INDIVIDUAL AND FAMILY PLAN

2020 Health Care Coverage Application/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

Subscribers use this form to inform us of changes. **This form is not used to notify us of a termination.**

For Sutter Health Plus to process your request, you must sign and send the completed form to Sutter Health Plus (see information below). Missing information may delay processing.

Email, fax or mail your completed form to:

Email: *shpifp@sutterhealth.org*
Fax: 1-916-736-5090

Sutter Health Plus
2480 Natomas Park Dr., Ste. 150
Sacramento, CA 95833

You must mail your first month's premium when you apply for coverage (for new policy holders). Make your check payable to Sutter Health Plus. Please use the remittance slip on page 9 and send to:

Sutter Health Plus
P.O. Box 740143
Los Angeles, CA 90074-0143

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.

Language Assistance

If you have questions about completing this application, please contact Sutter Health Plus Member Services at 1-855-315-5800 (TTY 1-855-830-3500), Monday through Friday from 8 a.m. to 7 p.m. Sutter Health Plus provides translation services and other language assistance services to you free of charge. If you are working with a broker, you may also call him or her for assistance. The broker who helped you read and complete this application must sign the application (see Section H).

Sutter Health Plus
Your Health Plan

Section A – Enrollment

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

If Yes, please include your Subscriber 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

☐ **Demographic Change Only**

Name Change

Address Change

Phone Number Change

Enrollment or Change Type

☐ **New Enrollment**

Subscriber Only

Subscriber and Spouse/Domestic Partner

Subscriber and Child(ren)

Child Only

Family: Subscriber, Spouse/Domestic Partner, Child(ren)

☐ **Existing Subscriber**

Change Plan

Add Dependent(s)

Requested Effective Date .....

Section A1 – Plan Details and Account Information

Select the plan you would like

☐ (2020) Platinum MI01 HMO* ☐ (2020) Gold MI02 HMO* ☐ (2020) Silver MI03 HMO* ☐ (2020) 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**.

*****This plan's prescription drug coverage is, on average, expected to equal or exceed the value of standard Medicare Part D benefit. 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 he or she was 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.*

******This plan's prescription drug coverage is not, on average, expected to equal or exceed the value of standard Medicare Part D benefit. Therefore, this coverage is considered non-creditable. This is important for individuals who are or will become eligible for Medicare Part D. Most likely, the individual would receive more help with medication costs if he or she joined a Medicare Part D plan than if he or she only had coverage through this plan. The individual could also be subject to a higher premium (a penalty) if he or she does not join a Medicare drug plan when he or she first becomes eligible.

****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.*

Section B – Subscriber Information

Last Name | First Name | MI

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

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 C – Dependent Information Cont.

Section C2 – Dependent One ☐ 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 C3 – Dependent Two ☐ 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 C4 – Dependent Three ☐ 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 – 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** | **MI**

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

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

☐ same as financially responsible party

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

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

Section F – Premium Payment Information and Effective Date

Section F1 – First Month's Premium Payment

For your application to be considered complete, you must mail your first month's premium when you apply for coverage. 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 Plus Member Services at 1-855-315-5800, Monday through Friday from 8 a.m. to 7 p.m.

Make your check payable to Sutter Health Plus. Please use the remittance slip on page 9 and send your initial premium payment to:

Sutter Health Plus
P.O. Box 740143
Los Angeles, CA 90074-0143

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 Plus
P.O. Box 740143
Los Angeles, CA 90074-0143

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 Plus portal account. The online payment center is not available for initial payments. For more information, please call Sutter Health Plus Member Services at 1-855-315-5800.

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 thirty days following birth. The child must be enrolled within 60 days after birth for membership to become effective and continue coverage beyond the first thirty 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 health care. Please reference the Indvidual and Family Plan Membership Agreement and *EOC* for more information on enrolling a newborn or adopted child.

Section G – Other Coverage Information

Do you or any of your dependents covered under Sutter Health Plus have any other health plan coverage (in addition to Sutter Health Plus)?

☐ Yes ☐ No (If "Yes," please complete all of the information below.)

Type of Coverage COBRA Group/Employer Individual Other _____

Will your current health care coverage be terminated upon acceptance or enrollment with Sutter Health Plus? Yes No

Primary Policy Holder Name(s) (Last, First, MI) | **Policy Number** | **Effective Date**

Insurance Carrier Name | **Policy Holder Date of Birth**

All Dependents' Names and Other Health Plan ID Numbers

Section H – Agent, Broker or Representative Information

For applicants using an insurance agent, broker, or representative

The broker of record may receive monetary payments from Sutter Health Plus in connection with the purchase of this coverage. Premiums are the same whether or not you use an agent, broker, or other representative.

Agent, Broker, or Representative Name _____

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 1389.8l 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**

Street Address

City | **County** | **State** | **ZIP**

Phone | **Fax** | **Email Address**

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 *Evidence of Coverage and Disclosure Form* (*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 Plus. To obtain a copy, contact your broker or call Sutter Health Plus Member Services at 1-855-315-5800 (TTY 1-855-830-3500).

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 health care coverage, terms and conditions set forth in the Individual and Family Plan Subscriber Contract and *EOC*.

Authorization To Release Information
I authorize Sutter Health Plus to disclose to my Sutter Health Plus 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 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 Individual and Family Plan Subscriber Contract and *EOC*.

Applicant/Financially Responsible Party **Date**

REMITTANCE SLIP

Sutter Health Plus
Your Health Plan

Effective Date _____

Subscriber Name _____

Social Security Number *(last four digits only)* _____

Address

_____

_____

_____

Amount Paid $

Please remit check or money order payable to Sutter Health Plus:

Sutter Health Plus
P.O. Box 740143
Los Angeles, CA, 90074-0143

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 َصتر 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 َصتر هيلث بلاس (Sutter Health Plus Member Services) على هاتف 1-855-315-5800 الناطق العربي (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 ។ អ្នកក៏អាចនឹងទទួលបានសេចក្តីនេះសរសេរជាភាសារបស់អ្នកដែរ។ សំរាប់ជំនួយដោយឥតអស់ថ្លៃ សូមទូរស័ព្ទទៅ ផ្នែកែសវោសមាជិក Sutter Health Plus តាមលេខ 1-855-315-5800 (TTY 1-855-830-3500)។ (Cambodian)

مهم: آيا می تواني اين مطالب را بخواني و بفهمي؟ اگر نمی تواني، Sutter Health Plus می تواند از فردی که به زبان فارسی وجود دارد. برای دريافت خدمات ترجمه اين مطالب به شما تلفن 1-855-315-5800 (TTY 1-855-830-3500)تماس بگيريد(Farsi).

महत्वपूर्ण: क्या आप इसे पढ़ सकते/सकती हैं? यदि नहीं, तो सट्टर हेल्थ प्लस इसे पढ़ने में किसी से आपकी सहायता करवा सकता है। आप इसे अपनी भाषा मे भी लिखिवाने में समर्थ हो सकते/सकती हैं। निःशुल्क सहायता के लिए, कृपया 1-855-315-5800 (TTY 1-855-830-3500) पर सट्टर हेल्थ प्लस मेंबर सर्विसिस 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? ຖ້າທ່ານອ່ານບໍ່ໄດ, ້ ທາງ Sutter Health Plus ມພ ີ ະນກ ັ ງານຊ ວ ່ ຍອ ່ ານໃຫ ທ ້ ່ ານ. ນ ອ ນ ອ ກ ຈ າ ກ ນ ນ ັ ້ , ພ ວ ກ ເ ຮ ົ າ ຍ ງ ັ ສ າ ມ າ ດ ຂ ຽ ນ ເ ປ ັ ນ ພ າ ສ າ ຂ ອ ງ ທ ່ ານ ໃ ຫ ທ ້ ່ ານ ອ ກ ິ ດ ວ ້ ຍ. ຖ ້ າ ທ ່ ານ ຕ ອ ງ ກ ານ ຄ ວ າ ມ ຊ ວ ່ ຍ ເ ຫ ຼ ື ອ ໂ ດ ຍ ບ ເ ສ ຍ ຄ າ ບ ລ ິ ກ ານ, ກ ະ ລ ຸ ນ າ ຕ ດ ິ ຕ ່ ໜ ວ ່ ຍ ບ ລ ິ ກ ານ ຂ ອ ງ Sutter Health Plus ທ ໜ ີ ່ ງ ໝ າ ຍ ເ ລ ກ ໂ ທ ລ ະ ສ ັ ບ 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)

ATTESTATION FORM

Qualifying Events for Special Enrollment

You may enroll or change your coverage outside of the annual open 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.

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 Health Care Coverage Application/ Enrollment/Change Form and first month premium (if applicable).

Qualifying/Triggering Events

☐ **Loss of minimum essential health care 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

Coverage will be effective on the first day of the month following either the date other coverage ends or the date Sutter Health Plus 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 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 your 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 Plus 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.

☐ Change in eligibility for federal financial assistance through Covered California, including if your employer is changing or discontinuing your current coverage options.

Qualifying/Triggering Events Cont.

☐	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 open enrollment 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 determined ineligible after open enrollment has 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: 1-916-736-5090

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