LARGE GROUP PLAN

2019 Employee Enrollment/Change Form

Enrollment

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*.

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. Individuals who do not have minimum essential coverage and do not qualify for an exemption may be liable for the individual shared responsibility payment. 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, an address, telephone number or sub-account change. **This form is not used to notify us of a 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 sign and return the last page of this form. Missing information may delay processing.

Fax or email your completed form to:

Fax: 916-736-5426

Email: *shpenrollmentmailbox@sutterhealth.org*

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.

Sutter Health Plus
Your Health Plan

Large Group Employee Enrollment / Change Form

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)*

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.

Section A – Benefit Plan Selection

Select the plan(s) you would like:

Plan

Plan

Plan

Optional Adult Vision Benefit

If selected by your employer, you and your dependents age 19 and older 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

Social Security Number *(Required)*

Subscriber 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

Section B – Employee Information Cont.

PCP Information – If you do not select a PCP, one will be assigned to you. 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 Name   Provider ID# P   Current Patient? Yes No

Section C – Dependent Information

Section C1 – Spouse/Domestic Partner

Add: Spouse / Domestic Partner

Last Name   Date of Birth   Gender M F

First Name   MI   Social Security Number *(Required)*

Residential Address   Mailing Address *(P.O. Box Accepted)*   same as residential

City   State   ZIP   City   State   ZIP

I would like to select my PCP   I would like a PCP assigned

PCP Name   Provider ID# P   Current Patient? Yes No

Section C2 – Dependent One

Add: Child 1

Last Name   Date of Birth   Gender M F

First Name   MI   Social Security Number *(Required)*

Residential Address   Mailing Address *(P.O. Box Accepted)*   same as residential

City   State   ZIP   City   State   ZIP

I would like to select my PCP   I would like a PCP assigned

PCP Name   Provider ID# P   Current Patient? Yes No

Section C3 – Dependent Two

Add: Child 2

Last Name   Date of Birth   Gender M F

First Name   MI   Social Security Number *(Required)*

Residential Address   Mailing Address *(P.O. Box Accepted)*   same as residential

City   State   ZIP   City   State   ZIP

I would like to select my PCP   I would like a PCP assigned

PCP Name   Provider ID# P   Current Patient? Yes No

Section C – Dependent Information Cont.

Section C4 – Dependent Three

Add: Child 3

Last Name

Date of Birth

Gender M F

First Name

MI

Social Security Number *(Required)*

Residential Address

Mailing Address *(P.O. Box Accepted)* same as residential

City State ZIP

City State ZIP

I would like to select my PCP I would like a PCP assigned

PCP Name

Provider ID# P

Current Patient? Yes No

Section D – 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.)

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 E – Agreement

Member accepts 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)

نوكى دق (Sutter Health Plus) سالب ثلىه رتصَ نأ ملعاف ارًداق نكت مل اذإ ؟اذه ةءارق ىلع رداق تنأ له: ةمهم ةظوحلم
ةدعاسم ىلع لوصحلل. كتغلُب ابّوتكم هاقلتت نأ اضًىأ كنكمى امك. صنلا اذه ةءارق يف كتدعاسم هنكمى اصًخش مهىدل
فتاه ىلع (Sutter Health Plus Member Services) سالب ثلىه رتصَ ءاضعأ تامدخب لاصتالا ءاجرب ،ةىناجم
1-855-315-5800 هاتف النص المرئي (Arabic) .(1-855-830-3500[TTY])

ԿԱՐԵՎՈՐՏԵՂԵԿԱՏՎՈՒԹՅՈՒՆ.Կարո՞ղեքկարդալսա:Եթեոչ,SutterHealthPlus-ըկարողէտրամադրելմեկին,ով կօգնիՁեզկարդալայն:ԴուքկարողեքնաևստանալայնգրվածՁերլեզվով:ԱնվճարօգնությանհամարխնդրումենքզանգահարելSutterHealthPlus-իԱնդամներիսպասարկմանբաժին՝1-855-315-5800(TTY1-855-830-3500) հեռախոսահամարով: (Armenian)

សារៈសំខាន់៖ តើអ្នកអាចអានសេចក្ដីនេះឬទេ? បើសិនមិនអាចទេ Sutter Health Plus អាចមាននរណាម្នាក់ជួយអានវាជូនអ្នក ។ អ្នកក៏អាចនឹងឲ្យបានសេចក្ដីនេះសរសេរជាភាសារបស់អ្នកដែរ។ សំរាប់ជំនួយដោយឥតអស់ថ្លៃ សូមទូរស័ព្ទទៅ ផ្នែកសេវាសមាជិក Sutter Health Plus តាមលេខ 1-855-315-5800 (TTY 1-855-830-3500)។ (Cambodian)

ىدرف زا دناوت ىم Sutter Health Plus ،ديناوت ىمن رگا ؟ديمهفب و ديناوخب ار بلاطم نيا ديناوت ىم ايآ: مهم هتكن
تامدخ تفايرد ىارب. دراد دوجو ىسراف نابز هب بلاطم نيا همجرت ناكما نينچمه. دناوخب ناتيارب ارنآ ات دريگب كمك
و كمک ناگيار ،افطل اب رتفد تامدخ ءاضعا ى Sutter Health Plus اب هرامش نفلت 1-855-315-5800 (TTY 1-855-830-3500)ديريگب سامت(Farsi).

सहत्वपूर्ण: 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: ທ່ານອ່ານໄດ້ຈົດໝາຍສະບັບນີ້ບໍ່? ຖ້າທ່ານອ່ານບໍ່ໄດ້, ທາງ Sutter Health Plus ມີພະນັກງານຊ່ວຍອ່ານໃຫ້ທ່ານ. ນອກຈາກນັ້ນ, ພວກເຮົາຍັງສາມາດຂຽນເປັນພາສາຂອງທ່ານໃຫ້ທ່ານອີກດ້ວຍ. ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໂດຍບໍ່ເສຍຄ່າບໍລິການ, ກະລຸນາຕິດຕໍ່ ໜ່ວຍບໍລິການ 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) ਕਸਿ ਤੋਂ ਇਹ ਪੜ੍ਹਨ ਵਿੱਚ ਤੁਹਾਡੀ ਮੱਦਦ ਕਰਵਾ ਸਕਦਾ ਹੈ। ਤੁਸੀਂ ਇਸ ਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ 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) ਉੱਤੇ 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)