Small Group Plan

2023 Employer Healthcare Coverage Application

How to submit this application:

You must email or fax your signed and completed form to Sutter Health Plus. Missing information may delay processing your application.

EMAIL
shpsales@sutterhealth.org

FAX
1-916-736-5418

To complete the application process, please make your initial premium payment online or by check. *(Please select one.)*

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

If paying by check, please include a copy with your application for faster processing.

☐ ONLINE
Pay your initial premium through the Sutter Health Plus Online Payment Center:

sutterhealthplus.org/binderpayment

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

Section A – Benefit Plan Selection *(All deductibles and out-of-pocket maximums will accrue on a calendar year basis.)*

STANDARD PLANS

Section A1 – HMO Standard Plan Selection

Platinum	Gold	Silver	Bronze
☐ MS68 HMO*	☐ SD02 HDHP HMO*	☐ SD01 HDHP HMO*	☐ SD48 HDHP HMO*
☐ MS80 HMO*	☐ MS62 HMO*	☐ MS84 HMO*	☐ MS86 HMO*
	☐ MS77 HMO*		
	☐ MS83 HMO*		

PLUS PLANS

Section A2 – HMO Plus Plan Selection *(Plus plans include embedded Infertility and Special Footwear benefits)*

Platinum	Gold	Silver	Bronze
☐ MP68 Plus HMO*	☐ SP02 Plus HDHP HMO*	☐ SP01 Plus HDHP HMO*	☐ SP48 Plus HDHP HMO*
☐ MP80 Plus HMO*	☐ MP62 Plus HMO*	☐ MP84 Plus HMO*	☐ MP86 Plus HMO*
	☐ MP77 Plus HMO*		
	☐ MP83 Plus HMO*		

** 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 they were 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.*

Sutter Health Plus
Your Health Plan

Section A – Benefit Plan Selection Continued

Section A3 – Optional Benefits Selection ☐ **Decline All Optional Benefits**

Please select the plan(s) you would like:

Acupuncture and Chiropractic (ACN)
Not available for HDHPs

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

Dental (Delta Dental)

- ☐ Adult Dental HMO/DS01
- ☐ Decline

Vision (VSP)

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

Section A4 – Subaccounts *(Enrollment/Billing Unit)*

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

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

- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____

Please list subaccounts (include address) that require a separate invoice:

- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____

**Cal-COBRA enrollees will receive a separate Cal-COBRA Election Notice and Enrollment Form to complete. The notice includes important information regarding healthcare coverage options and rates.*

Section B – Group Information

Legal Company Name

Street Address *(P.O. Boxes not accepted)* | **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

Type of Organization

☐ Sole Proprietorship ☐ Corporation ☐ Partnership ☐ LLC ☐ Other _____

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

Section B – Group Information Cont.

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

Correspondence Address *(P.O. Boxes accepted)* | **City** | **State** | **ZIP**

Billing Contact *(If different from above)* | **Billing Address** ☐ Same as correspondence address

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

Billing Contact Email | **Billing Contact Phone**

Employer Contribution *(A value is required for both employees and dependents. If N/A, enter "0".)*

Employees _____% of premium or $ _____ Dependents _____% of premium or $ _____

Please apply: ☐ Across all plans ☐ To the lowest-cost plan

Note: Employer must contribute a minimum of 50% of eligible employee premium for the lowest-cost medical plan offered by the employer.

Employee Eligibility Minimum hours worked per week _____

Total Employee Participation *(Please enter a value for each line. If N/A, enter "0".)*

_____ Full-time and full-time equivalent employees *(Sole proprietors, spouses of sole proprietors, partners of partnership and the spouses of partners are not eligible employees pursuant to California Health and Safety Code section 1357.500.)*

_____ Eligible employees in group

_____ Eligible employees enrolling in Sutter Health Plus

_____ Eligible employees waiving medical coverage from all plans

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.

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 _____

Section B – Group Information Cont.

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)*

Federal COBRA Administrator's Contact Information

Vendor | **Contact Name**

Correspondence Address | **City**

State | **ZIP** | **Phone** | **Email**

Please mail the COBRA billing statement to: ☐ COBRA Administrator ☐ Group Benefits Administrator

Section C – Broker & General Agency Information

Section C1 – Broker Information

Broker/Agent Name | **Broker Agency**

Broker Account Manager Name | **Sutter Health Plus Agent ID**
C-

Agent License Number and Expiration Date
Exp.

Agency License Number and Expiration Date
Exp.

Section C2 – General Agency Information

General Agency Name
Amwins Connect 942757978

General Agency Contact

Section D – Premium Payment Information

Section D1 – Initial Premium Payment

You can make your initial premium payment online or by check. If paying by check, it must be in the form of a corporate check payable to Sutter Health Plus and 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.

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

ONLINE
Pay your initial premium through the
Sutter Health Plus Online Payment Center:
sutterhealthplus.org/binderpayment

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 Sutter Health Plus account name and account number in the memo line of your check.

You also have the choice to pay your premium online once you've created your Sutter Health Plus Employer Portal account. The online payment center is not available for initial payments. For more information, please call Sutter Health Plus Account Services at 1-855-325-5200.

Section E – Employer Agreement

If you have questions about completing this form, please contact Sutter Health Plus Account Services at 1-855-325-5200.

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 at 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.