Large Group Plan

2022 Employee Enrollment/Change Form

Important Note
The Affordable Care Act (ACA) requires Sutter Health Plus to collect the Social Security numbers (SSN) for all enrolled family 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.**

Change Request
This form is also used to inform us of changes to existing members, such as a name, address, telephone number or sub-account change. **This form is not used to notify us of a subscriber termination.** 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.

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
You must encrypt or secure any documents sent by email. If you cannot encrypt or secure emails, please fax all documents and keep a copy for your files.

Group Name _____ **Effective Date** _____

Subaccount Name _____

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 health care 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*

Sutter Health Plus
Your Health Plan

Section A – Benefit Plan Selection

Select the plan(s) 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 ☐ M ☐ F | **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 Member Services at 1-855-315-5800 (TTY 1-855-830-3500) or on the Member Portal.

To find a PCP, please visit ***sutterhealthplus.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

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

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

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

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

☐ 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

Section C2 – Dependent ☐ Add to my plan ☐ Remove from my plan

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

Gender
☐ M ☐ F

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

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

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

☐ 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

Section C – Dependent Information Cont.

Section C3 – Dependent ☐ Add to my plan ☐ Remove from my plan

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

Gender ☐ M ☐ F | **Date of Birth** | **Social Security Number** *(Required)*

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

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

☐ **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

Section C4 – Dependent ☐ Add to my plan ☐ Remove from my plan

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

Gender ☐ M ☐ F | **Date of Birth** | **Social Security Number** *(Required)*

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

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

☐ **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

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 1-855-315-5800 (TTY 1-855-830-3500). 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**

Notice of Language Assistance

IMPORTANT: Can you read this? If not, Sutter Health Plus can have somebody help you read it. You may also be able to get this written in your language. For no-cost help, please call Sutter Health Plus Member Services at 1-855-315-5800 (TTY 1-855-830-3500). (English)

IMPORTANTE: ¿Puede leer esto? Si no puede, Sutter Health Plus puede proporcionarle alguien que le ayude a leerlo. También puede obtenerlo por escrito en su idioma. Llame a Sutter Health Plus Member Services al 1-855-315-5800 (TTY 1-855-830-3500), sin costo alguno. (Spanish)

重要提示：您能讀懂這份文件嗎？如果不能，Sutter Health Plus 可以找人幫助您讀它。您還可能得到用您的語言書寫的這份文件。若需要免費幫助，請致電Sutter Health Plus會員服務，電話號碼 1-855-315-5800 (TTY 1-855-830-3500)。(Chinese)

ملحوظة مهمة: هل أنت قادر على قراءة هذا؟ إذا لم تكن قادرًا فاعلم أن لصتر هيلث بلاس (Sutter Health Plus) قد يكون لديهم شخصًا يمكنه مساعدتك في قراءة هذا النص. كما يمكنك أيضًا أن تتلقاه مكتوبًا بلُغتك. للحصول على مساعدة مجانية، برجاء الاتصال بخدمات أعضاء لصتر هيلث بلاس (Sutter Health Plus Member Services) على هاتف 1-855-315-5800 هاتف النص المرئي (Arabic) .(1-855-830-3500[TTY])

ԿԱՐԵՎՈՐ ՏԵՂԵԿԱՏՎՈՒԹՅՈՒՆ. Կարո՞ղ եք կարդալ սա։ Եթե ոչ, Sutter Health Plus-ը կարող է տրամադրել մեկին, ով կօգնի Ձեզ կարդալ այն։ Դուք կարող եք նաև ստանալ այն գրված Ձեր լեզվով։ Անվճար օգնության համար խնդրում ենք զանգահարել Sutter Health Plus-ի Անդամների սպասարկման բաժին՝ 1-855-315-5800 (TTY 1-855-830-3500) հեռախոսահամարով։ (Armenian)

សារៈសំខាន់ៈ តើអ្នកអាចអានសេចក្តីនេះឬទេ? បើសិនមិនអាចទេ Sutter Health Plus អាចមាននរណាម្នាក់ជួយអានវាជូនអ្នក ។ អ្នកក៏អាចនឹងធ្វើយ៉ាងនេះសរសេរជាភាសារបស់អ្នកដែរ។ សំរាប់ជំនួយដោយឥតអស់ថ្លៃ សូមទូរស័ព្ទទៅ ផ្នែកសេវាសមាជិក Sutter Health Plus តាមលេខ 1-855-315-5800 (TTY 1-855-830-3500)។ (Cambodian)

نكته مهم: آيا می تواني اين مطلب را بخواني و بفهمي؟ اگر نمی تواني، Sutter Health Plus می تواند از فردی کمک بگيرد تا آنرا برايتان بخواند. همچنين امکان ترجمه اين مطلب به زبان فارسی وجود دارد. برای دريافت خدمات و کمک رايگان، لطفا با دفتر خدمات اعضای Sutter Health Plus با شماره تلفن تماس بگيريد(Farsi).1-855-315-5800 (TTY 1-855-830-3500)

महत्वर्पूण: क्या आप इसे पढ़ सकते/सकती हैं? यदि नहीं, तो सट्टर हेल्थ प्लस इसे पढ़ने में कसिी से आपकी सहायता करवा सकता है। आप इसे अपनी भाषा मे भी लखिवाने में सर्मथ हो सकते/सकती हैं। नःशुल्क सहायता के लएि, कृपया 1-855-315-5800 (TTY 1-855-830-3500) पर सट्टर हेल्थ प्लस मेंबर र्सवसिेस को कॉल करें। (Hindi)

LUS TSEEM CEEB: Koj nyeem puas tau tsab ntawv no? Yog koj nyeem tsis tau, Sutter Health Plus muaj neeg pab nyeem rau koj. Tsis tas li ntawd xwb, peb tuaj yeem muab sau ua hom lus koj nyeem tau rau koj tib si. Yog koj xav tau kev pab pub dawb, thov hu rau Sutter Health Plus Lub Chaw Pab Cuam Tswv Cuab ntawm tus xov tooj 1-855-315-5800 (TTY 1-855-830-3500). (Hmong)

重要なお知らせ：これを読むことができます？読めない場合は、Sutter Health Plus が読むのをお手伝いします。あなたの言語で表示できるかもしれません。無料のご相談は、Sutter Health Plus Member Services、電話: 1-855-315-5800 (TTY 1-855-830-3500) まで。(Japanese)

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 1-855-315-5800 (TTY 1-855-830-3500)에 전화를 하시어 무상으로 도움을 받으십시오. (Korean)

ໝາຍເຫດ: ທ່ານອ່ານໄດ້ຈັດໝາຍສະບັບນີ້? ຖ້າອ່ານບໍ່ໄດ້, ທາງ Sutter Health Plus ມີພະນັກງານຊ່ວຍອ່ານໃຫ້ທ່ານ. ນອກຈາກນັ້ນ, ພວກເຮົາຍັງສາມາດຂຽນເປັນພາສາຂອງທ່ານໃຫ້ທ່ານອີກດ້ວຍ. ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໂດຍບໍ່ເສຍຄ່າບໍລິການ, ກະລຸນາຕິດ ຕໍ່ພະນັກງານ ບໍລິການ ຂອງ
Sutter Health Plus ທີ່ໝາຍເລກໂທລະສັບ 1-855-315-5800 (TTY 1-855-830-3500). (Laotian)

ਅਹਮਿ: ਕੀ ਤੁਸੀਂ ਇਸ ਨੂੰ ਪੜ੍ਹ ਸਕਦੇ ਹੋ? ਜੇ ਨਹੀਂ ਤਾਂ, Sutter Health Plus (ਸੱਟਰ ਹੈਲਥ ਪਲਸ) ਕਸਿੇ ਤੋ ਇਹ ਪੜ੍ਹਨ ਵਚਿ ਤੁਹਾਡੀ ਮੱਦਦ ਕਰਵਾ ਸਕਦਾ ਹੈ। ਤੁਸੀਂ ਇਸ ਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਚਿ ਵੀ ਲਖਿਵਾ ਸਕਦੇ ਹੋ। ਮੁਫ਼ਤ ਮੱਦਦ ਲਈ ਕਰਿਪਾ ਕਰ ਕੇ Sutter Health Plus Member Services ਨੂੰ 1-855-315-5800 (TTY 1-855-830-3500) ਉਤੇ 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 1-855-315-5800 (TTY 1-855-830-3500). (Russian)

MAHALAGA: Nababasa mo ba ito? Kung hindi, maaari kang bigyan ng Sutter Health Plus ng taong ba-basa 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. 1-855-315-5800
(TTY 1-855-830-3500). (Tagalog)

สำคัญ: คุณอ่านออกหรือไม่ ถ้าอ่านไม่ออก Sutter Health Plus สามารถให้คนมาช่วยคุณอ่านได้ นอกจากนี้ คุณยังสามารถขอรับเนื้อหานี้เป็นภาษาของคุณได้อีกด้วย หากต้องการความช่วยเหลือโดยไม่มีค่าใช้จ่าย
กรุณาโทรหา Sutter Health Plus Member Services ที่ 1-855-315-5800 (TTY 1-855-830-3500) (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 1-855-315-5800 (TTY 1-855-830-3500). (Vietnamese)