my 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

☐ Spouse
☐ Domestic Partner

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

Gender
☐ M ☐ F ☐ U[1]

Date of Birth (Required) | **Social Security Number** (Required) | **Email**

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 One ☐ Add to my plan

☐ Child
☐ Parent/ Stepparent

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

Gender
☐ M ☐ F ☐ U[1]

Date of Birth (Required) | **Social Security Number** (Required) | **Email**

Residential Address ☐ Same as subscriber | **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 Continued

Section C3 – Dependent Two ☐ Add to my plan

☐ Child
☐ Parent/ Stepparent

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

Gender
☐ M ☐ F ☐ U[1]

Date of Birth (Required) | **Social Security Number** (Required) | **Email**

Residential Address ☐ Same as subscriber | **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 Three ☐ Add to my plan

☐ Child
☐ Parent/ Stepparent

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

Gender
☐ M ☐ F ☐ U[1]

Date of Birth (Required) | **Social Security Number** (Required) | **Email Address**

Residential Address ☐ Same as subscriber | **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 – Financially Responsible Party for Applicant to be Covered (for child only or court ordered coverage obligations)

If the financially responsible party is someone other than the applicant, please complete the information below.

Last Name | **First Name**

Email (Required) | **Home Phone** | **Mobile Phone** | **Work Phone**

Section E – Parent or Legal Guardian (if the primary applicant is a child under 18)

Parent or Legal Guardian #1

☐ Same as financially responsible party

Last Name | **First Name**

Email (Required) | **Home Phone** | **Mobile Phone** | **Work Phone**

Parent or Legal Guardian #2

Last Name | **First Name**

Email (Required) | **Home Phone** | **Mobile Phone** | **Work Phone**

Section F – Premium Payment Information and Effective Date

Section F1 – First Month's Premium Payment

To avoid any delay in coverage, we will begin processing your enrollment as soon as we receive your completed application. Please make your first month's premium payment online or by check when submitting your completed application. If we do not receive your first month's premium payment within 45 days of your application's postmark date, your application for coverage will be considered void. We will notify you of your effective date in your acceptance letter. If you have questions regarding your enrollment status, please contact your broker or Sutter Health Plan Customer Service at **855-315-5800** (TTY 855-830-3500), Monday through Friday, from 8 a.m. to 7 p.m.

ONLINE

Pay your first month's premium through the Sutter Health Plan Online Payment center:

sutterhealthplan.org/binderpayment

CHECK

Make your check payable to Sutter Health Plan. Please use the Remittance Slip on page 10 and send your initial premium payment to:

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

[1] Unknown/Undeclared/Nonbinary

Section F – Premium Payment Information and Effective Date Continued

Section F2 – Subsequent Premium Payments

To ensure we promptly process and post payments to your account, please mail premium checks to the following address:

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

Please include the subscriber identification number in the memo line of your check.

You also have the choice to pay your premium online once you have created your Sutter Health Plan Member Portal account. For more information, please call Sutter Health Plan Customer Service at **855-315-5800** (TTY 855-830-3500).

Section F3 – New Dependent Effective Date Notification

If you and your dependents are enrolling together, the effective date for the primary applicant (subscriber) will also apply to all dependents.

A newborn child is automatically covered from the moment of birth for 30 days following birth. The child must be enrolled within 60 days after birth for membership to become effective and continue coverage beyond the first 30 days after birth. A newly adopted child's (including a child placed with you for adoption) membership will begin on the date when the adopting parent gains the legal right to control the child's healthcare. Please reference the Indvidual and Family Plan Membership Agreement and Evidence of Coverage and Disclosure Form (EOC) for more information on enrolling a newborn or adopted child.

Section G – 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 H – Agent, Broker or Representative Information

For applicants using an insurance agent, broker, or representative

A $20 per member per month commission will be paid to the agent or agency on a monthly basis for which the coverage is effective and premium has been received. Premiums are the same whether or not you use an agent, broker, or other representative.

Agent, Broker, or Representative Name .....

[1] Unknown/Undeclared/Nonbinary

Section H – Agent, Broker or Representative Information Continued

Section H1 – To be completed by your agent, broker or representative after completion of this application.

If you have assisted the applicant in submitting the application, the law requires that you attest to this assistance. If, in making this attestation, you state as true any material fact you know to be false, you will be subject to a civil penalty of up to ten thousand dollars ($10,000), as authorized under California Health and Safety Code section 1389.8I or Insurance Code section 10119.3, in addition to any other applicable penalties or remedies available under current law.

I assisted the applicant in submitting this application. To the best of my knowledge, the information on this application is complete and accurate. I explained to the applicant, in easy-to-understand language, the risk to the applicant of providing inaccurate information, and the applicant understood the explanation.

Agent, Broker or Representative Signature

Date

Last Name

First Name

MI

Mailing Address

City

County

State

ZIP

Phone

Fax

Email

Agency Name

Agent License Number

SHP ID Number

C-

Section I – Member Agreement (Please read the following information carefully.)

This application is part of the Individual and Family Plan Membership Agreement and EOC. By signing this form, you are accepting the terms, conditions, and provisions contained in this form and the Individual and Family Plan Membership Agreement and EOC. You have the right to read the Individual and Family Plan Membership Agreement and EOC before applying for coverage or enrolling in 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).

Agreement to be Bound
I declare that I have read this application, the answers provided, and the documents enclosed. I have had an opportunity to review the Individual and Family Plan Membership Agreement and EOC (Agreement) and by signing this document accept all terms and rates and conditions set forth in the Agreement. I certify that the information provided with this application is true, complete and correct to the best of my knowledge.

If this application is accepted by the health plan, then my signature will result in a binding contract with the healthcare coverage, terms and conditions set forth in the Individual and Family Plan Subscriber Contract and EOC.

Authorization to Release Information
I authorize Sutter Health Plan to disclose to my Sutter Health Plan broker or agent the status of my application for coverage, as well as that of any Applicant on whose behalf I am executing this authorization, including whether an application was received, accepted, or rejected; if accepted, the effective date of coverage; and information regarding the status of bills and payments for amounts due for coverage.

Third-Party Recovery
I understand that by signing below I am agreeing to grant a lien on third-party recoveries. For more information please refer to the section entitled Third-Party Responsibility – Subrogation in the Individual and Family Plan Subscriber Contract and EOC.

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 Individual and Family Plan Subscriber Contract and EOC.

Applicant/Financially Responsible Party **Date**

HICAP Contact Information by County

Alameda
333 Hegenberger Rd., Ste. 850
Oakland, CA 94621
510-839-0393

Contra Costa
400 Ellinwood Way
Pleasant Hill, CA 94523
800-510-2020

El Dorado
505 12th St.
Sacramento, CA 95814
916-376-8915

Nevada
505 12th St.
Sacramento, CA 95814
916-376-8915

Placer
505 12th St.
Sacramento, CA 95814
916-376-8915

Sacramento
505 12th St.
Sacramento, CA 95814
916-376-8915

San Francisco
601 Jackson St., 2nd Floor
San Francisco, CA 94133
415-677-7520

San Joaquin
505 12th St.
Sacramento, CA 95814
916-376-8915

San Mateo
1710 S. Amphlett Blvd., Ste. 100
San Mateo, CA 94402
650-627-9350

Santa Clara
3100 De La Cruz Blvd., Ste. 310
Santa Clara, CA 95054
408-350-3200, option 2

Santa Cruz
3333 Soquel Dr., Ste. A
Soquel, CA 95073
831-462-5510

Solano
1129 Industrial Ave., Ste. 201
Petaluma, CA 94954
707-526-4108

Sonoma
1129 Industrial Ave., Ste. 201
Petaluma, CA 94954
707-526-4108

Stanislaus
3500 Coffee Rd., Ste. 19
Modesto, CA 95355
209-558-4540

Sutter
505 12th St.
Sacramento, CA 95814
916-376-8915

Yolo
505 12th St.
Sacramento, CA 95814
916-376-8915

Remittance Slip

Sutter Health Plan

Effective Date _____

Subscriber Name _____

Social Security Number (last four digits only) _____

Phone _____

Email _____

Amount Paid $

Address

_____

_____

_____

Please remit check payable to Sutter Health Plan:

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

Attestation Form

Qualifying Events for Special Enrollment

You may enroll or change your coverage outside of the annual enrollment period if you meet one of the requirements for a qualifying event. To be considered eligible in most cases, your application for coverage due to a qualifying event must occur within 60 days of the qualifying event. An eligible individual or dependent who experiences a loss of minimum essential coverage has 60 days prior to and 60 days following the loss of coverage to enroll. Unless otherwise indicated, coverage will become effective the first day of the month following receipt of the application.

The monthly premium rate is determined based on the member's age as of the coverage effective date. It's important to note individual and family plans follow a calendar year cycle and will renew on January 1 of the following year, regardless of the initial effective date. When coverage renews, the renewal rate is based on the member's age as of January 1 of the new plan year.

Instructions: Select the applicable qualifying/triggering event below and complete the qualifying event details section. Be sure to sign and date the attestation and submit this form along with your Healthcare Coverage Application/Enrollment/Change Form and first month's premium (if applicable).

Qualifying/Triggering Events	
☐	**Loss of minimum essential healthcare coverage due to a reason that is not your fault. For example:** • Changes in employer-sponsored coverage, such as termination of employment, reduction in work hours, changes in employer premium contribution, or exhaustion of COBRA benefits • The death of the individual responsible for coverage • Changes in dependent status • Termination of government-sponsored coverage, such as Medi-Cal • Nonpayment of premium by a financially interested third-party entity Coverage will be effective on the first day of the month following either the date other coverage ends or the date Sutter Health Plan receives the application, whichever is later. Loss of coverage due to voluntary termination, failure to pay premiums and rescission do not qualify as triggering events.
☐	Gain or become a dependent due to marriage or domestic partnership.
☐	Gain a dependent parent or stepparent pursuant to California Health & Safety Code Section 1374.1.
☐	Gain or become a dependent due to birth, adoption, placement for adoption, or placement in foster care. Coverage will be effective on the date of the event unless you request a later effective date.
☐	Court order to provide coverage. Coverage will be effective on the date the court order is effective unless you request a later effective date.
☐	You are receiving services for one of the following conditions from a contracting provider that is no longer participating in the health benefit plan: • Acute condition • Terminal illness • Pregnancy • Serious chronic condition • Authorized surgery or procedure • Care of a newborn child between birth and age 36 months
☐	Permanent relocation into a Sutter Health Plan service area.
☐	Return from active duty service in the U.S. military reserve forces or the California National Guard.
☐	Divorce, legal separation, or dissolution of domestic partnership.
☐	Death of a dependent.

Qualifying/Triggering Events Cont.

☐	Change in eligibility for federal financial assistance through Covered California, including if your employer is changing or discontinuing your current coverage options.
☐	Released from incarceration.
☐	Health coverage issuer substantially violated a material provision of the health coverage contract.
☐	Did not enroll in health coverage during the previous annual enrollment period because you were misinformed that you were covered under minimum essential coverage.
☐	Enrollment or non-enrollment in health coverage was unintentional, inadvertent, or erroneous due to the error, misrepresentation, misconduct, or inaction of a Covered California employee, agent, or other entity providing enrollment assistance or conducting enrollment activities.
☐	Victims of domestic abuse or spousal abandonment, including a dependent or unmarried victim within a household, who are currently enrolled in minimum essential coverage and seek to apply for coverage apart from the perpetrator of the abuse or abandonment. Dependents of a victim of domestic abuse or spousal abandonment, on the same application as the victim, may enroll in coverage at the same time as the victim.
☐	Applied for Medi-Cal coverage, either through Covered California or a local county human services agency, and was determined ineligible after open enrollment ended after a qualifying event.
☐	You (or a dependent) newly gains access to, or are being provided a Health Reimbursement Arrangement Integrated Individual Health Insurance Coverage or Qualified Small Employer Health Reimbursement Arrangement.

Qualifying Event Details

Date of Qualifying Event .....

Individual(s) that experienced the Qualifying Event

Requested Effective Date .....

I hereby attest that I and/or my dependent(s) have experienced a qualifying event to be eligible for a special enrollment period. By signing this attestation, I certify that the information provided above is true, complete and accurate to the best of my knowledge.

Applicant / Financially Responsible Party **Date**

Email, fax or mail your materials to:

Email: **shpifp@sutterhealth.org**
Fax: **916-736-5090**

Sutter Health Plan
P.O. Box 160345
Sacramento, CA 95816

sutterhealthplan.org