LARGE GROUP PLAN (101+)

2020 Employer Health Care Coverage Application

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

Email or fax your completed form to:
Email: *shpsales@sutterhealth.org*
Fax: 916-736-5418

Legal Company Name	DBA *(Account Name)*	Requested Effective Date

Section A – Benefit Plan Selection

Section A1 – HMO Plan Selection

Summit	Peak	Ridge	Vista
ML28 HMO*	ML20 HMO*	ML57 HMO*	HD19 HDHP HMO*
ML54 HMO*	ML21 HMO*	ML58 HMO*	HD08 HDHP HMO*
ML26 HMO*	ML22 HMO*	ML56 HMO*	HD18 HDHP HMO*
ML29 HMO*	ML24 HMO*		HD09 HDHP HMO*
ML50 HMO*	ML25 HMO*		
ML27 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? ______

**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.*

***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.*

Sutter Health Plus
Your Health Plan

Section A – Benefit Plan Selection Cont.

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 HDHPs

- 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 HDHPs
- 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 Workers' Compensation Carrier? | **Workers' Compensation Policy Number**

Are your benefits subject to ERISA regulations? Yes No

**Look up your SIC Code on the Division of Corporation Finance: Standard Industry Classification (SIC) Code List at sec.gov/info/edgar/siccodes.htm.*

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 ....

Section B – Group Information Cont.

Employer Contribution Employees ____ % of premium or $ ____ Dependents ____ % of premium or $ ____

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

Employee Eligibility Minimum hours worked per week ____

Total Employee Participation

____ Full-time and full-time equivalent employees

____ Eligible employees in group

____ 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.

Eligible Employees – Employees eligible for health plan benefits who live, work or reside within the Sutter Health Plus licensed service area.

Full-time Employee – Employee working a minimum of 30 hours per week on average.

Full-time Equivalent (FTE) Employee – A combination of employees, each of whom individually is not a full-time employee, but who, in combination, are equivalent to a full-time employee.

Sutter Health Plus by default will set deductibles and out-of-pocket maximums to calendar year.

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	Agent License	Agency License	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. Temporary 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 account identification number in the memo line of your check.

Section E – Employer Agreement

If you have questions about completing this form, please contact Sutter Health Plus Member Services at 1-855-315-5800.

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 1-855-325-5200 (TTY 1-855-830-3500).

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: 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.