LARGE GROUP PLAN (101+)

2019 Employer Health Care Coverage Application

Enrollment

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 Plus. To obtain a copy, contact your broker or call Sutter Health Plus Account Services 1-855-315-5800 (TTY 1-855-830-3500).

For Sutter Health Plus to process your request, you must sign and return the last page of this form. To complete the application Sutter Health Plus must receive a binder check. Missing information may delay processing.

Fax or email your completed form to:

Fax: 916-736-5418

Email: *shpsales@sutterhealth.org*

Need Assistance?

If you have questions about completing this form, 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.

Sutter Health Plus
Your Health Plan

Employer Health Care Coverage Application

Group Name _____ DBA _____ Requested Effective Date _____

Section A – Benefit Plan Selection

Section A1 – HMO Plan Selection

Summit	Peak	Ridge	Vista
☐ ML32 HMO*	☐ ML20 HMO*	☐ ML36 HMO*	☐ HD16 HDHP HMO*
☐ ML30 HMO*	☐ ML21 HMO*	☐ ML37 HMO*	☐ HD11 HDHP HMO*
☐ ML34 HMO*	☐ ML22 HMO*	☐ ML35 HMO*	☐ HD14 HDHP HMO*
☐ ML50 HMO*	☐ ML24 HMO*		☐ HD12 HDHP HMO*
☐ ML31 HMO*	☐ ML25 HMO*		
☐ ML51 HMO*			
☐ Other _____	☐ Other _____	☐ Other _____	☐ Other _____

Section A2 – Subaccounts *(Enrollment/Billing Unit)*

Please select any and all subaccounts that apply. Write the name of any additional subaccounts if needed.

- ☐ Active
- ☐ COBRA
- ☐ Cal-COBRA***
- ☐ Early Retirees

_____

- ☐ _____
- ☐ _____
- ☐ _____

How many invoices do you need? _____

***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 A3 – Optional Benefits Selection

Please select the plan(s) you would like:

Dental (Delta Dental)

- ☐ Dental Low / DL01
- ☐ Dental Mid / DL02
- ☐ Dental High / DL03
- ☐ Decline

Acupuncture and Chiropractic (ACN)

Not available for HDHP plans

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

Vision (VSP)

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

Other

- ☐ IF50 Infertility 50% Coinsurance
- ☐ OH20 Orthotics and Special Footwear
- ☐ OP20 Orthotics and Special Footwear
  Not available for HDHP plans
- ☐ Decline

☐ **Decline All Optional Benefits**

Section B – Group Information

Legal Company Name

Street Address *(P.O. Boxes Not Accepted)* | **City** | **County** | **State** | **ZIP**

Mailing Address *(P.O. Boxes Accepted)* ☐ same as above | **City** | **County** | **State** | **ZIP**

Federal Employer ID Number | **SIC Code**

Phone | **Fax** | **Chief Executive Officer or Proprietor**

Who is Your Worker's Compensation Carrier? | **Worker's Compensation Policy Number**

Are your benefits subject to ERISA regulations? ☐ Yes ☐ No

Benefits Administrator | **Title** | **Phone** | **Email**

Billing Contact *(If Different From Above)* | **Billing Address** ☐ same as contact

Billing City | **Billing State** | **Billing ZIP**

Billing Contact Email | **Billing Contact Phone**

Type of Organization ☐ Sole Proprietorship ☐ Corporation ☐ Partnership ☐ Other _____

Employer Contribution Employees _____% of premium Dependents _____% of premium

Note: Employer must contribute a minimum of 50% of eligible employee premium.

Employee Eligibility Minimum hours worked per week _____

Employee Participation

_____ Total full-time equivalent employees

_____ Total eligible employees in group

_____ Total eligible employees waiving medical coverage from all plans

Note: A minimum of 50% participation of eligible employees is required, unless offered on a slice basis.

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)*

Section B – Group Information Cont.

Sutter Health Plus by default will set deductibles and out-of-pocket maximums to calendar year. Please check if you would like a different option.

☐ Other *(Requires prior approval)* .....

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

If "No," list total number of employees enrolled in other group health plan(s) .....

Name of other carrier(s) .....

Plan(s) offered .....

Prior carrier .....

Federal COBRA Administrator's Contact Information

Vendor			Contact Name	
Street Address				**City**
County	**State**	**ZIP**	**Phone**	**Email**

Section C– Broker Information

Broker/Agent Name	Broker Agency	Broker Account Manager Name
Sutter Health Plus Agent ID	**ACal L&D Licesnse**	**License Expiration Date**
C-		

Section D – Premium Payment Information

Section D1 – Initial Premium Payment

Initial premium payment must be in the form of a corporate check payable to Sutter Health Plus and must be received before the group submission is considered complete. Starter checks will not be permitted unless accompanied by a letter from your financial institution confirming your account name and address.

Please send initial premium payment to:
Sutter Health Plus
Attn: Sales Department
2480 Natomas Park Dr., Ste. 150
Sacramento, CA 95833

Section D2 – 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 group or subscriber identification number in the memo line of your check.

Section E – Employer Agreement

Mandatory Arbitration

Group, member (including any heirs or assigns) and Sutter Health Plus 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:** 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.

Waiting period information is for Sutter Health Plus information only. Employee eligibility dates are determined by the employer as listed on the employee enrollment form. 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.