LARGE GROUP PLAN
2020 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 sign and return page 6 of this form. Missing information may delay processing.

Please email or fax you completed form to:
Your District Office

Group Name Schools Insurance Group

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)*

Sutter Health Plus
Your Health Plan

Section A – Benefit Plan Selection

Select the plan(s) you would like:

☐ HMO ML41 with Acu/Chiro rider XA05 ($15 copay per visit, up to 20 visits in a calendar year)

☐ HD19 1500/3000

☐ HD18 2500/5000

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 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 C – Dependent Information Cont.

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 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 – 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

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 صَتر 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 صَتر 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 ។ អ្នកក៏អាចនឹងទទួលបានសេចក្តីនេះសរសេរជាភាសារបស់អ្នកដែរ។ សំរាប់ជំនួយដាយឥតអស់ថ្លៃ សូមទូរស័ព្ទទៅ ផ្នែកែសវោសមាជិក Sutter Health Plus តាមលេខ 1-855-315-5800 (TTY 1-855-830-3500)។ (Cambodian)

نکته مهم: آیا می توانید این مطلب را بخوانید و بفهمید؟ اگر نمی توانید، Sutter Health Plus می تواند از فردی کمک بگیرد تا آنرا برایتان بخواند. همچنین امکان ترجمه این مطلب به زبان فارسی وجود دارد. برای دریافت خدمات و کمک رایگان، لطفا با دفتر خدمات اعضای Sutter Health Plus با شماره تلفن 1-855-315-5800 (TTY 1-855-830-3500)تماس بگیرید(Farsi).

महत्वर्पूण: क्या आप इसे पढ़ सकते/सकती हैं? यदि नहीं, तो सट्टर हेल्थ प्लस इसे पढ़ने में कसी से आपकी सहायता करवा सकता है। आप इसे अपनी भाषा मे भी लखिवाने में सर्मथ हो सकते/सकती हैं। नःशुल्क सहायता के लिए, कृपया 1-855-315-5800 (TTY 1-855-830-3500) पर सट्टर हेल्थ प्लस मेंबर र्सवसिस 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: ທ່ານອ່ານໄດ້ຈັດີໝາຍສະບັບນີ້ບໍ? ຖ້າທ່ານອ່ານບໍ່ໄດ້, ທາງ Sutter Health Plus
ມີພະນັກງານຊ່ວຍອ່ານໃຫ້ທ່ານ. ນອກຈາກນັ້ນ, ພວກເຮົາຍັງສາມາດຂຽນເປັນພາສາຂອງທ່ານໃຫ້ທ່ານອີກດ້ວຍ. ຖ້
າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໂດຍບໍ່ເສຍຄ່າບໍລິການ, ກະລຸນາຕິດຕໍ່ໜ່ວຍບໍລິການ 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) 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 babasa 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 สำมำรถให้คนมำช่วยคุณอ่านได้ นอกจำกนี คุณยังสำมำรถขอรับเนือหำนีเป็นภำษำของคุณได้อีกด้วย หำกต้องกำรควำมช่วยเหลือโดยไม่มีค่ำใช้จ่าย
กรุณำโทรหำ Sutter Health Plus Member Services ที 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)